'An exploration of how Clinical Commissioning Groups (CCGs) are tackling health inequalities in England'

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An exploration of how Clinical Commissioning Groups are tackling health inequalities

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Table of Contents

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Abbreviations

Full Title	Abbreviation
Alternative Provider of Medical Services	APMS
Clinical Commissioning Group	CCGs
Commissioning Support Unit	CSU
Equitable Access to Primary Medical Care	EAPMC
Equality Impact Assessment	EIA
Foundation Trust	FT
GP Commissioning Consortia	GPCCs
GP Fundholding	GPFH
Health Authorities	HA
Health Action Zone	HAZs
Health Inequalities	HI
Health Education Authority's Integrated Purchasing Programme	HIPP
Health and Wellbeing Board	HWB
Joint Strategic Needs Assessment	JSNA
Joint Health and Wellbeing Strategy	JHWS
Local Authority	LA
Local Area Agreements	LAAs
Local Strategic Partnerships	LSPs
NHS Commissioning Board	NHSCB
NHS England	NHSE
National Health Service	NHS
Overview and Scrutiny Committee	OSC
Practice Based Commissioning	PBC
Public Health	PH
Public Health Consultant	PHC
Public Health England	PHE
Primary Care Groups	PCG
Primary Care Trust	PCT
Personal Medical Services	PMS
Patient and Public Involvement	PPI
Patient and Public Advisory Group	PPAG
Strategic Health Authorities	SHA
Total Purchasing Pilot	TPP
Walk in Centre	WIC

Table of Figures

Abstract

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'An exploration of how Clinical Commissioning Groups (CCGs) are tackling health inequalities in England'

This research aimed to explore how newly forming Clinical Commissioning Groups (CCGs) were tackling health inequalities (HIs) (if at all) in the UK. In 2010 the current coalition government was formed between the Conservatives and Liberal Democrats. Shortly after this, the White Paper Equity and Excellence: Liberating the NHS (Department of Health, 2010a) was published. This was the starting point for a large variety of policy documents being published outlining the healthcare changes that were to happen within the UK. Following the 'pause' a number of amendments to the initial policy proposals were outlined (Department of Health 2011). These included the newly named GPCCs being restructured and renamed as CCGs. Additionally, the Government took on board the recommendations of the Future Forum (June 2011) to make tackling HIs a duty for CCGs.

The concept of HIs itself is very complex with a wide variety of definitions that have been discussed within the literature. It was acknowledged early on within this project that because of the complexities and variations in people's understandings and interpretations of HIs that a fundamental element of understanding how CCGs are tackling health inequalities would be underpinned by individual's own and organisational conceptualisations of HIs.

Three CCGs in the North of England were recruited and qualitative methods, including interviews, observations and document analysis were used to collect data, over a period of 12 months from January 2012-December 2012. The timing of the project meant that data collection was conducted when the NHS was in a state of flux; CCGs were in shadow form, preparing themselves for the authorisation process. Interviews and observations ascertained that HIs were being conceptualised and tackled differently across the three CCGs. There were several common themes that were evidentially important to CCG members when describing the wider influences on their HI understandings and strategies to tackle HIs. These included history, relationships and the role of Public Health. The history of both organisations and relationships were acknowledged by all CCGs in shaping how they had developed under the current policy agenda and how they planned to tackle HIs (if at all). The role of Public Health was a key finding from this research, three different roles were identified, defined and explored in practice, examining how the roles influenced the HIs agenda differently. The Public Health roles of 'service provider', 'co-owner' and 'critical friend' have the potential to shape working relationships between Public Health and the CCG and shape the HIs agenda. Weick's (1995) concept of sensemaking was used to examine how these main findings helped define the HIs agenda. Overall, HIs conceptualisation, strategies to tackle HIs and wider organisational relationships with PH and the LA are not consciously developed by these organisations. History and local contexts help generate schemata that underpin action.

Declaration and Copyright Statement

Declaration:

that no portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning;

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Chapter 1: Thesis Overview

1.1 Introduction

Health inequalities (HIs) have existed on the policy agenda for a number of years. Edwin Chadwick a utilitarian social reformer wrote the first report on HIs in 1842 looking at the sanitary conditions of labourers (Oliver, 2008). After this initial report there was a gap where HIs were no longer a focus. In 1948, with the introduction of the National Health Service (NHS), it was assumed that by introducing free healthcare for all, HIs would be eradicated (Oliver, 2008). However, this dream was not realised, and since then HIs have been a fixture on the policy agenda for both Public Health (PH) and the healthcare service. Policy focusing on HIs has been variable in its political popularity, dependent upon who was in power at any given time. At the same time, the approach taken to tackling HIs has also changed. Initially, policy addressed sanitation and housing, with a clear PH focus. Overtime, other factors deemed influential on health, such as societal position and income have also been researched and used as explanations for HIs. The role of healthcare in tackling HIs has been portrayed as minimal (Exworthy et al., 2006), and has tended to concentrate on the issues of access, prevention and early disease detection to reduce inequalities. However, HIs can be seen to be what has been called a 'wicked issue' (Stewart, 1990), persistent, complex and very difficult to tackle. The most recent publication on HIs in the UK was a comprehensive report by Sir Michael Marmot (2010). He concluded that, although there has been a whole population improvement in health, there is still a clear gradient in health with people at the bottom of the gradient suffering from shorter life expectancies and generally poorer health.

'In England, people living in the poorest neighbourhoods, will, on average, die seven years earlier than people living in the richest neighbourhoods. Even more disturbing, the average difference in disability free life expectancy is 17 years. So, people in poorer areas not only die sooner, but they will also spend more of their shorter lives with a disability' (p 10).

This brief introduction has illustrated how the issue of HIs has been conceptualised differently at different times and from different political perspectives. The HIs agenda has had a long and variable journey through policy within the UK.

1.2 Novelty of the Research

The novelty of the project is that the research was taking place in a period of policy change whilst Clinical Commissioning Groups (CCGs) were forming themselves as new organisations. The research explored how the central government policy objective, a duty to tackle HIs, was constructed and implemented at a local level. This project was conducted across three CCGs so that different perceptions and outcomes could be explored over different geographical areas, enabling site comparisons to be made.

This research project was carried out in a rapidly changing policy environment. When the research project was initially conceptualised the main organisational focus was Primary Care Trusts (PCTs) and their role in tackling HIs. However, since the projects inception, a new Coalition Government was formed and the White Paper Liberating the NHS: Equity and Excellence (2010) was introduced. The proposed changes to the NHS introduced by the White Paper were to abolish PCTs and introduce GP Commissioning Consortia (GPCC) who were to commission services for their local populations. Local Authorities (LA) were given the responsibility of PH with a ring fenced budget. Alongside this Health and Wellbeing Boards (HWB) were being introduced, whose role it is to ensure that the services that are being commissioned are the right ones to address the needs of the local population and provide strategic oversight. These changes were all proposed alongside other recommendations and alterations to the NHS. The proposed changes led to much opposition bringing about a 'policy pause' whereby a listening exercise was sanctioned by the Prime Minister David Cameron to ensure that people's views to the changes were taken onboard and relevant changes could be made before the policies were fully introduced. The listening exercise led to further changes that impacted upon this project as GPCCs were changed to CCGs, the board of which consists of GPs, lay members, a nurse and specialist doctor from secondary care. The changes were initially to be made by 2013 but full control was only to be sanctioned when CCGs themselves and NHS England (NHSE) (previously the NHS Commissioning Board (NHSCB)) felt they were ready. These changes in the policy context were accounted for during the project's development.

There are clear duties that have been imposed on CCGs to tackle HIs. Tackling HIs has never previously been seen as a key responsibility of health services; previously greater responsibility was placed upon PH which is discussed within the thesis. However, under the current policy changes CCGs have been given a responsibility to tackle HIs with area teams of NHSE responsible for ensuring that CCGs are carrying out their duties. NHSE is the new body that will commission certain services, monitor the development of CCGs and also monitor the progress of CCGs ensuring that they deliver their outcomes. (Department of Health, 2011b).

1.3   Thesis outline

This project explored how CCGs were planning to tackle HIs. The aim was to examine how CCGs perceived HIs within their local populations and how these perceptions impacted upon local initiatives to tackle HIs and subsequent outcomes for the community.

The remainder of the thesis will examine the literature around HIs, the policy context of HIs and the clinicians role in tackling HIs. The literature review explores the complexities that are found within the literature, and the influence the changing policy context has had on the overall project. From the literature, clear questions were identified for this project, alongside clear justifications for the choices made. The methodology chapter introduces the methods that were adopted, explaining why they were

chosen and how they were used. Remaining sections then cover the main findings from the research project in detail and discuss the implications of the findings and how they can help shape future work and research projects.

Chapter 2: Literature Review

2.1 Introduction

Health inequalities (HI) is a term widely referred to within the areas of politics, health and research. However the concept itself is very complex and can be explained using a number of different theories. HIs can be described in many ways, and notions of how to deal with HIs differ dependent upon what is perceived as an inequality. This chapter will summarise the different causes / models of HIs and highlight the arguments of how HIs might be tackled. Additionally, this chapter will explore in more detail the potential role of GPs in tackling HIs. The World Health Organisation refers to HIs "*as differences in health status or the distribution of determinants of health across different population groups*" (The World Health Organisation, 2013). HIs can be determined by biological factors, through free will (people's own individual choices) (Kawachi et al., 2002) and also be influenced by an individual's external environment. The London Observatory use a diagram to illustrate the complexities of HIs, illustrating all elements of inequalities from individual risk factors to health outcomes. The model (figure 1 below) demonstrates the complexities of HIs, displaying a number of influential factors.

Figure 1: **Spectrum of Inequalities**
http://www.lho.org.uk/LHO_Topics/National_Lead_Areas/HealthInequalitiesOverview.aspx (Public Health England, 2013 (accessed 19th February 2013))
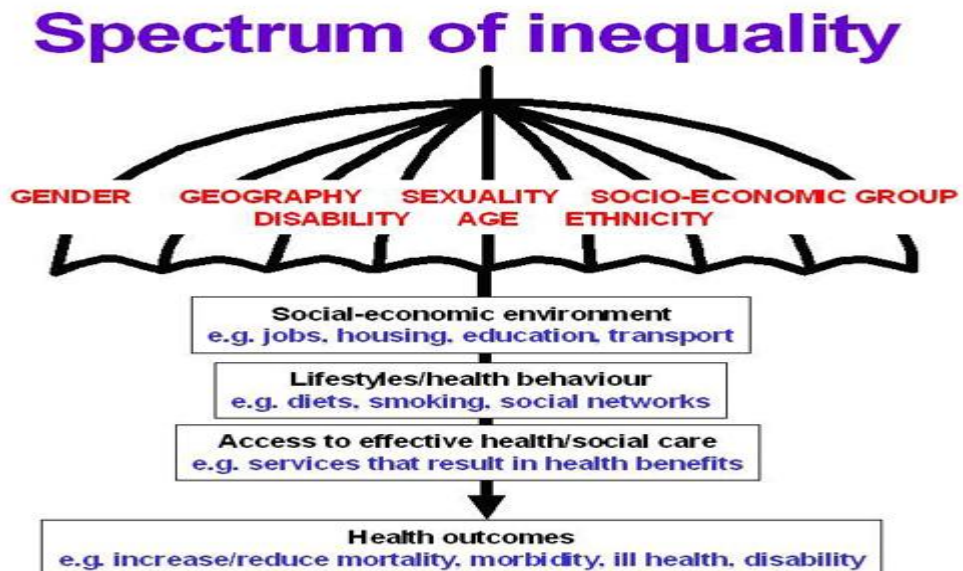
In this chapter I will explore definitions of HIs and different models and arguments of causation that have been constructed around this difficult concept including; the material model, behavioural model, psycho-social model, life course approach and the social determinants of health. Each different model implies a different type of problem and by extension a different way of tackling it. Graham and Kelly (2004) usefully summarise approaches which could involve the healthcare system in tackling HIs.

These consist of, improving health for poor people, tackling health gaps and working with the issue of HIs across the gradient.

2.2 Equity and Equality

Equity is an important component of HIs and is often referred to as an objective; to ensure that people have equal access to services. The concept of health equity suggests that ideally everyone should have a fair opportunity to attain their full health potential (Dahlgren and Whitehead, 1992). The concept of health equity brings its own complexities, and has been defined in many different ways (Whitehead, 1992). Powell and Exworthy (2003) suggest that there are three policy objectives that are of importance to health services. These are universal access, affordability and comprehensive covered benefits. Policy developments have recognised these three main areas; however there has been little success in transferring these concepts of equity into measurable targets (Powell and Exworthy, 2003).

Equity has been defined as both vertical and horizontal, incorporating the needs of individuals as well as referring to the treatment that people receive (Harrison and Hunter, 1999). Morris et al. (2005) define horizontal inequity as the use of differing amounts of care for the same needs, whereas vertical inequity refers to differing amounts of need, which leads to different amounts of care being utilised. This study claimed that most research has focused on issues associated with horizontal equity.

It has been suggested that there are seven different ways in which equity can be defined (Mooney, 1986, Mooney, 1994, Powell and Exworthy, 2003). This supports previous comments that there is no universal agreement on the concept. Thus, resulting in a lack of measurement in the clinical setting to enable professionals to measure equity and challenge any problems they find. The seven definitions of equity suggested are (Exworthy and Powell, 2003 p 53):

- equal expenditure per capita
- equal inputs per capita
- equal need indicators
- equal access for equal need
- equal utilization for equal need
- need met will be identical in all areas
- equal health focuses on health rather than healthcare

From this it can be seen that although equity is seen as a key policy issue within the UK and tackling it is a way of healthcare reducing HIs, there is much confusion around the issue, even in its definition.

Robertson and Burge (2011) examined how patient choice, a key issue in the Health and Social Care Bill (2010) could impact upon equity. Overall, their findings suggested that patient choice could increase inequities. Patients who were more educated and affluent were found to be offered and / or

able to ask for more choice for their services leading to a gradient in inequities of patient choice. Baum (2007) concentrated on PH, arguing that when conducting work on health promotion and HIs, it is important to ensure that these areas are viewed with equity in mind. Otherwise, key programmes that are being used to narrow the gap in health may increase the gap between the groups. Strategies should consider equity, ensuring that population health increases overall whilst the gap is also narrowing between the different groups. Graham & Kelly (2004) suggested that narrowing health gaps by increasing the health of the poorest the fastest was a key strategy for tackling HIs. Trying to improve the health of the poorest at a quicker rate than others will ensure that poorer groups of people are not being continually left behind. Health of all individuals is continually increasing, therefore by increasing the health of poorer groups in a targeted way will take this into account allowing interventions and programmes of work to focus on groups where improvement is needed the most, thus trying to close the gap.

2.3   Models and Causes of Health Inequalities

2.3.1   The Inverse Care Law

This is an area that is directly linked to health services and to primary care. The inverse care law refers to the variation in good primary care provision dependent on the population that is being served (Tudor Hart, 1971, Payne and Saul, 1997, Hippisley-Cox and Pringle, 2000). Overall, areas with greatest need often receive poorer funding and less resource for what is required in the area. Tudor Hart (1971) summed up the following trends that define the inverse care law.

'In areas with most sickness and death, general practitioners have more work, larger lists, less hospital support, and inherit more clinically ineffective traditions of consultation, than in the healthiest areas; and hospital doctors shoulder heavier case-loads with less staff and equipment, more obsolete buildings, and suffer recurrent crises in the availability of beds and replacement staff' (p8).

More recent research has also found that medical doctors are more likely to choose to work in areas where health is better (Hann and Gravelle, 2004). This is not related to health treatment but associations have been made with doctors preferring to work and reside in areas of better health (Dorling, 2013, Knox and Pacione, 1980). Further to this Watt (2002), emphasised that affluent groups in society would continue to accrue the overall benefits of improvements in PH and the health system. Evidence from around the world confirms the operation of the inverse care law (Peters et al., 2008). However, there is less evidence of the impact of this because it is difficult to distinguish the impact of poorer care from the impact of deprivation. However, Pell et al. (2000) suggest that patients in deprived areas are less likely to get heart surgery than more affluent patients. If they were referred, they were found to experience longer waiting times, because of the classification of their illness. Thus, poorer groups in society will continue to suffer from inequalities when using the NHS. From this brief summary

of the inverse care law, the importance of healthcare and its resources are apparent for health care provision and HIs in particular areas.

2.3.2   Behavioural & Cultural Model

The behavioural and cultural model concentrates on individual behaviours and how they impact upon health. It suggests that both behaviours and culture have different influences over health. Direct behaviours such as exercise and smoking have a direct impact upon health. Increased smoking behaviours are linked with major diseases such as cancer and coronary heart disease, accounting for one in four deaths in the UK (Cancer Research UK). Bosma et al (1999) used the behavioural model approach and found that individuals from a lower social position are more likely to engage in risky behaviours. Engagement in risky behaviours was linked to social class and personality. A relationship was found between psychological attributes, childhood and adult health. Within this research it was found that people from different social positions have different psychological characteristics, which in turn impacts upon behaviours. Other behavioural model research has taken a more anthropological approach to health and identified that it is in fact culture that impacts upon health behaviours. Kroeber & Kluckhorn (1952) explain that societal norms impact upon the way that individuals behave, influencing health. Blaxter (1990) compared different social class attitudes in relation to smoking and concluded that very little could be attributed to societal norms in relation to smoking behaviours. However, Umberson (1987) found that social relationships such as family and parenting impact upon health behaviours, individuals are more likely to take better care of their health within a family setting, it promotes social control. This type of theory argues that behaviours carried out by individuals are influenced by culture and impact upon HIs levels. This model does not account for medical care and sees the responsibility of HIs as down to the individual and wider society.

Research has shown that poorer health is linked to disadvantaged members of society (Milburn, 2001, Wanless, 2001). Graham & Kelly (2004) suggest that by creating positive changes in poorer group's lives improving social conditions and reducing risky behaviours, will have a long term impact on better health outcomes. These groups of people can be targeted in set areas, allowing certain initiatives to target specific groups of people rather than the population as a whole. Thus, these are specific initiatives targeted at key individuals. The introduction of Health Action Zones (HAZs) and Sure Start Centres are examples of specific initiatives targeting key groups of individuals to tackle HIs.

2.3.3   Psycho-Social Model

Blane et al (1996) argued that genetics, social selection and health services can only explain minor aspects of HIs. They suggest further concentration is needed on psychological stress and relative deprivation. Relative deprivation refers to the perception that there is a disparity between an individual's situation and society as a whole. Relative deprivation often leads to reduced societal

involvement; the further an individual feels they are from mainstream society the more ill health they will suffer (Wilkinson and Pickett, 2009).

Bartley et al (1998) believed the psycho-social model to be complex, consisting of a number of different factors. Firstly, the social stress approach, states that HIs mirror social inequalities leading to a demonstration of psychological stress. Selyes (1956) looked at socio-environmental stressors and their impact upon psychological stress. All areas of life such as moving house, a new job, marriage, births and deaths were found to impact upon stress levels for all individuals. However, disadvantaged people were found to be more likely to suffer from more negative life experiences than advantaged people, thus leading to a negative impact upon their psychological stress levels and health. Long term stressors were found to be unevenly distributed across society leading to poorer health in disadvantaged groups. Secondly, the self efficacy approach looked at the notion of control. Karasek (1979) developed a work stress model demonstrating that an individual's capabilities within the workplace impacted not only on their decision making process but also their health outcomes. The overall notion of self efficacy is developed by an individual's social environment; if an individual has control within the workplace it acts as a buffer to reduce stress. Therefore, the more a person is found to have control, the better their health outcomes. Thirdly, sociology of emotions refers to the idea that negative external circumstances impact upon emotions and mental health. Sociology of Emotions theory has found that negative emotions are more noticeable down the societal ladder. Thoits (1989) argued that emotional attachment influences individual's behaviours. Finally, the psycho-social model looks at the importance of social cohesion. This is linked to work carried out by Durkheim regarding societal facts, stating that individuals can only be understood when they compared with a society's collective traits. This approach takes individual level theory and applies it to macro-level. Overall, the psycho-social model approach to HIs focuses upon psychological influences on society and how these areas impact upon health and inequalities. Little, if any attention is given within this framework to health services and their capabilities in causing or reducing HIs.

2.3.4   The Material Model

This model refers to material wealth and deprivation and how these factors impact upon HIs. The Black Report (1980) concluded that people residing in more deprived areas did not have the same standards of living as other members of society e.g. housing conditions and transport were not to the same standard. A link between material deprivation and health deprivation was identified. As society has developed people have been provided with better working and living conditions however, there is still a gradient across society from the most wealthy to the deprived in terms of material ownership and health (Bartley, 2004). Life expectancy has frequently been used to highlight the materialist model's findings. Wilkinson (2005) argued that many studies have compared income against life expectancy. It was shown in America that there is a relationship between income and age adjusted deaths when comparisons are made across the states (Ram, 2005). Bartley (2004) further argues that social position is related to income, the more money a person has the more likely they are to be able to buy

more things that will benefit their health. Healthy lives in terms of food and housing all cost, the better these resources are, the more it will cost the individual. The increased cost of healthy living highlights how only certain members of society can afford to live this life, which in turn leads to HIs. Lynch et al (2000) stated that good housing, healthcare and a good diet are all factors that influence the longevity of life. This model also highlights the importance of access which could place responsibility upon the NHS to provide the public with better healthcare services which in turn, could lead to increased health and reduced inequality. The overall focus is on material goods and living conditions which have a much stronger link with PH rather than primary or secondary care.

2.3.5   Life Course Approach

This approach was introduced in the 1980s and suggests that HIs are something that happen over time rather than being caused by any one particular factor. The approach originally focused on differences in health across different social groups stating that these relationships were caused by experiences that may have happened earlier in their lives (Bartley, 2004). Other applications of the model have concentrated on vulnerability, focusing on previous experiences. Past experiences can make people more susceptible to the same incident occurring again. The life course approach, like the other models, is complex as it consists of numbers of years of comparative research that focuses on different periods over the life course. Its main focus on health states that health outcomes are a reflection of psychological, social and biological characteristics. It is whether these characteristics are positive or negative which brings about different health outcomes. This model highlights the importance of social position including the position of individuals as well as a families' collective social position in society. Social position is argued to be mediated by cultural and economic factors, impacting on good or bad health. This model defines health across the life course in terms of direct and indirect selection. Selection refers to health as something that is irrelevant of society and is related to natural effects. Therefore, inequalities can be regarded by selection as natural inequalities e.g. intelligence can bring about a better education and improved career prospects which are linked with better health outcomes.

Caspi et al (1998) found that genetic psychological attributes help individuals to achieve more, frequently leading to better health. Indirect selection refers to the by-products of natural selection like social position. Therefore, better societal position leads to better health chances. Holland et al. (2000) applied the life course approach using an addition approach, measuring the accumulation of health across the life course. A life course approach is being used to research social inequalities in health, to investigate how experience and exposures at different life stages accumulate and create social inequalities in morbidity and mortality, observed in middle and old age (The World Health Organisation, 2000).This model suggests that health outcomes are not as clear as stating that one social group is more likely to suffer from poor health in comparison to another but is about the amount of time that people suffer in a disadvantaged location that will put them at greater risk of suffering from ill health. This approach focuses on the differences across the gradient rather than just the disadvantaged groups. Thus by improving the health of all people across the gradient, no focus is specifically

associated with one group of individuals. Graham & Kelly (2004) believe that that the standards of health enjoyed by societies deemed better off, should be attainable for all.

2.3.6   Social Determinants of Health

Social determinants of health refer to a number of different areas of health that have been demonstrated as having a relationship with inequality. Research has concentrated on trying to understand what the social determinants of health are and how altering them can reduce HIs. Dahlgren and Whitehead (1992) constructed a model (see figure 2 below) to try and bring together all factors that have been found to impact on HIs and what have been listed as determinants of health.

Figure 2: Dahlgren and Whitehead's Model, Factors influencing health
Reproduced, with the permission of the publisher, from Dalgren and Whitehead, European strategies for tackling social inequities in health: Levelling up Part 2. World Health Organisation, 2006. (Figure 1, http://www.who.int/social_determinants/resources/leveling_up_part2.pdf, accessed 2nd February 2014)
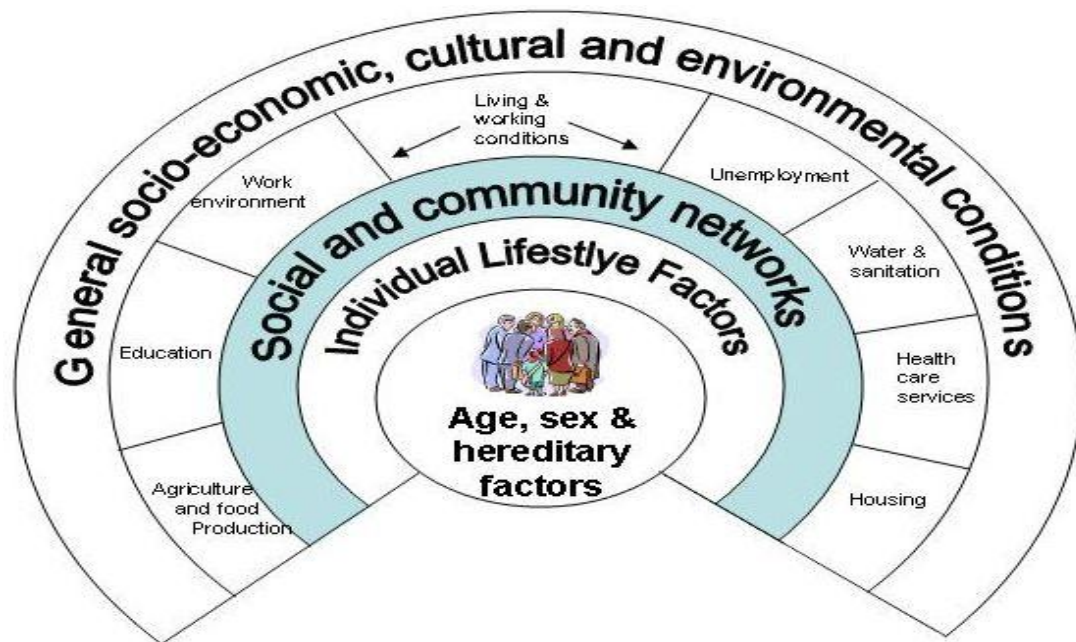
At the centre of the diagram there are biological factors, these are the things that individuals have no control over e.g. a mother's health when a baby is in the womb. Research has shown that *biological factors* that are out of an individual's control can impact upon HIs. Barker (1992) found that boys who had low birth weights were at an elevated risk of suffering from cardio vascular disease at a later date. *Individual lifestyle* factors that are included in the model concentrate on the area of behaviour. Behaviour is argued to be something that individuals do have some control over, although research denotes that certain types of individuals are more likely to carry out more risky behaviours (as noted in section 2.3.2). Tuinstra et al (1998) found that adolescents in specific socioeconomic groups were more likely to engage in risky behaviours. Behaviour can be affected by personality, in essence

individual personalities can define how people behave and respond to health initiatives (Warwick-Booth et al., 2012). *Social and Community influences* refer to individual's social relationships and connections. Umberson (1987) found that social contacts and social integration impacted upon mortality rates. Individuals with fewer social networks had increased mortality rates. *Living and working conditions* refers to the impact of working environments, unemployment, healthcare and education on HIs. The second Whitehall study (Marmot et al., 1991a) identified that people who have no job control or status are more likely to suffer from poor health than those that do. In terms of healthcare inequalities these can arise from GP attendance rates, immunization rates and getting the care that is required. The final layer of the model refers to *socioeconomic, cultural and environmental conditions*, indicating the materialistic elements of HIs which are determined by higher forces such as income and minimum wage. This model demonstrates how different determinants of health impact upon HIs, allowing a number of reasons to be taken into consideration when defining HIs. The causation of HIs in this model, locates the problem wholly outside of the health care system. For example, it implies a need for macro-level policies to reduce income inequalities.

2.3.7   Summary

Overall, these different models highlight the complexity of defining the notion of HIs. These models take into account the differing perspectives of HIs and have demonstrated through research the impact these notions have on tackling HIs. Healthcare is very rarely focused on in terms of the cause or the solution to the problem of HIs, healthcare priorities remain as providing a 'sickness service' (Warwick-Booth et al., 2012) to the population rather than following a preventative model, thus having little influence on the HIs agenda. However both policy initiatives and associated research have highlighted that healthcare plays its role in trying to tackle HIs (see chapter 3). Bartley (2004) stated that alongside HI models there has also been research carried out on areas of gender, ethnicity and income. HIs are experienced by many groups and individuals in society and to deal with these issues there needs to be a population level strategy rather than individual group targets to make a difference (Marmot, 2010). Although, all these different models and theories of HIs have been discussed it is vital to recognise the importance of how HIs are perceived, as this will impact upon outcomes. This is a key component of this research project, an understanding of how CCGs conceptualised HIs as an organisation was required in order to understand how CCGs were trying to tackle HIs.

2.4   General Practitioners Role in Tackling Health Inequalities

The main focus of this research project is to see how CCGs are tackling HIs within their local areas. As CCGs are supposed to be clinically led it is important to focus on the literature that has looked at the General Practitioner role in regards to HIs. This section will look at the role of GPs in more detail, highlighting evidence that has shown where GPs can make a difference on the HIs agenda. Three main areas of research will be introduced and discussed; avoidable mortality, access to services and partnership working. This section does not necessarily include initiatives to tackle HIs that would be

deemed outside of CCG / GP power (e.g. poor housing conditions effecting health). However, broader questions of how successive governments have conceptualised and addressed HIs are discussed in chapter 3.

2.4.1 Avoidable Mortality/Amenable Deaths

In the policy context (chapter 3) it is discussed how policy frequently concentrates on the wider influences on health e.g. housing and education when trying to tackle HIs. The Local Authority (LA) is responsible for these wider areas; therefore the wider influences on health are not often deemed the direct responsibility of clinicians. Thus, how much can healthcare contribute towards population health? Nolte and McKee (2004) attempted to answer this question with the introduction of the concept of avoidable mortality. The term avoidable mortality was introduced in the late 1970's by John Charlton and is described as deaths that should not occur if effective and timely healthcare is provided for people under the age of sixty five. Nolte and McKee (2004) stated that this concept was appropriate for the time it was introduced; however the age restriction is no longer relevant in today's society as life expectancy is now much higher and further technological advancements have impacted upon healthcare and people's life experiences. Thus, the model is not as applicable for health problems that are prevalent today. The concept itself was originally constructed by a working group at Harvard Medical School for preventable diseases; an initial list of ninety diseases was compiled that the working group felt could be avoided with the correct, effective and timely healthcare. The list of 'sentinel health events' can be seen as an index of care for the providers of services (Nolte and McKee, 2004), and enables service providers to know which diseases are preventable if the correct care is being provided in a timely manner.

As society has changed and developed the list of preventable and treatable diseases has undergone a number of revisions to ensure that the list reflects disease progression. Charlton et al (1978) were the first group to test this measure at population level in England and Wales. They not only looked at avoidable mortality but also introduced conditions that were receptive to medical interventions. The study measured regional variation, concentrating on fourteen different disease groups, the diseases were selected to try and reflect all aspects of medical care including both primary and secondary care.

The application of the model highlighted that where a person lives geographically can impact upon disease. The findings were argued to be too strong to be regarded as chance. Thus, where a person lives affects disease prevalence. Charlton et al (1978) claimed that although certain areas had a higher prevalence of certain diseases, the application of correct medical treatment could treat certain diseases and prevent untimely deaths. Further to this they also argued that dependent upon the disease, medical intervention could be applied at different stages to reduce disease and again prevent death. Thus, this model took into account the characteristics of different diseases acknowledging that they needed to be managed differently to obtain the preferred outcomes.

Primary care is usually the initial point of call for patient consultations; it was shown to play an important role in preventing untimely deaths with early case detection. In 1986 Charlton et al carried out a follow up study to see how avoidable death indices had changed across the years of 1974-1978 compared with 1979-1983. The study found that there had been an overall decline in mortality nationally across all diseases except asthma. However, the indices still demonstrated that there was a variation of mortality rates after standardization measures had been used across different health authority areas. The study's findings suggest that variation was still a persistent issue across England and Wales. Charlton et al (1986) also claimed that although disease causality was not directly related to medical services it identified where medical services may have shortcomings, highlighting where better provision may be needed for patients.

The concept of avoidable mortality over time has become less popular and is no longer used as frequently. However, the concept itself and studies investigating it have shown that population diseases may not be preventable by medical services but medical services do have a place in providing the correct intervention to treat disease and prevent untimely deaths that are occurring within populations. By using a population focus, clinicians can ensure that the correct services and treatments are available to match the need in their local communities, this is reflected in the use of the Joint Strategic Needs Assessment (JSNA) by PH, LA and CCGs (Department of Health, 2013). The JSNA is used to analyse population health within LA areas to help inform and guide the commissioning of health and social care services (NHS Confederation, 2011).

2.4.2   Access to Services

Access to services is often discussed when looking at health services and HIs. Equity and access were key principles that underpinned the establishment of the NHS. Equity and access to services refers to equal access to services for all people (see section 2.2). Benzeval (1996) explained that there is little actually known about whether the reality of equity matches the initial NHS principles. Equity and access have been described as key areas where medical services can have an impact on HIs. However, Klein (2010) stated that true equity can never be fully achieved within the NHS, arguing that it would be impossible to achieve 'a uniform standard for all' unless public control followed public money; (p289). Research in this area has been varied, incorporating a number of different elements that have been found to be influential on when and how people access services e.g. individual health and bone density programmes. For the purpose of this project the focus will be on general practitioners and access to their services.

Chapman et al (2004) conducted a systematic review looking at service provision and improved access to services in primary care. The paper states that access itself is difficult to define as there is no general recognition of what is actually deemed as appropriate access. Within their study access was defined as "*The right service, at the right time, in the right place.*" (p374). The review identified thirty two papers and two reports, all demonstrating that various schemes impacted upon primary care

access differently. For example, Personal Medical Services (PMS) were introduced to provide services that targeted local need. This scheme focussed on local population need, partnership working and enhanced service provision in deprived areas. The pilot scheme itself was small but it did allow nurse led care to take place where it was difficult to recruit GPs into certain geographical areas. A key finding from this research was the emphasis on collaboration being a key component in providing access to services. The paper argued that to address inequalities in access a bottom up approach was needed whereby services could be provided appropriate to local need rather than a national target led provision of services.

Benzeval and Judge (1996) also found that access to services was related to the number of GPs in the local area, with fewer GPs leading to poorer access to services. Benzeval, Judge and Whitehead (1995) previously stated that there was a mismatch at local level between the need and supply of services. Benzeval and Judge go on to argue that for equal access to services to occur GPs need to be distributed equitably based on the healthcare needs of local populations. Although Benzeval and Judge claim that better GP provision is a good way to improve equity they also consider that even if GPs are to be there, this does not mean that the local population will utilise the services. Research has demonstrated that GP attendance rates are linked to factors such as locality and socioeconomic status, gender (Morris et al., 2005), ethnicity (Smaje and Le Grand, 1997) and overall GP numbers. Therefore, access to services is not just related to GP numbers but also a number of other contributing factors.

Canvin et al (2007) examined service levels, claiming that people who live in deprived areas suffer from poorer health and have poorer preventative services. This qualitative study found that the people who needed the services most did not utilize the service provision for a number of different reasons. Patients claimed that there were certain risks associated with the utilisation of services e.g. losing children to social services and benefit losses. Overall, it was found that even though people needed the services they felt that the risks were too high for them to attend; risks outweighed those of the illness or medical need. These preconceptions can lead to adverse consequences, when access was found to be a last resort for individuals they were often found to suffer from isolation and general poorer health. Such families were found to be more likely to attend Accident and Emergency than consulting primary care and other public services. It was identified that there are broader reasons why people do not use services; availability was found to be only one of a number of factors that influence service use. This study suggests that to improve utilisation of services good communication and relationships need to be built into the community demonstrating how attendance to services is beneficial for long term health.

Benzeval, Judge and Whitehead (2005) illustrated a number of different barriers to healthcare that need to be taken into consideration when examining access to services. These include geographic factors, for example, are the services located in easy to reach locations and financial factors, not all services are free, which will impact upon service use (such as ophthalmology and dentistry). Such

hindrances are in place before a person even considers using the service. Finally, culture also impacted upon access to services, for example ethnic minority females have a lower uptake on screening programmes dependent upon their socioeconomic group (women in lower socioeconomic groups are less likely to attend screening programmes) (Tucker et al., 1991, Bell et al., 1999). Communication and stereotypes were found to impact upon attendance. Benzeval, Judge and Whitehead (2005) highlighted the role of commissioners when purchasing services in local settings. They need to ensure that they are taking equity and access into consideration when purchasing services for their local population. This is relevant to this study; CCGs will be dealing with the commissioning of health services as well as ensuring that they are tackling HIs.

In 2004, the Alternative Provider Medical Services (APMS) contract was introduced as a way of commissioning primary care organisations. The APMS contract enabled PCTs to be specific about what they expected and wanted from their providers. However, there was little uptake to carry out primary care commissioning in this way (Peckham, 2007). From 2007, several initiatives were put in place to try and tackle HIs by increasing access to primary care services in areas that were argued to be under doctored (Coleman et al., 2013). Two rounds of procurement were stipulated by Government: Fairness in Primary Care in 2007 / 2008 and Equitable Access to Primary Medical Care (EAPMC) initiative in 2008. Fairness in Primary Care procurement was to try and provide greater access and choice to patients in their area (Secretary of State for Health, 2006). Flexible opening hours and changing service provision hours was intended to improve the overall access to primary care. The EAPMC initiative was first raised in an interim report (Department of Health, 2007), outlining that the NHS would introduce 100 new GP Practices in the 25 percent of the country which was viewed to have the poorest primary care provision. Additionally to this, 150 GP led health centres (one in each PCT) were to be opened to improve the access to GP services (Coleman et al., 2013). Chapman et al. (2004) found that the PMS initiative and other initiatives implemented to increase access (e.g. NHS Direct) had little impact on HIs. The introduction of walk in centres was found to increase inequalities by providing services for more affluent members of society. Overall, it was found that a more collective / partnership approach was needed to tackle HIs.

From this brief discussion on access to services it has been demonstrated that this is a complex area that consists of a number of factors. Interventions to increase numbers of GPs in deprived areas as well as schemes to provide care focusing on local need all help deal with the issue of access. However, broader considerations also need to be accounted for; access issues are not just about service provision.

2.4.3   Partnerships

When New Labour came into power in 1997, emphasis was placed on partnership working (Snape, 2004); policy initiatives have placed emphasis on partnership work for tackling HIs including Health Action Zones, Spearhead areas, Local Strategic Partnerships (LSPs) and Local Area Agreements (see

chapter 3). Although partnerships have been encouraged and enforced by national policy, there is no clear definition that can explain what a partnership is and how it should operate (Glendinning, 2002). Martin and Guarneros-Meza (2013) discuss the different steering principles that help operate partnerships, differentiating between hard and soft steering. Hard steering refers to Government attempts to dictate how partnerships should operate, using top down political targets to impose partnership working on organisations. In comparison, soft steering is defined in this paper as partnerships being based on funding and expertise distribution. The Audit Commission (1998) in their management paper explained that the concept of partnership working was slippery. The paper refers to formal and informal partnerships; formal partnerships refer to the process where a partnership process is established whereas informal partnerships refer to the arrangements that help form the partnerships. It is the arrangements that are often difficult to define especially when a partnership has not been established in a formal manner; in these circumstances people do not identify their processes as partnership working. Skelcher et al. (2004) define partnership working as the involvement of various organisations working together for a common good. If we reflect on this definition of partnerships within the context of this study; partnership working refers to a number of organisations working together to try and tackle the issue of HIs.

The Audit Commission (1998 p9) outlined five reasons why organisations choose to work in partnership.

- To deliver co-ordinated packages of services to individuals
- To tackle so called 'wicked issues'
- Reduce the impact of organisational fragmentation
- To bid for or gain access to new resources
- To meet a statuary requirement.

These reasons have been discussed within the wider literature. Huxham and Macdonald (1992) argued that collaborative working was a way of reducing organisational individualism whereby issues are only focused on by one group. Charlesworth (2001) concentrated on New Labour's approach to partnership working which was implemented to tackle issues that cross cut domains such as health, education and crime, where voluntary, community, public and healthcare organisations are required to work together to tackle the issue. Exworthy and Hunter (2011) focused on the complexities of joined up working for tackling the issue of HIs, explaining how HIs are a 'wicked issue'. 'Wicked issues' are defined as a complex public policy challenge, which continue to change and are hard to resolve because of multiple causes and solutions that influence the issue (Rittel and Webber, 1978). Thus, problems transcend organisational boundaries (Clarke and Stewart, 1997). A focus on partnership work has meant that primary care has been expected to work alongside other organisations to try and deal with the health of local populations whilst ensuring that they continue to meet central policy targets.

Callaghan et al (2000) stated that partnerships and collaborative working emerged because of the significance that was placed upon localism (where political ideology places emphasis on local areas, allowing them to have local autonomy in decision making) and local purchasing by local district health

authorities. Additionally, Marks et al (2011) say that policy commitments for the NHS emphasise the importance of working across both health and local government domains to prevent ill health and reduce inequalities. The Department of Health (1998a) claimed that joined up solutions would enable local problems to be challenged. However, Smith et al. (2009) were unable to clarify the extent partnership work had on overall health improvement.

Partnership strategies have been introduced over a number of years and have included initiatives such as Health Action Zones (HAZ) (Sullivan et al., 2004). These were introduced by the Labour Government in 1997 whereby cross sector approaches were implemented to try and improve health within a local area whilst tackling HIs. The HAZ schemes were abolished once data began to be produced; the changes that the schemes brought about were found to be inadequate (Benzeval, 2003). Other initiatives have included the Health Education Authority's Integrated Purchasing programme (HIPP). HIPP was introduced to help guide LAs, primary care and health authorities to make progress on health strategies ensuring that local areas met their national targets. Evans and Killoran (2000) argued that HIPP was not able to create fully functioning conditions to bring about change. However, some criteria did come together which brought about improved results. The study suggested that for partnership groups to find success they had to have a shared vision.

Overall, Evans and Killoran (2000) stated that partnership working brings with it its own difficulties. GPs were found to struggle with issues that they found were too broad, such as public health (as their focus has previously been the health of individuals presenting at the practice) whereas LAs struggled when trying to focus on the healthcare setting. Overall, the findings from the study illustrate that although partnership working can make some differences in health it is not an easy thing to construct and develop. People who are working together, but are coming from different organisations have issues with disparities in accountability, funding and culture etc across the organisations. Martin (2010) found that managers tend to be primarily concerned with the targets and areas that their particular organisations are accountable for and to, thus collaboration adds an extra layer of complexity.

Marks et al (2011) found that a balance between clinical and social interventions, when working in partnership was difficult. This study highlights that when people are from varied backgrounds they may have differing opinions on effective strategies, these disparities need to be dealt with whilst working in partnership. Further issues were found around job role, people struggled to see their role in the bigger picture. In addition, individuals struggled to adjust when trying to work with other people. Joined up working may open up an array of different solutions but it also opens up an avenue of uncertainty for those working within the partnerships across organisations. Charlesworth (2001) claimed that history is also another factor that impacts upon partnerships, in terms of their histories play a role in the development and progression. History contributes to what is happening on the ground when new policies are implemented. A further factor influenced by history was relationships. Many commentators found that relationships between the NHS, LA and social services were problematic (Glendinning, 2002, Lewis, 1999). Under the current NHS reform relationships between the CCG, LA, PH and the

HWB are all deemed important. Joint working and accountability has been strategically enforced by the Health and Social Care Act (2012) and CCGs have a statutory duty to work with and alongside the HWB to ensure that local healthcare needs are being met whilst trying to reduce HIs. The HWB is a sub-committee of the LA and includes a number of health and political representatives including elected members and LA officers.

Focusing specifically upon GPs and primary care, research has shown that GPs do not collaborate well as their working culture is not collaborative across organisational boundaries (Callaghan et al., 2000). Since government reforms in 1974 collaborative working has been encouraged, both Primary Care Groups (PCGs) and PCTs have all existed where GPs have had a specific role within the wider health economy. Under the current political changes it will be clinicians (generally GPs) leading the commissioning of healthcare for local communities. To ensure the provision of good and relevant services across a local area they will need to have knowledge of the local area which will mean developing good relationships with HWBs (whose roles include carrying out JSNA and the development of health and wellbeing plans (JHWS), providing overall strategic guidance locally), service providers and other public and community organisations. Partnership working will be relevant not only for commissioning services but also tackling HIs.

2.4.4   Summary

The purpose of the literature review has been to highlight the variety of different models associated with defining HIs and the causes of them within the academic literature. This chapter illustrates how each different understanding of HIs involves different solutions to tackle the issue, based on the overall understanding of the problem. For example, if an organisation conceptualises HIs by the life course approach, initiatives targeting early year's development could be a possible solution to try and overcome the issues the population are facing. If a social determinant's of health approach underpins someone's understanding of HIs, solutions could include much broader societal influences on health, such as income redistribution. The different causes of HIs and the models to describe them are of importance for this research project, firstly the plurality of models highlights the complexities faced when examining the literature and trying to understand HIs. For CCGs, a newly developing organisation, it is important to understand how CCGs are thinking about HIs, exploring how academic theories of HIs are being used in the real world. Secondly, the models often fail to account how healthcare and clinicians can attempt to tackle HIs; instead larger prominence is placed with public health (PH) and local government. This chapter has explored in more detail the GP role for tackling HIs that has been documented within the literature to try and understand how the duty imposed on CCGs could be enacted locally by the clinicians who are in charge of commissioning healthcare services for their local populations. The literature surrounding the definition of HIs and the role of healthcare in tackling HIs is linked to the development of my research questions. Rather than trying to define the notion of HIs and examine a specific theory of HIs, a more exploratory approach was adopted,

whereby this research tried to understand and explore how CCG members were thinking about and planning to tackle HIs.

Chapter 3: Policy Context

3.1 Introduction

This section will examine and discuss the policy context of HIs in the UK across changing governments to see how this has impacted upon policy creation and implementation. HIs are a long standing societal trend that has been both introduced and dismissed over time from the policy agenda based on different government's priorities. The National Health Service (NHS) was introduced in 1948; the function of the NHS was to provide free universal healthcare at the point of use for all UK residents by the state. Asthana & Halliday (2006) claim that the NHS brought about a feeling of social justice. Healthcare was no longer a luxury based on wealth; it had become a right that all people had access to. The NHS was introduced by a Labour Government and was intended to provide equal access to healthcare for all; the founding principles of the NHS meant that little regard was given to HIs. The NHS's establishment was perceived as a way of overcoming the HIs that people had previously faced.

3.2 History of policy relating to health inequalities

Pickstone (2000) suggested that the public policy rationale for healthcare has changed over time. The initial introduction of the NHS in 1948 was based upon The Beveridge Report (1942). The introduction of the NHS was there to offer people help for health problems that were caused by communicable diseases and poor housing etc (All Party Parlimentary Group, 2013). This report, later to be referred to as The Beveridge Fallacy, argued that free health services for all would ensure that the sick would be returned to work, creating a healthy workforce and therefore health services were seen as an investment. Pickstone (2000) refers to this as productionist medicine, whereby medicine was used to contribute towards the health of individuals to produce a strong army and workforce. Ham (1999) writes that NHS expenditure has continued to increase over time because of the changing demography and technology in society that medicine is now working with. This was not accounted for in The Beveridge Report and thus The Report's initial predictions on the purpose of the NHS have become redundant. Although productionist medicine had its place in the time of the establishment of the NHS, over time society developed and changed, leading to a new form of medicine. Communitarian medicine came about because of a time of social solidarity; medicine was no longer a luxury but something that should be available to all (Pickstone, 2000).

Post 1960, the public policy rationale for health changed again towards a more consumerist approach to medicine. Society had high expectations of good health and medical services. Harrison (2003) found that medical provision had changed to involve users in the service. From Pickstone's work it is evident that the role of medicine and the NHS has changed over time. The initial introduction of the NHS was seen as a way of dealing with HIs, however as society developed the needs and expectations of the public changed, HIs was still an unsolved issue.

Around thirty years after the NHS's introduction there was an emergence of awareness that HIs existed and that the NHS had not made a significant improvement on HIs (Oliver, 2008). During the 1970s there was recognition that factors such as poverty, employment status and housing affected health (Ham, 1999). Ham argues that there was a rediscovery of public health (PH) from the 1970s onwards, health was not just related to medical services (Baggott, 2004). In 1977, the Labour Government commissioned a research project within the UK to look at HIs focusing on policy; this was to ensure that equal health could be obtained by all across society. The resulting Black Report (1980) found that there had been an overall continuation of health improvement across society, however it was identified that there were differences in health across the social classes within the UK. The Black Report used mortality rates to measure the differences across the classes and identified that mortality rates increased the lower an individual was on the social ladder. The report highlighted four key areas that could be linked to HIs, artefactual explanations, natural or social selection, materialist or structuralist explanations and cultural or behavioural explanations (Exworthy and Oliver, 2012) (see 2.3.4 Materialist Model). The report claimed that healthcare had its role in reducing HIs through improved access and better services. Although healthcare was mentioned, more emphasis was placed on wider community factors such as housing and living standards. The evidence gained within the Black Report was used to formulate key recommendations for the Government to influence their policies on HIs, offering practical advice to reduce the number of people suffering from inequalities within society. There was an acknowledgement within The Black Report that the recommendations were modest first steps towards reducing inequalities in health. The suggestions that were provided focused on child benefit increases and increasing maternity grants to try and reduce child poverty. Further recommendations referred to housing, with joint funding for Local Authorities (LA) and Health Authorities (HA) to encourage better facilities for the community. Overall, the report found that there was a direct relationship between poor health and lower class status as well as an indirect relationship between health, childhood and social position in adulthood.

The report was commissioned by the Labour Government in 1977 but it was not published until 1980, this time lapse affected how the final report was received and taken forward as a policy initiative. Within the timeframe from the report being commissioned and published the Government changed and was being led by the Conservatives. The report was coolly received by the Conservative Government and little action was taken (Asthana and Halliday, 2006). Exworthy et al (2003b) claims that the Conservative Government rejected the proposals as they were argued to be too costly. The Black Report therefore had limited impact upon public policy in regards to HIs.

Policy theory allows an examination of why The Black Report had little success in influencing and changing HI's policy. Kingdon's (2003) model of policy windows suggests that parallel streams need to come together (problem recognition, policy proposals and the political process) for a policy window to be opened allowing a policy to be introduced. This model suggests that the policy window is only open for a limited time for any policy to be constructed and implemented. If this model is applied to The Black Report it can be argued that The Black Report was constructed over a lengthily time period

which may have led to the policy window closing. The change in political leadership was also important in influencing the policy journey of The Black Report. A different leadership in government will bring a different set of values and political recommendations; this could impact on how the report was received. Overall, the key findings from this report showed that for political changes to happen researchers need to work to a short time frame ensuring that reports are being delivered to the original political party who commissioned the report.

The Conservative Government remained in power for seventeen years and within this time little work was carried out in relation to HIs. HIs were not high on the Conservative Governments priorities, their political ideology implies that HIs are the responsibility of the individual rather than a wider social issue and state intervention was seen to be 'nannying' (Jones and MacGregor, 1998).

When the Labour Government regained power in 1997 they commissioned an independent inquiry. At this time no political window (Kingdon 2003) was open on HIs, the government did not express HIs within their policy initiatives and there was little public outcry or media attention raising awareness on the issue to put HIs on the policy agenda. The issue of HIs were not aligned with Government ideology or seen to be financially feasible to deal with. All these different criteria can be seen as factors that restrict access onto the policy agenda (Hall et al., 1975).

Oliver (2001) writes that the Acheson Report (1998) was led by Sir Donald Acheson and concentrated on the period between the 1970s and 1990s, the report started where the Black Report had finished. The Acheson Report was welcomed by the Labour Government (Exworthy et al., 2003a).

The report's recommendations were strongly aligned with Labour's policy strategy and therefore the recommendations were aligned to Labour's existing strategy. The Acheson Report findings were aligned with Labour Government's espoused policy of trying to reduce HIs. Labour believed that HIs were not individualistic but influenced by society and socio-economic differences which reduced choices (Jones and MacGregor, 1998). Macintyre (1997) wrote that it was difficult to measure the true impact of the Acheson Report as it was clear that the Government would have probably introduced a number of the policy recommendations anyway. The interest shown by the Government led to the policy window being opened (Kingdon, 2003). The espoused policy (what the government wanted to do), became an enacted policy by the Government, via legislation. The Acheson Report replicated the findings of The Black Report demonstrating that inequalities in health were related to social class; the report also examined HIs across other areas including education, gender and ethnicity. The Acheson Report produced thirty nine general recommendations, with three listed as high priorities. These three recommendations are outlined below:

- All policies that were likely to have an impact on HIs should be evaluated in terms of the impact on HIs.
- High priority should be given to health of families with children, as the health of a child can have an impact across the life course.

- Further steps should be taken to reduce income inequalities and improve the living standards of poor households.

The resulting policy recommendations were a mixture of both upstream and downstream policies involving both the government and frontline workers in creating strategies to tackle HIs. Out of the thirty nine recommendations made only three were directly related to healthcare, highlighting that within policy, healthcare was not strongly linked with tackling HIs (Exworthy et al., 2003b). Integrated partnership working was advised to be developed across the NHS, LAs and other agencies to create a programme to reduce HIs. The overall recommendations covered areas from employment to young mothers and children. The three recommendations in relation to the NHS were:

- that equitable access to care in relation to need should be the governing principle underlying the whole of the NHS.
- Better equitable allocation of resources should be provided based upon area and need.
- Directors of PH should create an equity profile for their population alongside population targets.

Although The Acheson Report received backing from a number of different agencies it did not go without its critics. Oliver (2008) criticised the report for producing a list of priorities without setting any precedence of what areas needed more attention. Oliver further criticises the report for its broad focus on maximising health rather than a specific focus on tackling HIs.

Other criticisms of the report fall into five categories. These are; that the report showed no prioritisation, no mechanisms, no advice into how to turn the research into a policy, the recommendations were vague making policy construction difficult and also no cost effectiveness of the proposals was offered. Although the report stipulated areas which needed to be dealt with, the report did not focus on the policy audience, it consisted of too many recommendations which meant that it lacked overall focus. Oliver (2008) suggested that an economist should have been included on the research board so that the policy recommendations could have been measured, identifying whether the recommendations were viable or not. Although The Acheson Report has been critiqued, researchers have argued that without it the policy window for HIs would never have been opened to deal with the issue (Exworthy et al., 2003a). Macintyre (2000) states that without the report it would be difficult to know whether any policies would have been introduced to tackle inequalities in health.

The policy response to The Acheson Report has shaped the way in which HIs have been dealt with over the last 12 years. Policy development fell into a number of typologies, meaning that the policies had set ways of trying to deal with the issue of HIs. Exworthy et al (2003a) assert that HIs policy fell into a six-fold typology; Figure 3 below identifies the areas of policy that have been linked with HIs. Health policy focus moved from healthcare alone i.e. quality and equity to a more encompassing model which included the social determinants of health.

Table adapted from Exworthy et al (2003, p1911)

Policy typology	Policy Focus
Life Course Approach	Early Childhood Years
Area Based Initiatives	Focus on disadvantaged communities
Redistribution	Tax credits
Healthcare	NHS Reform, healthcare provision
Targets and Performance Culture	HI Targets
Structures and Processes	Joined up Government

On the back of The Acheson Report the Labour Government implemented a large number of area based initiatives referred to as Health Action Zones (HAZs) as well as the introduction of Sure Start Centres, these initiatives were to concentrate on deprived areas of the UK following the life course approach (Abrahams, 2013). Organisations such as LAs, Primary Care Trusts (PCTs) and Educational organisations were to form partnerships to try and reduce HIs within their areas (Bauld et al., 2005).

Partnership working was a central policy objective within the Labour Governments strategy to address PH issues. Perkins et al (2010) suggested that the reason that partnership working was introduced was to try and meet wider policy objectives. Locally focused strategies were introduced, including Local Strategic Partnerships (LSPs) and Local Area Agreements (LAAs). These partnerships included public, private and third sector organisations, attempting to reduce HIs. Gillam and Florin (2002) suggested that although primary care organisations (e.g. GP Practices) did not have a central role within the partnerships, they were still able to play their part and offer support to the programme of work. Partnerships themselves were found to be complex; complexities arose from issues surrounding identity, past histories and people's perceptions of their roles within the partnership (Charlesworth, 2001). History / past relationships across the LA and health care services were found to be influential on how current partnerships were formed. Overall, Perkins et al (2010) claimed that there was little supporting evidence for the success of partnership working. Whitehead and Popay (2010) when examining partnership working found that programmes and initiatives were wound down too quickly and therefore true progress of initiatives could not be properly measured and evaluated. Mackenbach (2010) supports these findings identifying that when governments introduce new policies they do not allow enough time to ensure that data is collected at the beginning of the intervention to collect baseline data. This alongside limited time frames and short term funding in many cases, means that interventions are rarely measured adequately for their effectiveness.

The focus of the targets for the health service concentrated on how clinicians could provide better service provision. Alan Milburn, the Health Secretary in 1999 began to reform the healthcare system by arguing that different parts of the NHS should work together to try to reduce and deal with the leading

causes of death including coronary heart disease, cancer, mental illness and accidents as well as dealing with practical issues such as waiting times (Bauld et al., 2005). Although definitions of HIs suggest that healthcare services have little influence on the HIs agenda (see chapter 2), The Health Select Committee set HIs targets for the NHS. Exworthy et al (2003a) suggested that this was to raise the profile of the NHS at the time. At a similar time the NHS was undergoing major reforms Health Authorities (HA) were abolished and replaced by Strategic Health Authorities (SHAs). There were also a number of local level changes; PCGs were introduced and later became PCTs, (Department of Health, 2001). This led to changes in the relationships between LAs and PCG/Ts as well as a shift in focus on targets with PCG/Ts having an overall responsibility to improve health (Wilkin et al., 2002).

In 2001 Alan Milburn, the health secretary at the time set two national targets to try and tackle HIs. This was the first time that any targets had been clearly set out in this area of policy (Oliver, 2008). The targets were to be reached by 2010 are outlined below:

- To reduce the mortality gap by at least ten percent for children under the age of one between manual groups and the population as a whole.
- HAs had a responsibility to reduce the gap for lowest life expectancy groups by ten percent when comparing with the whole populations life expectancy.

These key targets were underpinned by specific methods, the implied methods to tackle HIs included aspects of housing, reducing road accidents and the prevention agenda. The NHS's role was early intervention, including immunisations and diet care (Carlisle et al., 2003).

Overall, Oliver (2008) believes that the Blair Government were initially proactive in trying to tackle HIs. Further initiatives such as Spearhead Groups were also introduced for LAs and PCTs to manage, concentrating on the poorest areas of Britain. Spearhead Groups set up a public service agreement locally to address key inequalities consisting of life expectancy, cancer, coronary heart disease, stroke and other related diseases (Department of Health, 2005). The aim of Spearhead Groups was to make progress across the health conditions stipulated above at a faster rate than the average population to try and reduce the health differences experienced in deprived areas. Policy implementation across time has placed little pressure or responsibility upon healthcare providers for tackling HIs and places the responsibility on PH to try and tackle HIs. As 2010 approached, child poverty had reduced but HIs still existed, a health gap between different groups in society was still evident.

Exworthy et al (2003a) state that Kingdon's Policy Window model can be used to demonstrate how HIs came onto the policy agenda and suggests how to evaluate policy targets. Figure 4 below puts Exworthy's arguments (as previously described) under the appropriate headings from Kingdon's model

Information adapted from Exworthy et al (2003, p1916-1918)

Problem Stream	Policy Stream	Politics Stream
• The Acheson Report identifies that HIs are a problem. • Both research and evidence is needed to impact upon policy change.	• The effectiveness of HI's policy is not truly known which makes the policy difficult to define. • Action to tackle HIs is a desirable policy which has barely been raised as a public issue. • Issues with timings arise, policies created with deadlines are not always seen out by the original government. • Policy targets have a shelf life.	• Although politicians may state that they want to tackle HIs, the correct people and networks are needed to put HI initiatives into practice. • Although HIs may be a political priority, HI's policy may have little influence in comparison to different policy initiatives and therefore lead to caution.

In 2008, Michael Marmot a Professor of Epidemiology and PH was commissioned to chair a review for the Secretary of State for Health specifically looking at HIs. The Marmot Review: Fair Society and Lives (2010) found that HIs are still evident and it is a social justice to reduce the levels of inequality. Marmot claims that there is a social gradient in health; the lower an individual's social position the poorer their health is. Marmot asserts that concentrating efforts on the disadvantaged groups alone will not offer the solution; issues need to be targeted across the gradient to try and reduce both the steepness of the gradient and the differences across the groups. Tackling the gradient is related to the concept of proportionate universalism which means that the intensity in which inequality is tackled is based upon the disadvantage across the gradient. The review suggested six policy objectives, outlined below (p14):

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention.

Marmot argues that for the policy initiatives to be successful Central Government, Local Government and the NHS will need to work together to put local delivery systems in place that empower individuals and communities as healthcare cannot tackle the issue of HIs alone. However, little direction was given

to the health service of how they should tackle HIs beyond the scope of partnership working, a larger prominence was placed on PH. Whitehead and Popay (2010) argued that the Marmot Review and the Global Commission have made statements arguing that social inequalities are caused by bad politics and inequalities within power. To deal with HIs there needs to be a whole population focus not just concentration on certain groups, focusing on the whole gradient of health. Marmot's review again puts focus on partnership working, which as identified earlier brings with it its own problems. Problems are formed before the issue is even dealt with, these include a lack of resources, key stakeholders and the discontinuation of funding (Perkins et al., 2010). The work that was published in the Marmot review is very different to Marmot's previous work, his research previously demonstrated that inequalities are largely down to differences in autonomy at work in the Whitehall studies (Marmot et al., 1991b) whereas the recommendations in the Marmot review are more conventional and could be argued to be reiterating the Black Report, and missing recommendations that could influence contemporary health (e.g. regarding the influence of chronic stress and the impact that rank and societal order has on health (Pickett and Dorling, 2010)).

3.3   Equity and Policy

Equity is a central element of the NHS, equal access to healthcare was a contributing factor leading to the introduction of the NHS. Powell and Exworthy (2003) write that it was assumed that by making healthcare free to all it would lead to equal access for everyone. Although, a central principle within the NHS, little policy has been related to equity. When equity is referenced in reports there is little guidance on how to improve equity. Powell and Exworthy (2003) examined the concept of equity and found that the different variations in equity understandings, leads to difficulties in operationalisability and interpretation. Equity as a concept needs to be more standardized and better understood by all actors to bring about better results.

With such little understanding it seems that the target to ensure equity is reached is rather difficult and there is little standardized measurement on what equity is. The Acheson Report (1998) suggested three recommendations related to healthcare that all focused on equity and providing more equitable services. Powell and Exworthy (2003) claim that throughout the history of the NHS the concentration of equity has been based around provision. Under New Labour equity principles and policies changed with a greater emphasis being placed upon fair access to services and a policy aim of reducing health gap differences. Klein (2010) argues that although policy focuses on equity and equitable services it must be noted that it would be unrealistic and untrue to ever think that the NHS can be completely equitable. Klein suggests that to reach full equity for all depends on the way that the concept is defined, if equity is perceived as everyone receiving the same healthcare, no matter where they geographically reside, then the principle of equity seems unlikely. A more consistent equity plan is needed to remove ambiguous targets to inform a clear plan on the issue.

3.4   The current NHS reform

3.4.1   Initial Proposals

In 2010 the current Coalition Government was formed between the Conservatives and Liberal Democrats. Shortly after the coalition was established a White Paper "Equity and Excellence: Liberating the NHS" (Department of Health, 2010a) was published. This White Paper referenced Marmot's independent review (2010), focusing on localism and the roles of GPs and LAs in tackling HIs, although there was no official guidance on how to tackle HIs within the new healthcare system. The publication of the White Paper was the starting point of a large variety of policy documents being published relating the healthcare changes that were occurring within the UK. The White Paper outlined the new proposed structure of the NHS; PCTs were to be abolished and replaced by GP Commissioning Consortia (GPCC). GPCC were to consist of a number of GP Practices grouped together to become a commissioning consortia. GPCC would commission healthcare (excluding primary care) for their community including both registered and unregistered patients within their geographical area. The White Paper proposed that GPCC would have full control of commissioning budgets to purchase secondary care services for their local population. The new structure encouraged GPCCs to work alongside their LAs to ensure that the community's health needs were being met. Within this structural change the government also called for greater choice for all patients, encouraging market competition within the NHS. To ensure that commissioning consortia were working effectively they will be monitored by the NHS Commissioning Board (NHSCB) to ensure that they were meeting the needs of the population whilst staying out of financial risk. In addition to this the NHSCB would be responsible for commissioning primary care services and some specialised services. In October 2010 a Pathfinder programme was announced. This programme was introduced to enable aspiring GPCCs to come together and begin to develop under new legislation (Checkland et al 2012). The Pathfinder programme consisted of five waves and the first Pathfinders were announced in January 2011. The Health and Social Care Bill (2011) was also introduced into the House of Commons in January 2011 introducing Health and Wellbeing Boards (HWBs), a new sub-committee of the LA that were charged with setting the overall strategic direction of health and social care at a local level. Additionally, local PH services were to be moved back to the LA and a new national level coordinating body called 'Public Health England' (PHE) was introduced. The relocation of PH from PCTs to the LA was broadly welcomed as part of the NHS restructure, however there were some concerns of how PH workers would function within the LA and adjust to their working practices (Hunter, 2013).

3.4.2   The Pause

The proposed changes to the NHS caused much outcry and received a great amount of opposition from health professionals, the public and wider organisations. Commentators struggled to grasp what the actual problem was with regards to the NHS, therefore the proposed solutions were not deemed necessary (Hunter, 2013). It was because of this outcry an official 'pause' in the legislative process

was called by David Cameron and Andrew Lansley (Secretary of State for Health) on the 4th April 2011 lasting for two months (Department of Health 2011). This 'pause' was referred to as a time of 'listening' where people could raise their concerns about the proposed policy changes. The 'pause' gave people an opportunity to provide opinions and suggestions on the policy proposals. The Future Forum (Field, 2011) was launched as part of the listening exercise on the Health and Social Care Bill, the purpose of the forum was to conduct a review of the policy proposals alongside the comments and opinions that were being fed into the listening exercise.

3.4.3   Policy Amendments after the Pause

After the 'pause' a number of amendments to the initial policy proposals were outlined (Department of Health, 2011c). The newly named GPCCs were restructured and renamed as Clinical Commissioning Groups (CCGs). CCGs would no longer consist of GPs alone; the Boards of CCGs would involve a wider membership including a nurse representative, a secondary care doctor and two lay representatives. This wider membership was to ensure that broader medical groups were being represented within CCGs and therefore they were not so dominantly GP led organisations. An interesting change following the 'pause' was that the government took on board the recommendations of the Future Forum (June 2011)   to make tackling HIs a duty for CCGs. This is an interesting policy development for healthcare as previously healthcare was perceived to have little overall impact on HIs (Exworthy et al 2003). Ongoing accountability for the CCGs was to be provided by the NHS Commissioning Board (NHSCB) to ensure transparency. On the 1st April 2013 the name of the NHSCB changed to NHS England (NHSE). All CCGs were to meet in public (where appropriate) and make their documents publically available. It was suggested that CCGs were not to cross LA boundaries. Therefore each CCG would be working with one LA, commissioning services for the whole CCG geographical population for both registered and unregistered patients. In certain circumstances, when approved by NHSCB, CCGs could work across LA boundaries with CCGs commissioning services over two LAs but this is not being encouraged. Sir David Nicholson, Chief Executive of NHSE (2011) sent a letter to all CCGs informing them of the clustering of PCTs. The letter informed CCGs that PCTs were to merge together to provide functions to CCGs throughout the transition of changes to the NHS. Managers from PCTs were to be assigned to CCGs to provide management expertise to help with their preparations for authorisation (Checkland et al., 2012). CCGs became subcommittees of their local PCT clusters by August 2011 because as yet they were not authorised as standalone organisations (they were due to go live April 1st 2013).

The policy process has moved very quickly, from the initial policy proposals the government hoped that fully functioning CCGs would be in place by April 2013. The Health and Social Care Bill was passed on 20th March 2012 which allowed policy implementation to begin. April 2012-March 2013 was classed as a shadow year whereby CCGs formed to prepare for an official authorisation process to examine the CCGs capabilities, workforce and to ensure that structures were in place to carry out the duties the government has set out. The authorisation process was outlined by the NHSCB (September 2011).

CCGs were expected to produce a wide range of evidence including future plans and evidence of current practice demonstrating their capabilities across six different domains, roughly evidencing 119 criteria including safeguarding, HIs etc (see figure 5). Once evidence was submitted, assessors measured the evidence against the key criteria and domains. Initial results were then sent back to CCGs, and a follow up panel day was conducted with each CCG and their assessors. This provided CCGs with an opportunity to provide further evidence of their capabilities against any outstanding conditions that remained from the initial assessment.

Figure 5: The authorisation domains (taken from NHSCB Clinical Commissioning Group Authorisation) October 2012 p 7)

Domain 1: A strong clinical and multi-professional focus which brings real added value.

Domain 2: Meaningful engagement with patients, carers and their communities.

Domain 3: Clear and credible plan which continue to deliver the QIPP challenge within financial resources.

Domain 4: Proper constitutional arrangements with the capacity and capability to deliver all their duties

CCGs were given four opportunities to apply for authorisation, when they felt ready. The process was separated into four waves throughout 2012 (see figure 6).

Figure 6: The four waves of authorisation (image taken from NHS Commissioning Board 2012, p41)
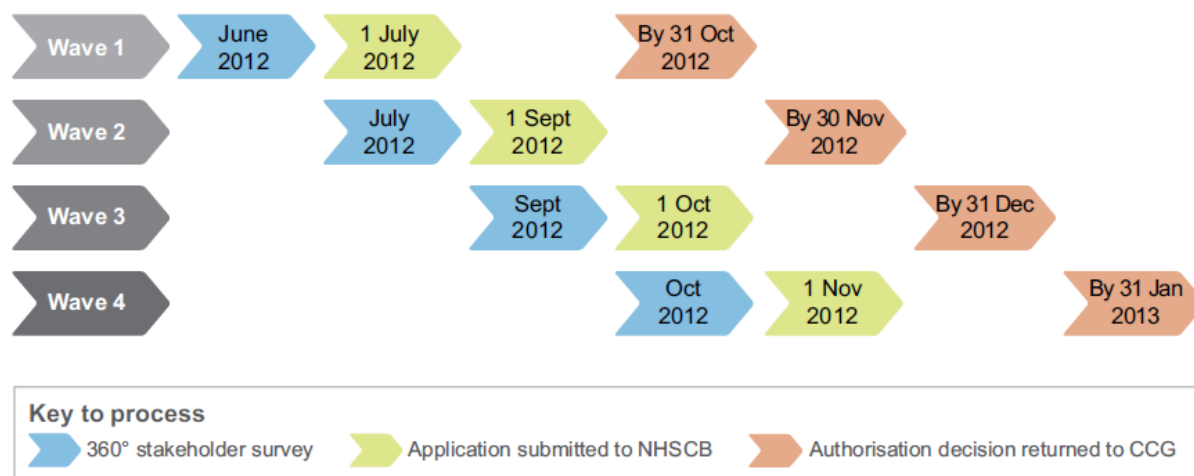
However, the government in later iterations of policy proposals has stipulated that no CCG would be given full commissioning responsibility unless they are seen by the NHSCB to be fully ready and capable. In this situation the CCG would still operate in 'shadow' until the NHSCB felt that the full responsibility could be discharged to the CCG (Department of Health, 2011a).

3.4.4   Previous GP involvement with Commissioning

There has been smaller scale GP commissioning with GP Fundholding (GPFH) (1991), Total Purchasing Pilots (TPP) (1995) and Practice Based Commissioning (PBC) (2004) in the past directed by both Labour and Conservative Governments. However, the success on a larger scale is still unknown. All three of these schemes were voluntary which is very different from the current reform with the changes being enforced on all. The past schemes did focus on commissioning but within all three schemes no practice was provided a full budget to manage themselves. GPFH was introduced in 1991 by central government to make healthcare more primary care led with no focus being placed on HIs. The initiative allowed GP practices either alone or grouped practices (dependent upon patient numbers) to commission a range of hospital and community services. The budgets for each consortium were based on historical patterns of expenditure. Any purchase of healthcare that was not included in the scheme was managed by the Health Authorities. During GPFHs initial introduction there was much opposition; people felt that it was a contentious decision for primary care to lead health services (Klein, 2010). GPFH received mixed reviews, GPFH never underwent a full government evaluation to truly measure the success or failure of the initiative but it did allow GPs to increase the power of primary care and allowed changes in relationships between GPs and hospitals, GPs felt they had more control. Within GPFH it was identified that GPs were able to fast track their patients over non GPFH groups, this led to discussions on the fairness of the system for patients (Klein, 2010).

In 1995 Total Purchasing was introduced by the Conservative Government, this initiative was to encourage multi-disciplinary commissioning by taking away the power of Health Authorities. Goodwin et al. (1998) found variation in the abilities of local TPPs in meeting the original objectives they had set themselves. The strength of TPPs was that they allowed positive relationships to be built with local actors, however; this did not necessarily lead to local agreement (Hurst et al., 2000). Wyke et al. (2001) found history to be an important factor, influencing the objectives of local TTPs. This enabled TTPs to challenge local problems that they had faced previously.

In 2004 PBC was introduced by the Labour Government, this scheme was introduced as a way of empowering frontline commissioners for providing better care and reducing inequalities. PBCs took on commissioning roles that had previously been managed by PCTs. Although PBCs were commissioning services they were working alongside PCTs (who still had ultimate accountability) making the decisions together. Checkland et al (2009) identified that developments in PBC showed slow progress due to a number of different factors identified by PBCs such as resources, time and problem relationships. Overall, little evidence was found to demonstrate how PBC impacted on HIs.

It can be seen from all three schemes that they have been beneficial in some areas although the schemes did receive some negative feedback. The introduction of GPFH and commissioning has enabled GPs to hold more power as well as provide primary care with better connections in terms of providing healthcare. However, under all three schemes local diversity has been identified as a

drawback (Peckham and Exworthy, 2003). If this information is applied to the current strategy it suggests that the introduction of CCGs may lead to further inequalities due to local differences in healthcare provision and different local strategic direction. The success of this new scheme may be dependent upon the relationships that are held between local organisations in different areas and the capabilities of GPs to be in charge of their own budgets.

3.4.5   Current Situation

Since the completion of fieldwork, the CCG authorisation process has continued with all 211 CCGs assessed and authorised (Naylor et al., 2013). However, initially 80% failed to meet the full assessment criteria. CCGs were ranked differently and therefore some CCGs only had a small number of outstanding criteria that they needed to achieve, whereas others had significant gaps in their evidence for authorisation and needed much more support post the authorisation process. NHS England (2013a) imposed significant restrictions on a small number of CCGs, meaning that they did not have the full legal functions of other CCGs until they could demonstrate that the authorisation criteria could be met. Whilst the policy was being implemented on the ground the NHSCB was renamed NHS England (NHSE), to try and provide a clearer definition of the organisation to the public (Hunt, 2013).

CCGs went live on 1st April 2013, charged with fulfilling the ambitions of the Health and Social Care Act 2012. Alongside the introduction of CCGs, several other organisations also took on their responsibilities from April 1st 2013, including NHSE, Public Health England (PHE) and local HWBs (see figure 7, NHS structure). NHSE are in charge of the overall system, monitoring and supporting CCGs. They are to ensure that CCGs are performing well in addition to providing developmental support to CCGs. It has been outlined by NHS England (2013a) in a draft proposal that an assurance framework is to be used to monitor CCGs. It has been suggested that CCGs will have to have quarterly checkpoint meetings and an annual check point meeting with NHSE. These set meetings will be used to monitor the overall capabilities and delivery of CCG duties and to highlight where more support is needed for CCGs. In November 2013, NHS England (2013) published the final CCG assurance framework, including a number of amendments from the original draft proposal. These included the quarterly CCG checkpoints being renamed quarterly assurance meetings and the meetings are to be based around six domains focusing on patient engagement, governance, outcomes, quality of service, partnership working and leadership. Further to this if CCGs are found to be performing well at the end of year one the frequency of ongoing meetings will be at the discretion of the CCG and the local area team.

The health & care system from April 2013
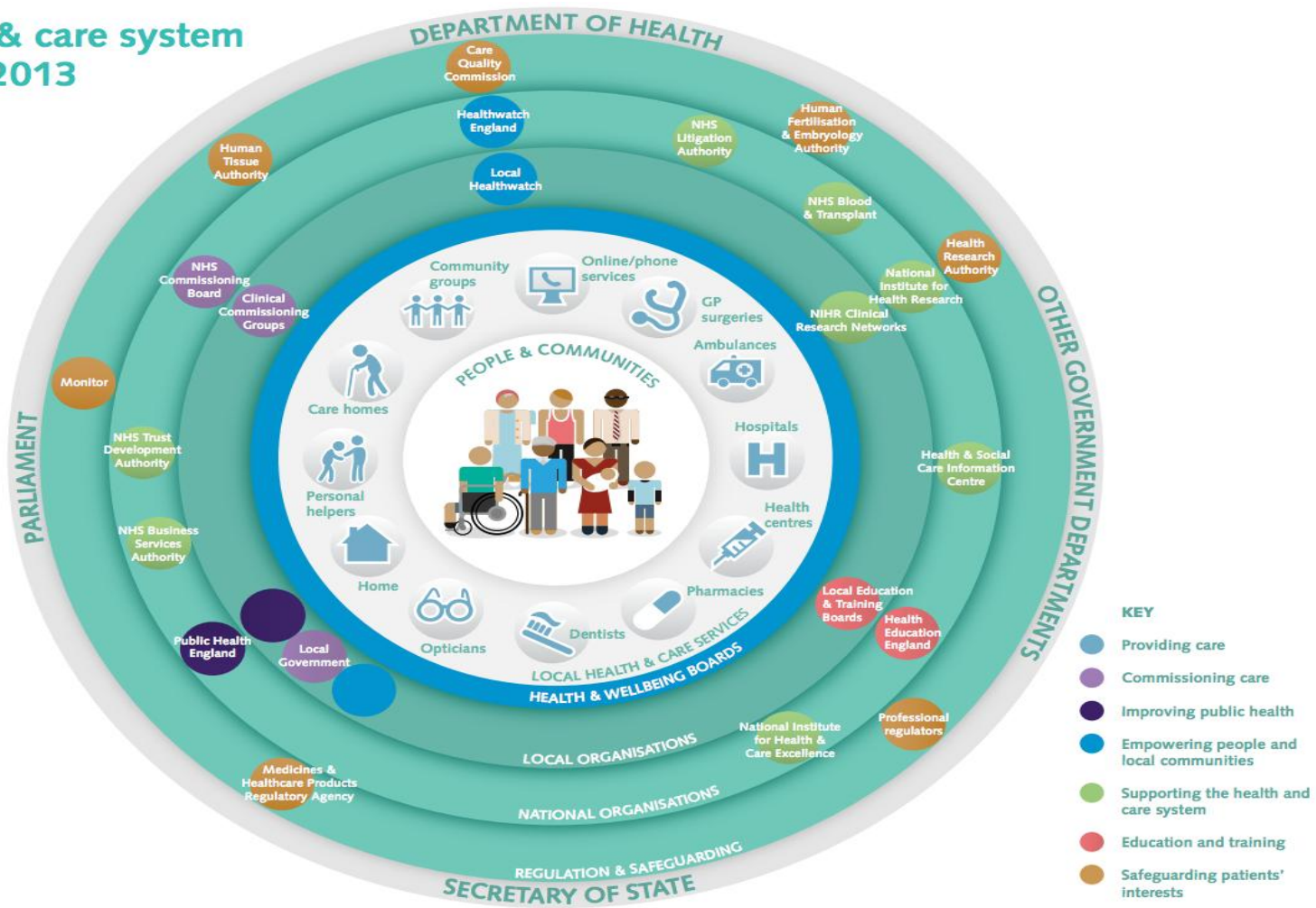
3.5 Summary of the Health Inequalities Literature and Policy Context

3.5.1 Health Inequalities and the Literature

This literature review (chapter 2) illustrated how complex the HIs arena is, and how there are numerous definitions and understandings of HIs that can be interpreted. Different theories and models have been used to demonstrate how inequalities in health are linked to many factors such as socioeconomic groups, race and gender. When research is specifically focusing on certain inequalities the terminology used to define them is often based on the particular inequality itself. It is because of the complexities of the HI's literature that a clear definition was not adopted for this project; instead this project aimed to explore CCG perceptions of HIs and how this influenced the HI's agenda at a local level.

3.5.2 The Role of Healthcare

The role of healthcare in tackling HIs has been portrayed within the literature as minimal. However, specific initiatives have outlined how healthcare can try to tackle HIs; these include avoidable mortality, access to services and partnership working (section 2.4). These initiatives provide different roles for healthcare to enact; avoidable mortality offers a list of diseases where deaths can be avoided if appropriate care is being provided, access provides an opportunity for healthcare providers to ensure that adequate service provision is available for their local population and partnership working enables a number of different organisations to work together to tackle HIs on a larger scale. Access to services and partnership working have been part of previous policy initiatives (as described in this chapter) to try and get health services to tackle HIs.

3.5.3 Policy Context

The policy context chapter has been included in this thesis to demonstrate the complexity of healthcare policy and the HI's agenda. Although this piece of research explored how CCGs, newly formed organisations were tackling HIs, it was important to highlight how CCGs have arisen out of previous NHS organisations. Although there was a re-organisation within the NHS, many CCGs were formed within the same geographical boundaries of what has gone before them, with the same people working in different roles. The current re-organisation is different from before, primary care commissioning organisations were no longer a voluntary scheme, they were imposed throughout the whole of England. The previous chapter (literature review, chapter 2) demonstrated that the role of healthcare for tackling HIs is often minimal, explanations that define and discuss the causes of HIs and how to overcome them often place little prominence on the role of healthcare. However, a new duty has been imposed on CCGs to tackle HIs, the duty itself lacked clarity or any formal guidance of how they should try and tackle the issue. Therefore it is unclear how CCGs will try and conceptualise and tackle HIs.

This project tried to explore CCGs understandings of HIs and ways in which they planned to tackle HIs locally.

Kingdon's (2003) model examining policy implementation (see chapter 3) can be used to examine the implementation of the HI's policy agenda within the current NHS re-organisation. Marmot's review (2010) examined the HI's agenda within England, discussing the continuation of the problem and suggestions of how the NHS, local government and other agencies could come together to tackle the issue. The Marmot Review (2010) can be argued to have brought HIs onto the current government agenda and into local government targets. This research project explored policy implementation at a local level, examining whether policy initiatives imposed from central government were being enacted locally. Figure (8) below summarises the literature, demonstrating a number of different factors (included in the larger circle) that could impact on how CCGs planned to tackle HIs. These will be investigated in the rest of the thesis.

Avoidable Deaths

Partnerships/Relationships

Minor role of the health service

Action to Tackle Health Inequalities

Access/Equity

Policy Changes

Perceptions of Health Inequalities

Inverse Care Law

Public Health Issue-Population Health
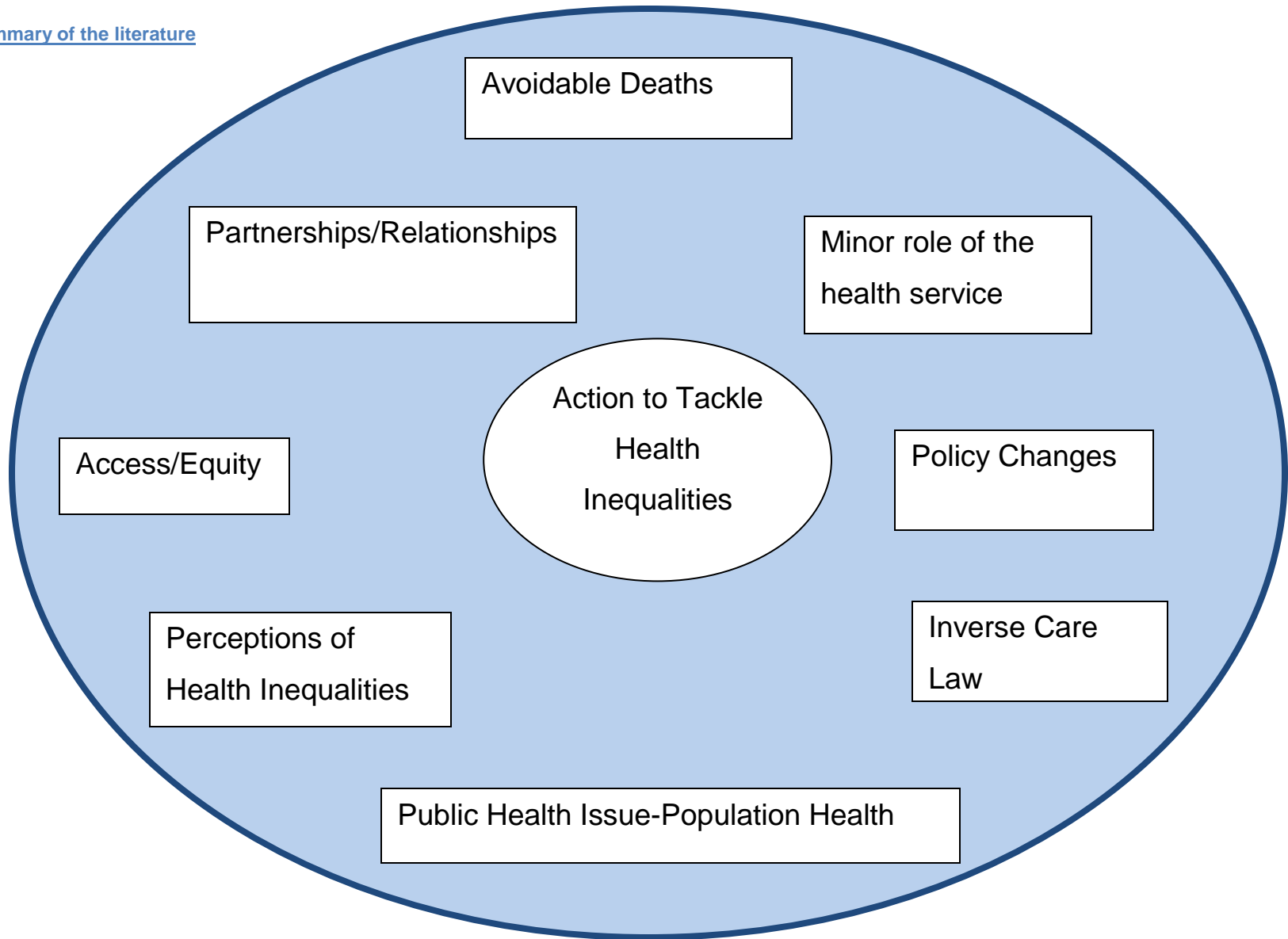
Chapter 4: Theoretical Framework

4.1   Introduction

The overarching aim of this study was to explore how CCGs were tackling HIs. Initial literature searching demonstrated how complex the term HIs is (see literature review chapter 2), with many different definitions and approaches adopted. This study was therefore designed to explore how members of CCGs conceptualised HIs as well as exploring the actions they were taking to tackle HIs. The purpose of this research was not to test the many different theories of HIs, instead a broader approach was needed to try and explore theories and understandings of HIs which resonated at a local level. Therefore, a theory of HIs was not relevant to help analyse the findings.

Understanding organisations can be complex and confusing as there is no clearly agreed definition of an organisation or agreed way of conceptualising what they do. Harrison and McDonald (2008) suggest that the concept of 'organisations' refers to the performance of collective tasks, which require group execution rather than work of one individual. Therefore, organisation itself implies social co-ordination. 'Social co-ordination is the process for seeking to align the efforts of mutual individuals involved in the task' (Harrison and Mc Donald, 2008 p79). This definition is useful in the context of this study, as the concept of 'social co-ordination' can be related to the efforts of CCGs trying to work (or not) on their centrally imposed duty to tackle HIs. Harrison and McDonald (2008) suggest that there are four core models of organisations; these are markets, bureaucracies, clans and networks. All four types of organisation use differing methods of control and co-ordination to ensure that tasks are carried out by the organisations (see figure 9). This pictorially shows a typology of control and co-ordination.
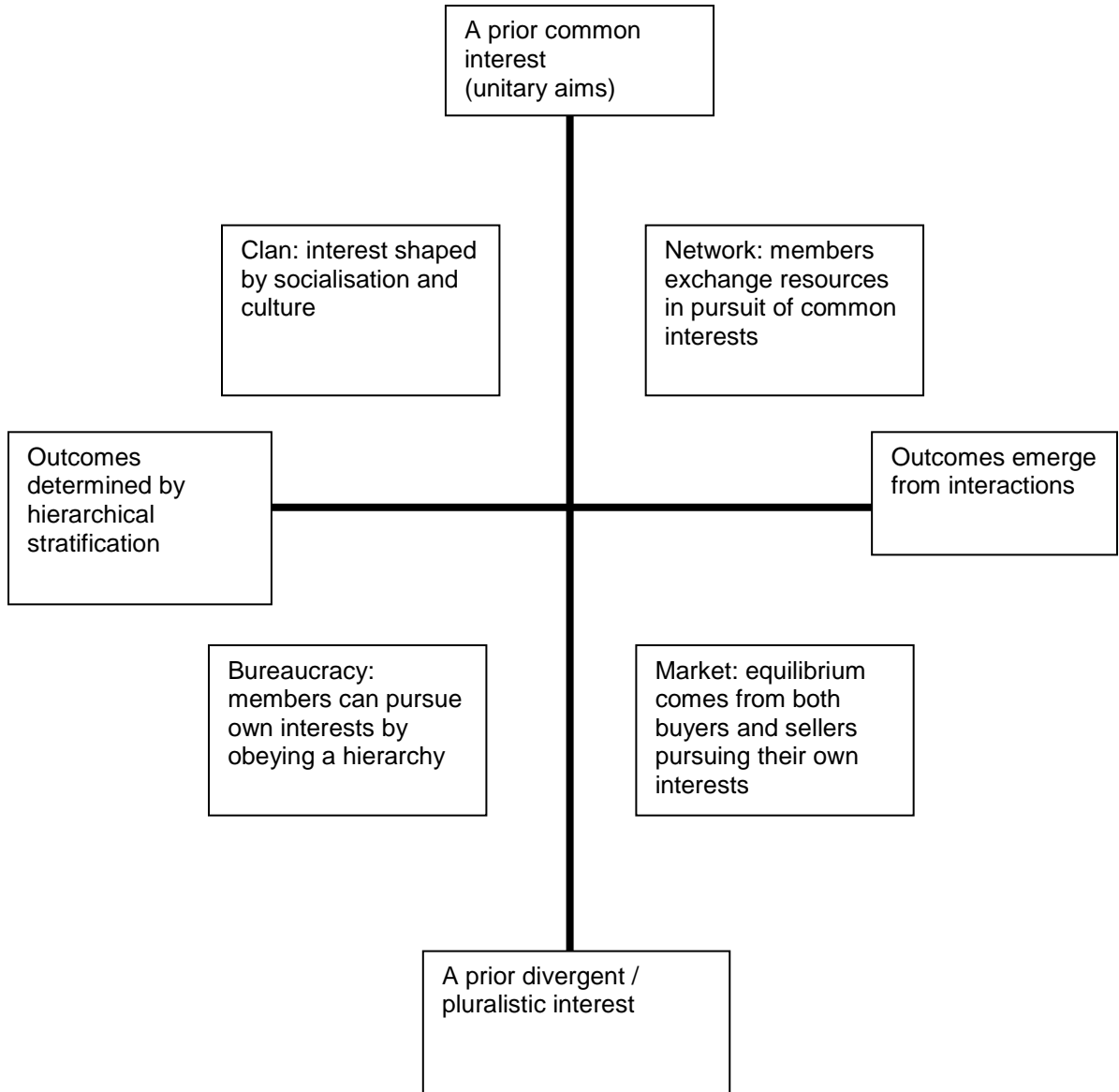
Markets freely pursue their own interests and exchange resources where they see fit, they are only constrained by the willingness of others to exchange with them. Markets themselves are political and shaped by powerful and political actors. Healthcare is unlikely to meet the conditions of markets, as the NHS is described as a non-profit making organisation. However, with the introduction of the purchaser and provider split, healthcare can be described as a quasi-market. Bureaucracy refers to the formalisation of rules and procedures. There is a formal hierarchy, whereby people obey instructions from those above them. Additionally, there is also a division of labour, with the separation of individuals and departments. Clans resemble a kinship network, whereby individuals are socialised through their membership with the organisation. Interestingly, Harrison and McDonald (2008) describe networks as primarily informal, whereby organisational flexibilities are broken down. Both hierarchies and markets can be seen as networks.

This typology of control and co-ordination allows us to investigate how organisations function and how they work towards common organisational goals. However, March (1984 p. 18) argues that 'organisational life is about interpretation, intellect metaphors of theory, and fitting history into understanding life as it is about decision making and coping with an environment'. Therefore, to understand what is happening in practice, you need to move beyond organisational structures and explore how processes are put into action, based on broader contextual factors. The purpose of this project was not to explore the entity of the organisation, instead an exploratory approach was required to see if and why action was occurring on the HI's agenda and if so, what was influencing it. Cicourel (1964) suggests that before a variable can be said to explain a certain action, it is necessary to understand the rules employed by participants to 'make sense' of it. This is what this project aimed to do when exploring the influences on the HIs agenda.

When CCGs were introduced, policy suggestions encouraged the idea of a membership organisation without any formal organisational structures. This broad framework for CCGs generally diffused common interests and therefore they fall at the 'network' end of the model (see figure 9). Outcomes emerge from interaction and therefore CCGs can be classified into the right hand side of the quadrant. Therefore, a theoretical framework of the emergent nature of outcomes was required. If CCG organisations had followed an organisational model such as a 'hierarchy' a theory which focused on how senior leaders make and carry out strategic decisions would have been useful. For example, the work of Mintzberg (1992) focuses on how people at the top of the hierarchy make and implement strategy within organisations. This theory is not so relevant to CCGs, as they are not clearly hierarchical. Also, if I was focusing on markets a model of market interaction may have been useful. Therefore, the models of organisations influence the theory that is required to examine them. Therefore, given the assumed nature of CCGs, Weick's concept of sensemaking allowed interactions to be explored, out of which outcomes occur.

Early data collection established how current approaches and conceptualisations of HIs arose out of past experiences and activities; therefore a framework that takes account of the role of history in influencing current situations was required to help examine the data obtained from this study. The current re-organisation of the NHS, may bring about change, however how change came about and the influences of history are clearly visible in primary care commissioning (Coleman et al., 2010). Weick's concept of sensemaking usefully unpacks the ways in which past experiences and history help to shape and inform current actions of both individuals and organisations. This concept itself is action focused, which is important in understanding how conceptualisations convert or do not convert into action. The aim of this chapter is to outline the concept of sensemaking, where it has been applied and the usefulness of the framework for this research project. The importance of history and the research question being action focused meant that sensemaking was identified as a useful concept to examine the findings through its particular lens. Sensemaking enabled the duty imposed on CCGs to tackle HIs and wider organisational influences to be viewed as a problem that CCGs had to face. Schon (1983) suggests that problem setting in sensemaking refers to a process, that organisations interactively,

name and frame the context in which a problem / situation is going to be addressed. The lens of sensemaking is appropriate to this research project as it enabled HIs to be viewed within the wider organisation and try and understand what the key influences on the HI's agenda were and why. This chapter describes the principles of sensemaking, its application to different research field and demonstrates its relevance to this research project.

4.2 What is Sensemaking?

Weick's (1995) concept of sensemaking is an attempt to answer the question: 'what is it that managers do when they manage?'. Weick argues that those responsible for managing organisations extract 'cues' from the ongoing stream of events that surround the organisation and make sense of them. What is 'noticed' as a relevant cue depends upon the pre-existing experiences of those involved. The sensemaking process generates action, which in turn alters the local reality. The process is ongoing and cyclical, with managerial action feeding in to change reality and therefore alter the cues that are noticed. Sensemaking moves beyond interpretation, interpretation implies that it is evident that an object / situation needs to be interpreted. Sensemaking, however asks is it possible to take things for granted? Weick argues that organisations have their own languages and symbols which in turn effect how they make sense of situations. Sensemaking focuses on how actors in organisations generate their interpretations of situations and seeks to explain how decisions are made. Action goes on in a state of inarticulate of half unconsciousness or actual unconsciousness of its subjective meaning (Weber, 1964 p. 111). The theory of sensemaking is underpinned by symbolic interactionism, a sociological theory that argues that people act towards things that have meanings for them (Clarke, 2001). Weick (1995) identifies seven properties of sensemaking which he claims distinguish sensemaking from other theories of management. The seven properties are a rough guideline of how sensemaking can be investigated, however Weick does point out that not all of the properties have to be present on every occasion. The seven properties are listed below:

Identity- Sensemaking is grounded in the construction of identity. In organisational theory the individual and the organisation are closely linked, whereby the image of the organisation reflects upon individuals who work within it. Thus, people will try to maintain a positive organisational image and if this is threatened they will adapt their behaviour to try to redefine the organisation to preserve a good self image.

Retrospective- the process of sensemaking itself is retrospective. By this, Weick means that rather than prospectively weighing up the pros and cons of different decisions, most managerial action takes place rapidly and reactively, with those involved retrospectively rationalising what they have done.

Enactive of sensible environments- this property focuses on enactment, implying that the organisational environment people are working in and face is often produced by the organisation itself. The environment itself is not fixed; it can change continuously.

Social- sensemaking is shaped by the social processes within which the organisation is embedded. This highlights the fact that sensemaking in organisations is generally a group activity, built upon collective experience and shared memory which is enacted via discourse.

On-going- processes are on-going and therefore 'cues' are extracted from moments of relevance. There is no stop and start in this process; organisations are continuously adapting to their environment, based on the 'cues' from past experiences that are relevant to the current situation.

Focused on extracted cues- 'cues' are moments or situations that arise and trigger sensemaking. Whether or not something is 'noticed' as a cue depends upon past experience and embedded ways of seeing the world. Similar organisations may differ significantly in whether or not they regard a particular 'cue' as important or require action, depending on the inbuilt assumptions that have grown through repeated rounds of sensemaking in the past.

Driven by plausibility rather than accuracy- a good story underpins sensemaking. Sensemaking does not rely upon an accurate analysis of reality, but upon perceptions. Weick argues that a plausible 'schema', which highlights the salient aspects of a situation and incorporates past experiences, is enough to enable relevant action to be taken, which in turn will generate more cues and refine the actor's understanding of the situation that they face.

In essence the sensemaking process is cyclical, and is often conducted in reverse. Meryl Louis (1980) views sensemaking as a recurring cycle where individuals form both conscious and unconscious predictions about the future. If a discrepant event arises, a process to understand and interpret this trigger is required. Thus, an event occurs and individuals collectively construct a plausible story about what happened based upon reflection on past experience and the history of the organisation (Weick 1995 p 11). Although it is often implied that sensemaking is established through 'shared values' and shared understandings of 'cues', Weick (1995 p180) emphasises that collective generation of 'sense' can depend as much upon disagreement and the voicing of alternative viewpoints as it does upon shared understandings.

4.3   Sensemaking in the literature

This approach to understanding management is useful because it provides a framework which takes account of specific local contexts and past histories. Sensemaking has been extensively used within the literature as a way of understanding organisations and organisational change. Sensemaking has been utilised in a number of different ways and can be loosely categorised into three groups; understanding responses to disasters, the impact of major change in organisations and exploring the power and institutions in sensemaking. The aim of this section is to explore how sensemaking has

been applied to these three different groups, helping to demonstrate the usefulness of this framework and the relevance to this study.

4.3.1 Studies of Disasters

Sensemaking has been applied to situations where disasters have occurred, highlighting how instinctive action, sets a response off on a path, which is difficult to change. Weick (1988) examined the impact of humans on crisis situations. The concept of enactment is examined and referred to as a material or symbolic record of action that is laid down (Smircich and Stubbart, 1985, p 726). This paper examines how the construction of words during a crisis can compose or limit stages of a crisis. Enactment itself is deemed to affect crisis management in several different ways, including the psychology of control, the effects of action on stress levels, the speed of interaction and ideology. Weick (1993) when examining the Mann Gulch fire explained that people become uneasy when situations arise that do not meet their expectations. When crises occur they impact on people's behaviours, instinctive action takes over which in turn can discredit previously performed roles. Thus, crises challenge organisations and individuals within them.

Other researchers have also examined sensemaking in times of crisis; Helms Mills and Weatherbee (2006) explored the responses of citizens and emergency organisations to a hurricane. Identity, construction and plausibility (three of Weick's properties underpinning sensemaking) were primary influences on behaviour that were demonstrated by both organisations and individuals. Little action was taken by individuals when the threat of a hurricane was looming because of their identity as citizens. The paper identifies that the storm was downplayed by people because of the location of their town and the weather forecast itself. The storm was not portrayed as plausible because of the lack of storm history in the area, this was shaped within a social context whereby people reacted to other people's behaviours around them, and thus little action was taken. In terms of the wider organisations in the area, the study reflects on the importance of memberships for organisations and the success of multi-agency working in crisis situations. Sensemaking identified that although citizens and the area were forewarned of a hurricane, little action was taken because of their collective identity, history of storms in the area and organisational working practices.

Wicks (2001) used Scott's (1995) three pillars of institutions, to emphasise the roles that were placed on individuals when an explosion occurred at a mine in Nova Scotia, killing twenty six men. Wicks argued that a regulative, normative and cognitive emphasis was placed on individuals, influencing the roles they adopted. Identity and roles were formed by the organisation and the social context that individuals worked within, shaping how they reacted to situations and conducted themselves on a daily basis. Overall, expectations are shaped by organisations, leaving little opportunity for scrutiny to occur, both history and tradition dominate expectations of workers.

4.3.2 Studies of Organisational Change

The framework of sensemaking has been applied to a number of different organisational contexts to examine how organisational change is made 'sense' of by middle managers in larger organisations. Parry (2003) used a framework of sensemaking to explore how executives in a local trust made 'sense' of their professional life whilst incorporating the three key themes of Life History (grasping the native's point of view), critical incident technique (an interview technique that investigates significant incidents) and the impact of storytelling and narrative. Parry explained that all seven properties that Weick (1995) included in his framework of sensemaking could be identified. However, action, reflection and experience were the key characteristics that helped shape executives understandings of their professional lives. In essence, the more experience an individual has, the fewer instances there will be where sense cannot be made of particular situations. Thus, history within an organisation shapes how situations are examined and enacted upon when sensemaking takes place. Balogun and Johnson (2004) used the framework of sensemaking to examine middle managers understandings of organisational change in a utility in the UK, exploring the implementation of decentralized management from previous hierarchical working. There were three periods of data collection where different sensemaking stages were identified. At stage one, sensemaking related to previous hierarchical working, whereby workers held the same 'schema' of themselves as part of an organisation with a common purpose. At the second stage of fieldwork, the common purpose of the organisation was lost and there was a sense of de-identification. The common purpose was replaced with more distributed sensemaking within new divisions. The periods of time between data collection gave managers the opportunity to resolve the conflicts they were experiencing whilst implementing organisational change, allowing contract implementation to occur at data collection point three. This study demonstrates how sensemaking and schematas are developed over time within a social setting surrounded by interaction. People were found to constantly compare their actions to both old and new expected behaviours until the new behaviours were fully adopted. Old behaviours are persistent when organisational changes are occurring.

Maitlis (2005) and Maitlis and Lawrence (2007) used the context of British symphony orchestras to explore sensemaking within organisations. Sensemaking occurs within set accounts and actions that are encapsulated within a social process. Sensemaking was not found to be a singular or homogeneous process, instead it was found to be complex and underpinned by four different forms of sensemaking processes, these included guided organisational sensemaking, restricted organisational sensemaking, fragmented organisational sensemaking and minimal organisational sensemaking. These different forms of sensemaking were underpinned by different levels of control and animation which help the decision making processes and action taken by organisations. Rouleau (2005), like others found that the use of words underpinned sensemaking, this study showed how middle managers used their vocabulary to influence stakeholders, during a period of organisational change. Managers were found to adjust their discourse on a daily basis, dependent upon who they were conversing with, this enabled them to set the strategic direction of the newly forming organisation. Four

practices of sensemaking were identified including, translating, overcoding, disciplining and justifying. These practices helped articulate the change; encapsulating specific elements that were important to the organisation e.g. gender, selling the new service that was being developed and providing good reasons for why the change was necessary.

Sensemaking has been extensively used within the health field and specifically focusing on primary care commissioning, thus demonstrating its relevance to this research project. Research conducted by Coleman et al (2010) and Checkland et al (2013) provide good examples of how a shared schemata from previous NHS incarnations can influence middle managers and organisational changes. Coleman et al (2010) used sensemaking as a framework to explore policy implementation of Practice Based Commissioning (PBC) and the role of local histories. They found that local sensemaking had been influenced by local history and a conceptual schemata that had been derived from earlier reconfigurations of the NHS. Overall histories of local health organisations were found to be important and influential in the sensemaking and local enactment of national health policy. Previously established norms and routines that had been established within the existing institutions were used in response to the new 'cues' that were occurring when PBC was being implemented. The relevance of history was a theme that was noticeable during the early stages of data collection for this research project reiterating the findings of Coleman et al (2010). Checkland et al (2013) add another element to the sensemaking literature, rather than focussing on how managers make sense of change in the discourse setting, this study examined the practical behaviours that managers enacted when sensemaking. Meeting attendance and absence, alongside the use of artefacts (written materials e.g. meeting minutes and presentation slides) in meetings were instrumental in enabling managers to have a greater impact within their organisations. This practical enactment of sensemaking was argued to be a positive element of sensemaking that can be implemented by proactive managers under NHS organisational change. Organisational change provided managers with an opportunity to introduce new practices and embed them as part of the wider organisational reforms. Overall, this section highlights not only the relevance of sensemaking to understanding organisational change and the importance of key individuals and the wider context the organisation works within. It provides an opportunity for this research project to build on the work that has gone before, focusing specifically on the HI's agenda within the current re-organisation of the NHS.

4.3.3   Studies of Power and Institutions

The influence of power on institutions has also been examined with sensemaking. These studies emphasise how institutional factors and power relationships shape how people on the ground are able to make sense of cues and changing situations. Long and Helms Mills (2010) focused on institutions, and the effect an organisation can have on the sensemaking process. Critical sensemaking methodology was implemented to demonstrate that the institutional context is able to affect the collective sensemaking of individuals by reducing room for interpretation, ensuring that particular norms and values are organisationally objectified. Thus, trying to overcome asymmetries in

sensemaking, by producing organisational values, which become rational and routine to those working within a particular context. Weber and Glyn (2006) chose to explore the wider impact of institutions in organisational sensemaking, macro-level institutions act to prime, edit and trigger sensemaking, influencing micro-level actors. Thus, institutions create the context that sensemaking occurs within. Hope (2010) found that middle managers framed their power using political tactics, to ensure that their influence could be exerted to change specific outcomes. This study was conducted in an insurance company, where power was deemed as an enabler of the construction of meaning. Whilst power invested in individuals by virtue of their position in the hierarchy was certainly visible, Hope (2010) also draws attention to the mechanisms by which other actors were able to act and manoeuvre themselves into positions whereby their interpretations and 'sensegiving' prevailed.

Within both of the second two categories there is a strand of literature about 'sensegiving', which emphasises how individuals can actively shape the sensemaking of those around them. In their papers, Gioia and Chittipeddi (1991) and Gioia and Thomas (1996) focus on the role of senior managers and how they actively decided to influence subordinates sensemaking in order to shape their responses. Identity was found to be malleable and fluid; managers were able to prime strategic change in an aspirational context. Thus, change was constructed in a manner allowing individuals to associate with the changing dynamics of the organisational transformation. By contrast, Checkland et al (2013) emphasise the way in which often instinctive routine behaviours such as setting agendas and being the person who writes the summary of a meeting can profoundly influence the way sense is made.

4.4 Summary

This brief description of Weick's work has shown how the concept of sensemaking has been used to understand organisational behaviour (in the health field and other areas), focusing on both discourse and practice of managers during organisational change. In particular I have emphasised how schematas are developed within social contexts, they are defined by the social interactions between individuals. The persistence of history and experience is a key component that helps shape how managers interpret and make sense of changes as and when they occur in their organisations; cues are compared to previous strategies and working practices, sensemaking occurs within the parameters of the influence of history. This framework is of particular relevance to this research project as it attempts to help examine and understand how wider contextual factors, influence how people and organisations cope with changing situations. Therefore, it allows the question of how CCGs are tackling HIs to be examined within the wider policy changes and re-organisation of the NHS, exploring how the context shapes the outcomes of policy initiatives at a local level. Thus, examining how local contexts influence action. Further to this, action itself, acts as a way to establish sensemaking, exploring what can or should be done within an organisation. These aspects of sensemaking will be returned to within the results and discussion chapters, where the data from the study will be explored in more detail (see chapter's 9 and 11).

Chapter 5: Methods

5.1 Introduction

The purpose of this research was to explore how CCGs were tackling HIs, qualitative research methods were identified and chosen as the most appropriate way to obtain data and answer the research questions. The research questions chosen take an exploratory approach, looking at how CCGs perceive HIs and how this affects the approaches taken to tackle them. Much research into HIs uses quantitative research methods (Doran et al., 2004, Doran et al., 2006, Gatrell et al., 2004). Such methods are ideal for measuring particular, well defined problems, and for comparing outcomes between areas. However, as discussed in the earlier sections (see literature review, chapter 2) this study explored perceptions of HIs and the wider influences impacting on HI perceptions and did not try to quantify HIs. For the purposes of this research project an understanding of what CCGs are doing to tackle HIs, underlying influences and their impact on HIs decisions were explored. Therefore, an exploratory qualitative case study approach was chosen.

5.2 Research Questions

Outlined below are the overarching **research questions** identified for this research project. These questions were the main focus of the research concentrating on how CCGs perceived HIs, how they were tackling HIs (or not) and what had influenced their decision making processes in relation to HIs. As shown in the literature review (chapter 2) there are numerous different models in use articulating the causes of HIs and ways that they can be tackled. The role of healthcare within the models is often minimal with little responsibility being placed on them to do anything about the issue. It is because of this that my first question explored how CCGs were conceptualising HIs, do they use a specific definition of HIs and if so what has influenced the ways in which they think about them. The new health system is to be clinically led, brought about by the changes under the Health and Social Care Act (2012) . Therefore, clinician perceptions of HIs could impact on how HIs are tackled in the new system. The policy context (chapter three) explored the development of the newly forming CCG organisations, HIs policy in England and past iterations of primary care commissioning. It was outlined that CCGs have a duty to tackle HIs, (Field 2011, p12) ; however there was no clear guidelines of how to do this. The second research question aimed to explore how CCGs were tackling HIs (if at all), examining how they were discussed in meetings and the influence of national policy on the development of the HI's agenda. The policy window (Kingdon, 2003) for HIs has been opened (see section 3.2), question two examined the extent to which the opening of the window has enabled local action. The concept of sensemaking (Weick, 1995) has been used as a framework to understand the wider context of the HIs policy, exploring the influence of relationships, history and organisation development on action to tackle HIs. This piece of research is novel, although the issue of HIs is a well researched area this project focused on the perceptions of HIs within the newly forming NHS structure. Therefore, perceptions of HIs and actions to tackle HIs are being explored in a new context. Overall,

the main research questions were developed from the literature, identifying a gap in existing research and the questions were constructed to address this gap.

Within each overarching question are subsidiary questions, these have been constructed to ensure that specific areas within each of the broad themes of the research were focused on. These subsidiary questions were developed to help underpin and answer the overarching research questions.

Question 1: How do CCGs conceptualise HIs?

- What theoretical approaches do they take?
- What influences CCGs' understandings of HIs?
- How do they define their individual and collective roles?

Question one aimed to identify how CCGs perceived HIs and what the underlying influences were on these perceptions. This question was used to explore how perceptions impact upon the development of strategies and how outcomes are devised and delivered to deal with HIs.

Question 2: What are newly established Clinical Commissioning Groups doing to tackle HIs?

- Are HIs discussed in meetings?
- Are HIs naturally included in plans?
- What practical steps are being taken to deal with HIs?
- Who makes the decisions about HI strategies?
- Are there individuals with specific responsibilities within the CCG to deal with HIs?

Question two was selected to see how often HIs were mentioned (or not) within CCG work and who was dealing with the issue of HIs. These questions were considered throughout the project, focusing on pathways, plans and strategies that were being developed within each site. This question relates to the policy proposal for all CCGs having a duty to tackle HIs.

Question 3: What are the contextual factors influencing the approaches taken by CCGs to tackle HIs?

Organisation

- What are seen as CCG priorities whilst commissioning health?
- Where do HIs fall into this?
- What policy expectations have been placed upon CCGs and what are their understandings of this?

Relationships

- How do relationships within CCGs and with other organisations impact upon tackling HIs?
- Does local NHSE provide governance in relation to HIs?
- What roles do GPs take on HWB's?
- How does the history of old relationships impact upon the current changes?

History

- How do local histories (past organisational structure, relationships, processes etc) impact upon the ways in which HIs are tackled?
- How do previous NHS reorganisations impact upon the current changes?

Question three was important; the subsidiary questions allowed relationships, histories and organisations to be explored in more detail focusing on how these factors influenced GPs and managers perceptions. These questions addressed the bigger picture, identifying that HIs are one issue in and amongst many others.

5.3 Research Design

CCGs were in shadow form and developing themselves as organisations at the time of data collection. Therefore, the methodology had to take into consideration the wider organisational context that the research questions were being set within. Organisational studies acknowledge that organisational behaviour is determined by the context that it is situated within (Ferlie, 2001). The main focus of the project was how CCGs conceptualised HIs and how they planned to tackle them, therefore the methodology needed to take into account contextual factors, such as relationships and histories (see research questions above, section 5.2). Therefore, to take into account the above contextual factors, the organisation itself, histories and relationships, an in-depth approach was required. Thus, a qualitative case study approach was adopted loosely based on the work of Yin (2003). Exworthy and Powell (2012) described the usefulness of case studies, explaining that they are a valuable tool, allowing patterns and outcomes to be explained between policy, institutions and ideas.

Yin (1994) stated that the case study approach allows an in-depth exploration of context; the diagram below outlines the approach that was initially selected to explore the proposed research questions. The

initial plan was to use a multiple case study model, whereby three cases would be selected, site visits would be made for a period of several months followed by a break in the fieldwork whereby research could take place. Thus, allowing for any outstanding areas or new themes to be identified and explored further when the case study sites were returned to (see figure 10). In addition to this, an option to add an additional fourth site was also contemplated to use as a comparator to my three in-depth case study sites.

Figure 10: Multiple Case Study Model
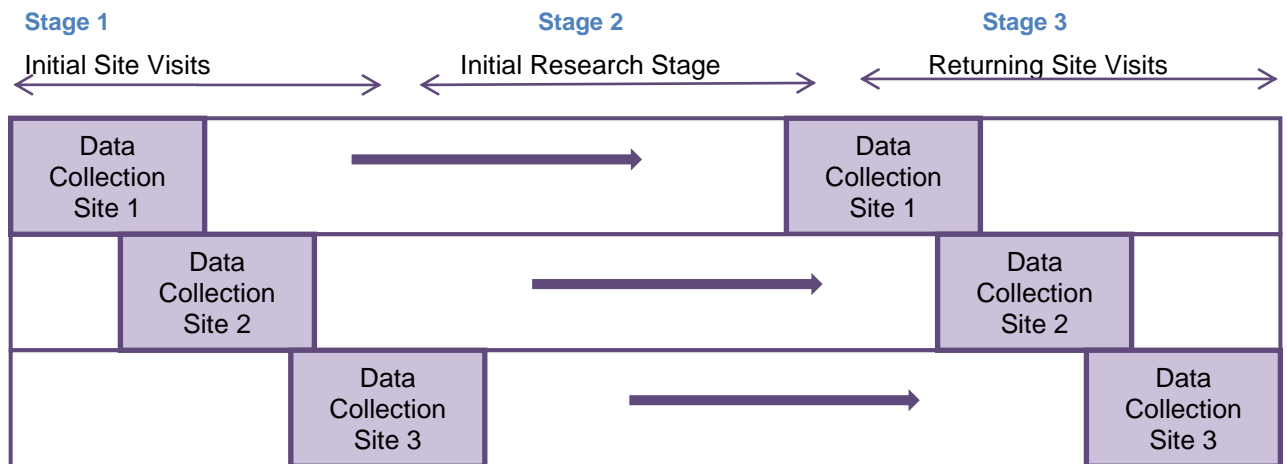
However, because of a number of practical issues relating to ethical approval, research governance and site recruitment this model was not used (see section 5.8). Three case study sites based across the North of England were recruited, and a more continuous longitudinal approach was adopted (Figure 11). On-going contact was maintained with all three sites, however because of research governance delays, site three access was not granted as quickly as sites one and two and therefore the data collection period was shorter. This was out of my control; therefore the research design model was adapted to ensure that the research was continuous across all three of the chosen sites.

Figure 11: Fieldwork Plan

This model was chosen to best answer the research questions, include the context of the study and to ensure that the practicalities of having only one researcher were taken into consideration. Policy in this area was rapidly changing; this model allowed on-going contact with sites ensuring that information was gained throughout the whole data collection phase, longitudinally. Further support for this methodological choice is offered by Keen and Packwood (1995) who argued that case studies are useful when, measuring a period of policy change within a complex setting. This methodological

approach has been peer reviewed and will be published as part of a wider piece of methodological work (Warwick-Giles forthcoming).

Although case studies are a well-used design they still come under criticism. Case study approaches have been critiqued as lacking rigour as they provide little evidence to base scientific replication on. Another criticism of the design is that of time, case studies can be time consuming and produce a large amount of documents and paperwork making the studies difficult to manage. Kidder and Judd (1986) made counter arguments against the critiques of case studies arguing that at different phases of the research tactics can be used to provide a more rigorous case study approach. The Figure below (12) outlines Kidder and Judd's argument (Yin, 1994). Within this research project multiple sites were used with a number of different qualitative data collection methods; increasing construct validity and external validity. Construct validity refers to the method that is being used to measure the specific concepts of any particular study during the time of research (Yin, 1994). Measuring a concept and the impact of it during any particular time frame has been referred to a problematic. Kidder and Judd claim that to strengthen construct validity when carrying out case study research, the researcher needs to use multiple sources of evidence; this allows a chain of evidence to be built over the period of fieldwork, allowing an evidence base to be constructed on the concepts. External validity refers to whether case study findings are generalizable beyond the case study that has been selected (Yin, 1994 p35). Although this is a common problem that is faced in case study research, it has been argued that by using multiple cases generalizability is more likely. Further to this, case study research helps generate theory that can be applied to similar case studies so that generalizability can be obtained within a similar context.

Figure 12: adapted from Yin (1994): Case Study Tactics

Test	Case Study Tactic	Phase of research tactic occurs
Construct Validity	Multiple sources of evidence Chain of evidence Key informants review the draft report	Data Collection
Internal Validity (Causal relationships)	Pattern matching Explanation building Time series analysis	Data Analysis
External Validity (Domain in which the studies can be generalised)	Use replication- multiple case studies	Research Design
Reliability (How operations of a study can be repeated)	Case study protocol	Data Collection

5.4   Sampling

There are a number of different ways to sample sites and informants within them in qualitative research. Murphy et al (1998) discussed how different sampling strategies are used dependent upon the type of research that is being carried out and what outcomes researchers want to gain. For the purpose of this project sites were chosen based on theoretical or purposive sampling approaches allowing for maximum variation (between the 3 sites). Miles and Huberman (1994) argued that selection with qualitative research methods should be theory driven enabling testing of theoretical principles. Silverman (2000) stated that purposive and theoretical sampling are overlapping strategies which is why for the purpose of this project both definitions were used. Purposive sampling allowed three different types of sites based on geography and deprivation homogeneity and heterogeneity to be selected. The use of different theories to sample enabled greater variation of data to be collected across different CCGs allowing for comparisons to be made. Purposive sampling enables meaningful comparisons to be made in relation to the research questions, theory and explanations (Mason, 1996).

Whilst looking at the sampling framework an element of pragmatism had to be considered for gaining access to sites. Site selection was not only dependent upon the theoretical criteria listed above but also whether CCGs were willing to take part in the research. It is also important to note, that because of the time restrictions of the project, full site coverage was not possible. For example, I was unable to have sites that were geographically located across the whole of the UK, purely because of the practical limitations of this project being singularly undertaken by myself. I wanted to conduct face to face interviews and carry out observations; sites that were geographically very distant would have impacted on my data collection methods.

Miles and Huberman (1994) argued that four aspects need to be taken into account when selecting research participants and locations. These are settings, actors, events and processes. For the purposes of this project the four categories are outlined below relating to the current research. The setting is geographical with the research taking place in the North of England including areas in the North West and Yorkshire. The actors (informants) included GPs, CCG managers, practice managers, other NHS managers (eg PCT clusters), PH professionals and lay representatives associated with the CCGs. In addition, contact was made with other managers, such as hospital managers engaged in contract negotiations, as well as LA officers / councillors associated with the HWB. These additional informants were identified from events that the CCG were involved in, including local HWB meetings and provider meetings.

Initially contact was made with four sites across Northern England incorporating a mixture of different population demographics, one declined because they felt that they were not able to take part in research when trying to establish themselves as an organisation. The three sites that were included in this project are briefly described below. Once data collection had commenced it became apparent that

four sites would not allow a full in-depth approach to be conducted, therefore a further fourth site was not asked to take part in this research.

Site one- covers a population of between 101,000 and 200,000 which is served by approximately forty practices within the CCG. This CCG suffers from high levels of deprivation across the area.

Site two- covers a population between 201,000 and 300,000 which is served by approximately fifty practices. This CCG has pockets of deprivation with many of the areas within the borough being affluent however; three of the wards are in the top ten per cent for deprivation in the country.

Site three- covers a population between 201,000 and 300,000 containing approximately forty practices covering both rural and urban locations meaning that there were a number of different health needs that needed to be thought of and addressed across the different areas. More site information is available in chapter 6.

5.5 Access

When accessing sites the University of Manchester's ethics regulations were followed. Formal letters were sent to all of the possible sites introducing the research topic outlining what taking part would involve for the CCG. Once interest was shown a telephone conversation was conducted, allowing the project to be discussed in detail and addressed any queries that CCG members had, covering practical issues for both the CCGs and the individuals working for the CCG. All sites were informed that they would receive a full copy of the thesis, any publications that arise from the project and a small report outlining the findings. This initial stage of access was conducted with one CCG member and therefore the information needed to be formally taken to each CCG governing body to be authorised. Once permission was granted, local research governance had to be obtained for each CCG; this led to a number of delays (see ethics section 5.8). The timeline of this stage of the project is shown below in figure (13).

Figure 13: Access to sites

Site	Initial Contact	Approval	Research Governance	Access Granted
Site One	July 2011	August 2011	January 2012	January 2012
Site Two	October 2011	October 2011	January 2012	January 2012
Site Three	November 2011	January 2012	January 2012	May 2012
Site Four	September 2011	No Approval- October 2011	N/A	N/A

Once sites had been accessed, another sampling technique was used to access key members of staff who were deemed relevant to the project. Snowball sampling was used. This refers to a technique where the observations and the initial group of informants were used to help recruit other individuals, (Bowling, 1997). Key informants, GPs and managers were identified from initial site visits and the organisational structures available. Subsequently, others were identified at observations and from interviews with other CCG members, whereby they recommended specific individuals to talk to.

5.6 Data Collection Methods

Organisational policy research is very complex and is made up of a number of different elements. Patton (1987) argued that there are four different types of triangulation including data sources, different evaluators, perspectives in the same data set and triangulation of research methods. Therefore to try and access as much information / data as possible on CCGs and HIs, triangulation of data methods was used. By using a multiple data sources approach more information was gained filling in the gaps that are often experienced when using a single method alone. Jick (1979) stated that the use of a number of different data sources allows a deeper understanding of the research situation to emerge. Other researchers such as Green and Thorogood (2010) conclude that the use of a multi-methods approach is beneficial as it allows for greater levels of validity. Although triangulation has been positively accepted this approach still receives criticism. Mason (2002) writes that triangulation is a complex strategy which leads to a variety of different data which can be difficult to link together at the analysis stage. Although, multi-methods can be seen as complex it was felt that for this project they would be beneficial as it allows for further coverage on the research topic at each site. Yin (2003) argued that policy research is not limited to only one form of data collection. Multiple data sources provide more in-depth data, increasing the validation of findings which overall increases the reliability. Data were collected for twelve months commencing in January 2012 and was completed in December 2012. Three different date sources were used including observations, interviews and documents, these are discussed below. Figure 14, outlines the number of observations and interviews that were conducted across the three sites.

	Interviews	Observations
Site One	7 3 GPs, 3 Managers and 1 Public Health Consultant	19
Site Two	8 4 GPs, 3 Managers and 1 Public Health Consultant	26
Site Three	7 3 GPs, 3 Managers and 1 Public Health Consultant	21

Interviews- Twenty two semi-structured interviews were carried out across the three sites with GPs, managers and Public Health Consultants (PHCs). Verbal consent was obtained before the interviews took place, when arranging the location and time at the convenience of those taking part. All informants were informed that the interviews would last approximately one hour. At the beginning of each interview each informant was asked to read an information sheet and complete a written consent form (see Appendix two and three). At this point all informants were asked whether they would be willing to have the interview recorded, this was included in the consent form. Out of the twenty two interviews, only one person did not want their interview to be recorded. The interview still went ahead and detailed notes were taken during the interview. Detailed note taking was carried out throughout all of the interviews, to help with analysis and question development. All semi-structured interviews were based on a topic guide (see Appendix four); which was developed from theory and was altered over time based on ongoing analysis. The use of a topic guide was to ensure that relevant questions were being asked and to enable further comparisons to be made across the three different sites. The interviews followed a topic guide; however divergence was allowed which helped rapport development between myself and the informants. The interview guide itself was a flexible tool, initial interview responses and policy changes throughout the fieldwork meant that the guide was developed to reflect the context the study was developing within. Burgess (1982) wrote that qualitative interviews allow researchers to follow up new ideas that arise from the interviews that were not originally expected, allowing flexibility to follow new research avenue. Semi structured interviews allow conversation to develop between the researcher and interviewee which often leads to rich and rewarding data (Wisker, 2001). The main use of the interviews was to find out how CCG staff conceptualised HIs and what had influenced their perceptions. These questions were addressed to offer more to the wider picture of HIs which had not been addressed previously. Although interviews are a very useful data collection technique, it was

noted for this project that the responses from individuals were based on the situation the interviews were taking place in. Mason (1996) recounted that information received during interviews is contextual and based on each individual interview. Therefore, to overcome this limitation a multi-methods approach was adopted to ensure that data were being collected from a number of different contexts.

Observations- Sixty Six (approximately 198 hours) non-participatory observations were carried out at CCG organisational meetings as well as other meetings that CCG representatives attended. Additional meetings such as the new HWBs (where wider strategy was discussed) were also attended where they were viewed relevant to HIs. Non-Participatory observation is when the researcher does not participate in the situation that is being observed. All people who were observed were made aware of my role, therefore they knew why I was sitting in on a number of CCG meetings. As time passed, CCG governing body members became more aware of my presence and began to include me in their meetings, requesting feedback and input into particular conversations. Although this occurred infrequently it illustrates how my non-participatory researcher role was adaptable and therefore my observations on occasion became partially participatory observations. Green and Thorogood (2010) argued that observational methods allow researchers to record features of everyday life that informants did not feel relevant to disclose in interviews adding to the context of the data. Mason (1996) argued that observation allows full immersion within the research setting. Data obtained from the observations helped illustrate what was being said about HIs and what decisions were being made organizationally about HIs. This information will deepen and enrich the data allowing comparisons to be made over interviews, observations and meeting documents. Field notes were taken during the observations and used as rich data sources when carrying out the analysis. The use of observation also allowed access to information that was happening rapidly, thus being discussed in meetings before any documents or roles were developed. Observations allowed full access to organisational meetings when exploring how HIs were being discussed and tackled by the CCGs. As the researcher, I followed a pattern of how I carried out the observations. Dependent on each site, I sometimes sat around the table with CCG members whilst in others I sat away from the table. These decisions were made based on each individual CCG and the preferences they held. When attending each meeting I would make notes on the room I was in and the people that were attending the meeting, this enabled me to build up my knowledge about people working within the CCG as well as keep a record of the different people attending different meetings (see figure 15).

> **Meeting:** XXX Clinical Commissioning Group Governing Body
>
> **Attendance:** Associate Director of Strategy and Governance, Accountable Officer Designate and Chair of meeting, Deputy Director of Public Health, Director of IM&T, Head of Communication, Acting Director of Finance, Associate Director of Performance & Market Management, Locality Managing Director, LINk Manager, Non Executive, Locality GP1, GP2, Locality GP2, Locality GP3, Lay Advisor, locality GP4, Director of Adult Social Care, GP3 and Lynsey Warwick-Giles
> **Date:** 9th May (Agenda 1:10-12.10pm, Agenda 2: 12.10-12.55)
> Monthly Meetings
>
> **Thoughts:** During this meeting there was no mention of health inequalities by any governing body member. This is the first time I have been able to stay for the whole meeting and it was interesting to see how rushed the meeting was. This meeting never runs to time but due to the bilateral running over many points were rushed over and the chair had to keep cutting people off due to a number of meetings that people had to attend afterwards. The key areas still relate to authorisation, CSS, Performance and Finance.

At the end of every observation, I wrote brief notes about each meeting, reflecting on any conversations relating to HIs or comments about the dynamics of the meeting. This helped develop a framework of analysis, incorporating common themes and codes. Additionally to this, I kept a personal research diary that I completed daily, exploring my thoughts about the development of the project and findings from meetings. This task was complementary of the on-going research analysis.

Documents- Documents were collected from CCGs and were based on meeting minutes and agendas, reports and strategies. Documents were included to see how CCGs used these in relation to policy development and HIs and how they were disseminated to other CCG members. Further documents were accessed via email; I became part of a number of mailing lists, allowing me to obtain as much information on the organisation as possible. The information from documents and basic document analysis was used to deepen the research, offering contextual information, rather than being used as a confirmation of findings. Coffey and Atkinson (1996) stated that documents are social; facts that are produced used and shared in socially organised ways. However, the documents are unable to provide descriptions of organisational routines / processes. It has to be acknowledged that access to documents was not comparative across all three of the sites and therefore the data have been used to enrich the study rather than being the main focus of data collection.

5.7   Data Analysis

The multi-method case study design enabled a large amount of data to be collected from several sources, including observations, interviews and documents collected. Data analysis was iterative in its nature and was conducted both throughout data collection and when data saturation was reached. Data saturation is commonly referred to when using the grounded theory approach and is when new data are no longer adding more to the emerging theory that is being developed, (Green and Thorogood 2010, p287). Thus, data collection is no longer contributing any further value to the research project

field notes were read and re-read to ensure that the questions being asked throughout the study would have continual development and attain the information that was relevant to the overall project. This method ensured that questions were providing insight to the study and not being used as a descriptive tool alone. The use of an iterative approach allowed further insight into the area; emerging themes were identified whilst data collection was ongoing. Thus, the approach adopted was simultaneous. Mason (1996) stated that this is one of the three ways in which theory can be generated in qualitative research. When questions were developed and changed, all sites were re-visited or contacted to ensure that appropriate questions were being asked across all three sites. For example, it emerged that the role of PH varied across the three sites (chapters 10 and 11). This emerged as data were collected and time was spent with all three sites. Therefore, to ensure that the relevant questions were being asked about the PH role, field notes were read and the interview questions were developed to explore this finding in more depth.

I wrote all the observation notes up in detail, each set of notes was completed in the same week the observation occurred to ensure that valuable wider information was not lost i.e. contextual factors. The amount of information that was generated from observations was vast and therefore Nuance Dragon software was used to help with the time consumption of write up. Nuance Dragon software is a voice recognition programme that recognises what the speaker is saying and transcribes the work into a word document. This tool was very useful to the project; it helped with timing demands across the three sites. Additionally to this, all interview digital recordings were either transcribed by myself into a word document, whereby speakers were identified as interviewer (I) or respondent (R) (see Appendix five) or by an external transcription company. Again the external transcription company was used to help manage the amount of data that were obtained. Once transcripts were sent back from the external companies, all transcriptions were checked against the digital recording to ensure that the transcription was correct. Once the interviews had been transcribed, observation notes were written up and relevant documents were identified they were then put into the computer data software system Atlas.ti (Scientific Software, Berlin). This computer package is recognised for being a useful tool when carrying out qualitative research. It allows all documents to be organised and stored. All documents are password protected, allowing confidentiality to be maintained throughout the analysis process. Emerging codes (see Appendix six) that were generated from theory and ongoing analysis were attached to portions of text, whilst more in-depth memos were written when the analytical process was being developed. Memos enabled codes and key concepts to be linked throughout the analytical process. Memoing and coding was carried out in parallel with data collection. Memoing consists of notes about hypotheses, ideas and certain categories to be developed allowing relationships between categories to be identified (Miles and Huberman, 1984, p287). The coding used followed an evolutionary process; it continually evolved throughout and post data analysis. As concepts and themes were generated and inductive an deductive approach was taken, to allow relevant qualitative approaches to be included in the analysis. Following an inductive approach allows for theory generation throughout the research, developing an iterative approach allowing concepts and categories to arise from the data (Glaser and Strauss, 1999). Comparatively, a deductive approach

tests hypotheses (Green and Thorogood, 2010). Although, this research was not hypothesis testing there were clear research questions that were being addressed and therefore a procedure needed to be followed ensuring that the correct questions were being asked (Ritchie and Spencer, 1994). The findings from the research were analysed with reference to previous research, allowing new themes to be identified. Further to this, emerging themes were regularly discussed in supervisory meetings which enabled wider insight into the data analysis and project direction. This allowed for a theoretical framework to be developed basing the framework on both current data and previous findings (see chapters 4, 10 and 11).

5.8   Ethical issues and limitations

At the time this project was being developed, NHS ethics and research governance were going through organisational and guidance changes, this unfortunately impacted upon the project's development. Research ethics was granted by the University of Manchester, NHS ethics was no longer required because my project was not focusing on patients and care but was classified as organisational research (working with professionals). At the time of developing my ethics form this was not initially clear which delayed the process. Further issues arose relating to research governance, again relating to the new guidance. The sampling strategy used meant that research governance was required from two different PCT clusters, which were facing different issues in each one because of the changes. Initially, there were some issues around whether an Integrated Research Application System (IRAS) form was needed to be completed or not. There were also problems with certain documents not being aligned to NHS rules but being ethically cleared by the university. Subsequently, the documents were ethically approved by the right institution but document details differed across the two different organisations. Eventually, this was overcome by the PCT cluster accepting the differences and enabling research governance to be obtained. One final issue related to the reduction in staff at the PCT clusters, linking to the policy changes. This meant that there was not someone there to sign the documents off. All these issues were resolved; however they impacted upon the timeline of the project and caused some delays with fieldwork starting in sites one and two in January 2012 rather than November / December 2011 and in site three in May 2012 rather than February / March time 2012.

When carrying out observational research, there are implications of being a researcher in the research setting. CCG staff were aware of my presence during meetings and unintentionally my behaviour may have impacted upon the way that CCG members conducted themselves. The 'Hawthorn Effect' (Adair, 1984) refers to the potential influence of the researcher on the setting that is being researched. The overall aim of the research is to ensure that in-depth knowledge of a context is generated over a long period of time. Thus, the presence and impact of the researcher is minimised the more contact and interaction they have within a particular setting (Green and Thorogood, 2010 p22-23). The influence of my presence was most notable in site three, although I was conducing non-participatory observations, CCG governing body members would draw my attention to specific areas they thought were relevant to my project throughout meetings (see section 11.7). This illustrates how my presence affected general

meeting behaviour. Further to this, CCG members across all three sites also included me in several of their meetings asking for feedback and thoughts when they were preparing for authorisation, meaning my non-participatory role was altered dependent upon the situation and the receptiveness of the CCGs. Another ethical implication for observational research is the presence of people not directly involved with the CCG. The CCG had granted me permission to research them; however external individuals attended CCG meetings and were unaware of my role there. As they were attending the meetings, they were unlikely to feel able to object to my presence, in those cases I tried to ensure that people were aware of who I was at the first available opportunity.

Research in this setting needs to ensure that anonymity and confidentiality is ensured for both individuals and the organisations they work for. All participants were informed that their identities and any information that was obtained as part of this research project would be anonymised. All sites and individuals have been numerically coded to ensure that quotes and data cannot be linked back to specific areas and individuals.

The sampling strategy and the location of the three CCGs in the North of England could be seen as a limitation. Sites were selected on both pragmatism and theory and therefore they were selected on location. As a lone researcher location of sites had to be within a reasonable travelling distance, so that regular observations and interviews could be conducted. This can be critiqued as not including more CCGs from different areas of the UK; however funding, time and resources couldn't have permitted a larger project. Future work could help overcome this problem if a larger research team was employed. For the purpose of this PhD project it was not plausible.

Further lone researcher problems included meeting clashes. Several CCG meetings were held on the same day across the three sites. When this occurred meetings were selected based on their relevance and importance to the research project. Apologies were sent for meetings that couldn't be attended and information was requested from the meeting i.e. agendas and minutes. This enabled me to be aware of what was discussed in missed meetings and follow up any lines of enquiries if I thought something was relevant.

When conducting qualitative research, a common criticism of the methodology is that findings lack generalizability. Marshall (1989 P146) states that traditionally external validity is perceived as a weakness of qualitative research, therefore to generalize the in-depth results across different groups and settings is problematic. However, the purpose of this study is grounded in the initial theoretical framework, whereby an in-depth longitudinal approach was implemented to ensure that the research questions were answerable and relevant to the current research project, the iterative approach that was adopted enabled research questions to be redeveloped and defined, ensuring that project findings were relevant to the research paradigm. This project used organisational policy and HIs literature to define the research topic, ensuring that it was relevant to current healthcare policy in the UK. This type

of research enabled an in-depth approach to be implemented and explore perceptions of HIs, adding a new area to the research field.

Chapter 6: Site Descriptions

6.1 Introduction

Previous chapters have discussed the literature surrounding this piece of research and the methods that were applied to carry out the research. The aim of this chapter is to discuss in more detail the characteristics of the three sites that took part in this research project including the demographics, history of the organisation and wider organisational relationships. Furthermore, this chapter briefly describes the committees that CCGs are comprised of whilst providing an overview of the CCG structure.

6.2 Site One

6.2.1 Population

Site one has a registered population between 101,000 and 200,000 patients which is served by approximately forty member practices. Site one's population has high levels of deprivation suffering from unemployment, and long term unemployment. The unemployment legacy is associated with the decline of industrial work in the North of England in the 1970s and 1980s. Economic decline has influenced the environment the population live in; higher crime rates, anti-social behaviour, poor housing, ill health and poor educational attainment are experienced by the population. In conjunction with the population suffering from poor health, 12% of the population are over 65 years of age impacting upon this site's commissioning and availability of health and social care services.

6.2.2 History

Site one CCG is loosely based on a previous structure of the NHS, this structure has been adapted to ensure that it is compliant with the newly forming NHS structure. Site one practices have operated using a locality model since the introduction of PCGs in 1998 and then continued with the locality model when PCTs were established in 2000. The locality model refers to an organisational approach that some CCGs have adopted. Locality groups, consist of GP practice representatives set within a geographical area. Locality groups will meet several times throughout the year (the frequency is decided by each CCG); to discuss local health issues and receive and discuss CCG information. In 2006 the PCT amalgamated with a further two PCTs in the area to concentrate on a city wide approach to health. The initial locality model was still maintained with the original three PCTs functioning as a city wide PCT with three further locality based PBC groups working as sub-committees of the PCT. It is the PBC group that site one has formulated its CCG structure on. The CCG officially became a pathfinder CCG in 2011 and since then has been operating under the PCT as a subcommittee until fully authorised in 2013.

6.2.3 Local Authority

Site one's population is set within one LA geographical boundary; however the CCG and the LA boundaries are not co-terminus. All LAs have a local HWB, a sub-committee of the LA which is charged with setting the strategic direction locally for health and social care. The local HWB is connected to three CCGs, this relates to the historical configurations of the NHS and the development of GP led commissioning. The nature of the CCGs sharing a local HWB and the model of locality based commissioning has steered the development of key documents being collaboratively written by the LA and the three CCGs via the HWB; both the JSNA and the Joint Health and Wellbeing Strategy (JHWS) have been developed by all four local organisations focusing on the whole city geographical area that they operate within.

Local demographics and the environment that the local population are residing in led the LA to construct a Strategic Regeneration Framework (SRF). SRFs aim to transform the area that people are residing in through engagement with the local population and wider public and private organisations to develop a strong economy, gain high quality housing and good public services. The framework is based on the potential of regeneration in the area taking into account the potential of the area based on location whilst taking into account all the complex factors that exist. This project highlights the poverty that is faced by the population residing in this area.

6.3 Site Two

6.3.1 Population

Site two has a registered population between 201,000 and 300,000 patients that are served by approximately fifty member practices within the CCG. The population in which the CCG serves is affluent with pockets of deprivation running throughout the area. This is demonstrated when life expectancy rates of both males and females are compared across the most affluent and most deprived areas that they serve. In the affluent area the life expectancy for men is 82 years for men and 84.4 years for women whereas it is 70.2 years for men and 76.3 years for females in the deprived area. These life expectancy differences highlight the health challenge that this site faces with health differences across their population. Additionally, this area has an ageing population which impacts upon the way in which health and social care services are used. This area is not ethnically diverse unlike the surrounding populations.

6.3.2 History

Site two is loosely based on a previous configuration of the NHS. The geographical boundaries the CCG are establishing themselves in have not changed from the PCT boundaries. In 2007 the GP practices in this area grouped together to take part in PBC. In 2011 the CCG became officially a

pathfinder building on the structure that existed in the PBC. The CCG was authorised with two conditions from the April 2013. The outstanding conditions for the CCG relate to the construction of clear and credible plans for transformation including finances for 2012/13, 2013/14 and 2014/15.

6.3.3 Local Authority

This site is co-terminus (holds the same boundary) with one LA boundary and therefore feeds into one HWB that the LA lead. Local documents have been jointly developed between the CCG and the LA including the JHWS focusing on key priorities in the area whilst outlining the duties each organisation must agree to deliver. The LA and the CCG have identified where a joint business need is required and are working together across the geographical footprint focusing on integrated commissioning.

6.4 Site Three

6.4.1 Population

Site three has a population between 201,000 and 300,000 registered patients who are served by approximately forty member practices of the CCG. The population of site three is diverse across both rural and urban locations. The differing locations has led to an understanding of different health needs in the area, in the central urban locations there are higher levels of deprivation when compared to the leafy locations surrounding the area.

6.4.2 History

Site three is a newly established organisation that has been configured under the current NHS changes. Previously within this area there were two separate PCGs which morphed into PCTs with separate PBC groups. The two PBC groups covered different areas, one covered the leafy suburbs whilst the other covered the inner city, which meant that management of different political issues was often required. This historical relationship impacted upon the plans for a new organisation to be developed within the current NHS reorganisation, ensuring that both PBCs were included within the same organisation. To ensure that the new organisation was perceived and viewed differently the GP governing body members were democratically voted into the CCG. Alongside this the CCG has not adopted a locality approach like other CCGs as it wants to avoid the feeling of the organisation separating into the two previous groups. This CCG has been fully authorised with no conditions enabling them to take full CCG responsibility from April 1st 2013.

6.4.3 Local Authority

The CCG is linked to one LA and therefore they have a more straight forward relationship for the health of their population. However, within this one LA there is an additional CCG that is serving another

geographical area. This means that their HWB that has a relationship with two CCGs. Site three believed that they have a good relationship with their LA, this was recognised with their Clinical Lead being the Vice Chair of the HWB. It has been suggested that they have put more of an effort in with the LA which is becoming more apparent as the two CCGs move forward. The LA and the CCG have worked jointly on a number of documents that focus on the population which they serve including the JSNA and the JHWS.

Site three identifies itself with a CCG that are served by a neighbouring Local Authority. This has led to the establishment of a transformation programme that is being developed across the two areas by both CCGs, both LAs and several other stakeholders in the area.

6.5 CCG Structures

There was little formal guidance on how CCGs should be constructed, although guidelines did state that CCGs should have a governing body which should include two lay members, one consultant and a nurse member. The remaining membership of the governing body was to be decided by each individual CCG. The lack of formal guidance has meant that CCGs have been able to design and formulate their CCG governing body themselves. The three case study sites that have been used for this research project had enlisted different numbers of people to sit on their governing bodies. All CCGs as part of the authorisation process had to outline their governing body structures in their constitutions.

In site one the governing body consists of nine different people including the two lay members, consultant and nurse representative, three GPs (including one senior GP), one senior manager (not a voting member) and a finance officer.

In site two the governing body is larger consisting of fifteen people. These include the two lay members, one nurse, a consultant, eight GPs (including a senior GP), a senior manager, a finance manager and a PH lead.

Site three's constitution outlined that the governing body was to consist of no less than fifteen members including two lay members, a nurse representative, a consultant, eight GPs (one a senior GP), a senior manager, a finance officer, a manager in charge of quality and two further members: a PHC and the Director of Adult services (both non-voting members).

The governing body is the overarching committee of the CCG where the lead members come together to discuss and report the work of the sub-committees and the strategic direction of the CCG. This is where high level decisions are made by voting members of the organisation. These meetings post authorisation are to take place in a public setting allowing individuals and organisations from the local

community to attend and observe the decisions are being made, with the hope of increasing transparency and accountability to the public.

6.5.1   Additional Committees

CCGs were also required to have an audit and remuneration committee in addition to their governing body. The purpose of the remuneration committee is to make suggestions to the governing body in relation to remuneration and fees for CCG employees and other individuals working for the organisation. The audit committee are there to provide independent and objective views on the CCGs' financial systems.

Figure 16: A diagram outlining possible CCG committees and affiliated organisations
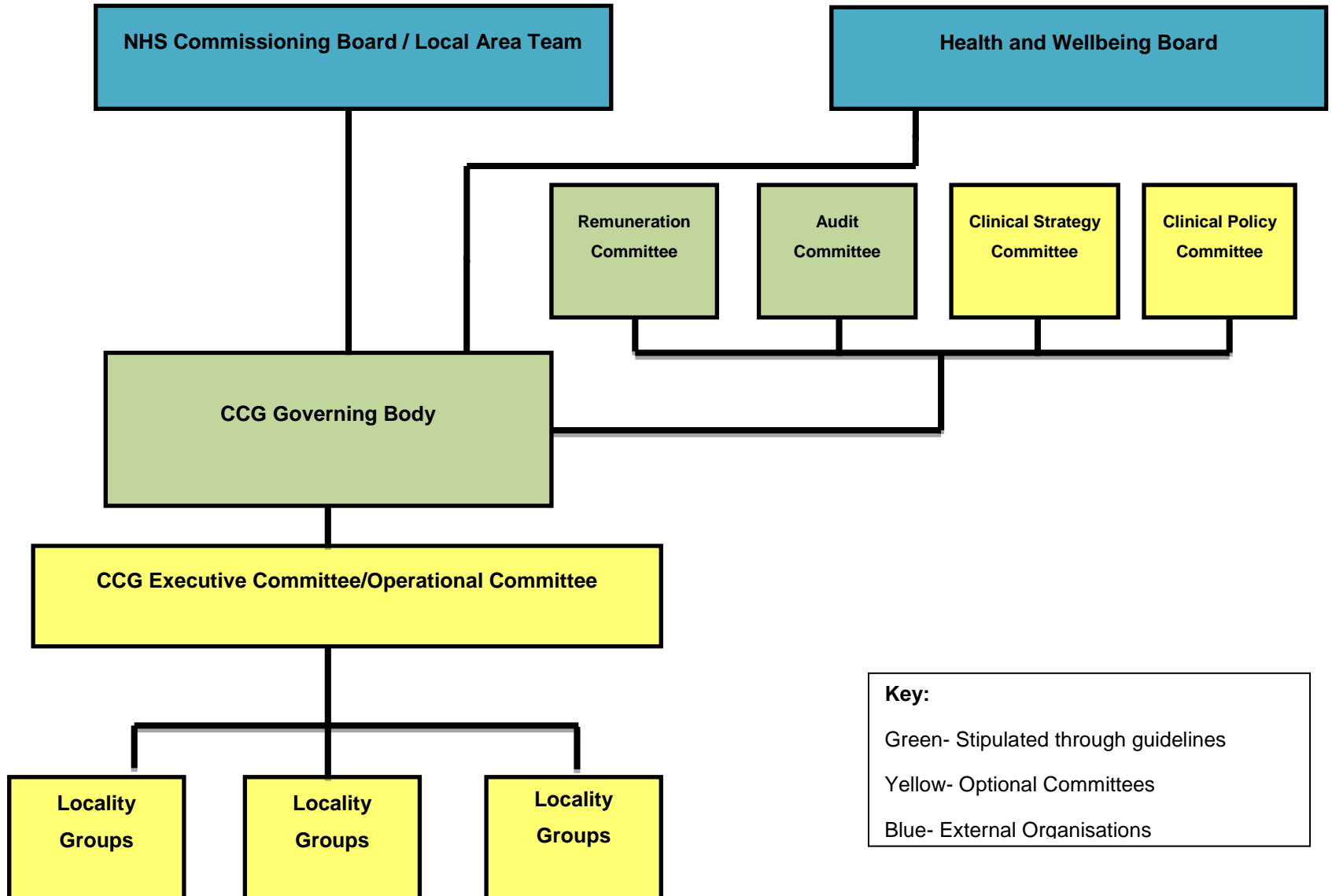
Chapter 7: Health Inequalities Conceptualisation and Role

7.1   Introduction

As demonstrated in the literature review (chapter 2), there are numerous models and causes of HIs that have been documented within the literature. The duty imposed on CCGs to tackle HIs lacked clear definitions of what HIs are and how to tackle them. The first research question (see section 5.2) wanted to step back from examining a specific definition of HIs and explore how CCG members were thinking about and conceptualising HIs locally. The aim of this results chapter is to answer question one, outlining how CCGs members conceptualised HIs, focusing on both individual and collective conceptualisations of HIs and the influence of different job roles (i.e. managers and clinicians) on perceived HIs and how this affects organisational understandings of HIs. This chapter is divided into three sections, discussing the results from each site separately, firstly drawing on interview data and secondly on observations. These are compared in terms of perceptions provided (interviews) and what was seen (observations) in practice. Observational data are presented throughout the results section in boxes so that different data collection methods can be easily identified.

7.2   Site One

7.2.1   Expressed views about health inequalities

In site one, GP 3 and GP 4 both explained that their understandings of HIs related to the differences in the health outcomes people experienced.

'Simply that certain sections of society have poorer health outcomes than others'. GP3 interview

'I suppose in its broadest term it's if you are a XXX resident, your risk of death, and your estimated age at death is significantly shorter, ten or fifteen years less, than if you were sitting in Kensington in inner London, and that's for all sorts of reasons, you also have a higher risk of developing heart disease, cancer, diabetes at an early age, but there is significant health, disease in inequalities than you've got in inequalities of outcomes, if you are sitting in XXX why should you have a higher risk of having an amputation if you're diabetic than if you're sitting in Kensington and Chelsea, and why should your life potentially run more risk of smoking related diseases and alcohol related diseases, and, I think, the, and, of course, the dental caries if you're a kid, it's not your fault if you have to live in XXX, and you've got rotten teeth. So, all those disproportionate risks of ill-health are what I'd term health inequalities'. GP 4 interview

GP 5 responded very differently, explaining that his understandings of HIs were based upon the inverse care law, whereby the availability of good medical care varies inversely to the needs of the

population (Tudor Hart, 1971) (see section 2.3.1). The inverse care law hinges largely on the big-picture and the influence of social and economic factors on health.

'Well that's a big question. I believe very strongly in the inverse care law and I think that is very much alive and well and, that you know there are huge inequalities in terms of the matching of spending. Not just sort of nationally but locally as well. So, I mean ultimately there is still a case that the people in greatest need receive the least. It is a big generalised principle because you think of rural areas and other areas where people might be perhaps more financially affluent but don't have access to healthcare for geographical issues for example. But I still think, when you look at the data in terms of health spend there is still a big divide with the greatest amount of need in that swathe across the North of England but still there is more spending on health, looking at the information in the home counties. So you know there is still more spent there even though our health need is greater. It seems to me'.
GP 5 interview

Thus, two out of the three GPs interviewed in site one identified the differences in health outcomes within and across populations as the most important aspect of HIs. However, the third GP had a very different understanding of HIs, focusing more on the differences in spending across areas with different needs. GP 5's understanding of HIs is frequently discussed within the literature (Tudor Hart, 1971, Payne and Saul, 1997, Hippisley-Cox and Pringle, 2000). Conceptualising HIs in this way could be seen as distancing the CCG from the problem, as the CCG is unable to influence the funding formula which determines overall spending and service distribution. Furthermore, this conceptualisation identifies the CCG's population as victims of a wider societal problem, which is beyond the reach of the CCG to solve. Overall, site one GP's did not appear to have a collective understanding of what HIs are.

GPs were then asked what they felt their role was in tackling HIs, and whether this was a formal or informal role. GP 3 believed that he did not have any job role regarding HIs.

'I don't have a specific role, no'. GP 3 interview

GP 5 identified his HI role as part of his role as a practising GP, rather than as part of his role in the CCG. The individual GP role was to act as an advocate for their patients, ensuring that they received the care they required from the NHS.

'So I think as a GP, my role is to try to advocate and to try to go that they extra mile, to try when people don't keep appointments, try to chase them up. When people aren't that bothered about their help and don't understand what services might be available, it's to kind of keep my expectations high and not to think what can you do because you can become a bit jaded and a bit kind of despondent really, that things can't change. I think you have to guard against that'. GP 5 interview

This ties in with this GP's focus on the inverse care law; if the principle issue is seen as being the failure of patients in deprived areas to receive the care they require, then the role of the GP comes to be seen as trying to mitigate those effects.

GP 4 spoke about his HI job role very differently to the other GPs. There was no mention of direct care with patients but the HI focus was more at population level, trying to ensure that there were high quality services for patients in the midst of the current financial and structural NHS changes. This situates the role at CCG level, rather than at the level of the individual GP.

'I mean, given that we're going to be in a significantly, in a situation of significant financial stress for at least the next five years, and some would say ten, given that the local authority is in even more financial distress than the health service, then there's only one thing that can happen out of that, if you've got basically a staff based industry, which is what health is, then if you have got financial pressures you are going to have to reduce your staffing, we also, sticking patients in beds as opposed to sticking them in their own bed at home is significantly more expensive, so, we're bound to end up with a reduced number of hospital beds. There is a better way of running hospitals, and it involves having a more efficient use of resources, and closing hospitals, so, we've got to be aware that that's on the agenda. So, my role in all of that, in the unpleasantness that is to come, and has already started, is to try and mitigate all that, and to try and hope that, and in our local health economy, we can preserve quality services for as many, for the population, and any, sort of, economic economies will hopefully have as low an impact as is possible, and, I think, you can see us doing that through the way in which we have tackled over costs on prescribing, costs on secondary care, I don't think it's actually caused a worse thing as the health of the population to have drugs of limited efficacy, because they stopped, you could say, I mean, and, equally, surgery that is, actually, cosmetic stopped…compared to surgery that is worthwhile in terms of quality of life'. GP 4 interview

Overall, GPs in site one expressed widely differing views about their roles in tackling HIs. One GP did not believe that they had a HI role, whilst another focused on being a GP and the role a GP can offer to help patients overcome HIs. For GP 4, a senior GP, HIs role focused on the wider influences on HIs outside of the GP profession, concentrating more on the role within the CCG and the influence that the GP could have on the wider health economy to improve quality for patients.

Interviews were also carried out with managers working within the CCG. The interviews were conducted with managers who fed directly and indirectly into the CCGs work across a number of different contexts. Manager 2 responded by claiming that HIs were the differences in life expectancy across different geographic areas (Doran et al., 2006, Davidson et al., 2008). This type of understanding of HIs is closely linked to the explanations that two of the GPs gave during their interviews linking HIs to health outcomes. The differences between the GPs and Manager 2's conceptualisations of HIs is that Manager 2 is referring to life expectancy as the HI measure whereas the GPs are specifically referring to different health outcomes.

'So my theoretical understanding of what health inequalities are basically zero. My practical understanding of what health inequalities are two-fold. There's measurable health inequality which is by life expectancy per postcode, super output area whatever you want it to be and sort of life limiting illness, so the difference in healthy life expectancy between somebody who lives in XXX which is quite long, to somebody who lives in XXX which is about 45, maybe 50, it's probably a little bit older than that or to somebody who's street homeless in XXX which is actually 36, I think, that's not healthy life expectancy, that's life expectancy, by the way'. Manager 2 interview

A senior manager (Manager 3) also referred to the differences in life expectancy and HIs. In addition, he also discussed the issue of access and HIs. He explained that certain people from different populations do not access services, and that this was an important issue for the CCG to address.

'The fact that some people die earlier, some people don't access services, those are my…from a single point of view. Different people get different things and some populations are poor and don't access them'. Manager 3 interview

Whilst not directly referring to the so-called 'Inverse care law', this way of thinking about HIs fits within Tudor-Hart's (1971) approach. Manager 1 also believed that the inverse care law was apparent in the area that they served, arguing that this was perpetuating HIs. Interestingly, Manager 1 also referred to socio-economic differences and their impact upon health (Marmot, 2010, Dahlgren and Whitehead, 1992) (see chapter 2) and the issue of access (Acheson, 1998, Goddard and Smith, 2001) which was also discussed by Manager 3. The quality of primary care was also understood to be an issue within the area that the CCG serves. The manager explained that there were a number of practices within the CCG that were not working to an adequate standard, and this was perpetuating HIs.

'That certain socio economic factors can lead to sort of ill health but that is perpetuated by the inverse care law in the sense of there are certain groups who are less likely to seek access, less likely to have, you know we have ten practices that are just really poor. I just don't think they would exist in other parts of the city but the inequality of health care is just exacerbated by them being here but also that our patients just don't complain about them. Patients think they are fine doctors because that is just what they expect but is perpetuating. Yeah so my understanding is about the inverse care law and that the areas of need tend to be the areas that get less for a number of reasons'. Manager 1 interview

The managers working in site one provided a variety of different responses when they were explaining their understandings of HIs. Only one manager spoke of the inverse care law which was discussed by GP 5. Access was spoken of by two managers when describing their understandings of HIs; they spoke of different people not accessing services and the impact on HIs. Comparatively, access was not discussed by any of the CCG GPs. A number of the GPs and managers spoke of the differences in

health outcomes and life expectancy when explaining their understandings of HIs, nevertheless not all CCG members conceptualised HIs this way.

The managers, like the GPs, had very different understandings of what their role was in tackling HIs. Interestingly, none of the managers claimed that they had a *formal* role to tackle HIs but they all believed that it formed some element of their jobs and personal goals. One of the managers explained that a small element of his job was to ensure that information was written appropriately so that all people could understand healthcare information. Besides this one segment of the manager's overall job, HIs were not perceived as a formal job role. However, they were an apparent motivator for doing things a certain way within the manager's work.

'Well, it's a motivator; it's not part of my role. So the only aspect of that job really, two perhaps, aspects of that job that are really linked to health inequalities are in terms of the engagement side, making sure that however you want to describe them, the hard to reach, seldom heard or difficult to email populations are afforded the opportunity to feedback and have their say in their involvement in decisions. That's one aspect that's part of my job and that public messages are clear and accessible and sufficiently easy to understand for the fact that average received wisdom is the average reading age in XXX is somewhere between seven and nine. And so the other part of my job that addresses health inequalities and must address health inequalities is writing stuff in the News of the World probes. That's it. Anything else isn't part of my job. It's the motivator for why I bother coming to work in the morning because, frankly, increasing shareholder value just doesn't float it for me'. Manager 2 interview

Manager 3 saw his role as trying to reduce HIs but pointed out that it was not documented that HIs were part of the senior manager's job role. He suggested that the accountability and responsibility for HIs lay with the CCG as a whole and the Senior GP, GP 4.

'Well, my drive is to reduce them, I mean, at the bottom of that, all the work we should do is, basically, I mean, that's why I say long term conditions is a key one for this, is to drive the health of the population so that people live longer, healthier, you know, more…the wellbeing influence, which is, obviously, work with the Council as well, we have to make sure the resources we use are used most effectively. I take on board, it's not for me, my job, I think, it's a CCG responsibility and accountable officer on board, as far as I can see, but individually, no, no one's putting my name…I think, I would see, personally, Public Health as being the major driver really'. Manager 3 interview

Manager 1 suggested that HIs was a contributing factor for her decision to work in the NHS. She explained that there were certain elements of her formal role, such as carrying out impact assessments, which related to HIs, but the rest of the work that she did on the topic was based on a personal interest.

'I think cos I've learnt a lot about it in the past and I think it is probably a reason why I came into the NHS. Personally I see it as really important, as part of our roles we are supposed to do equality impact assessments and understand how service changes might impact certain groups disproportionately. I'm not sure whether it is always explicitly stated, so besides it being a personal goal of mine, I'm not sure of whether a different individual was in this post it would be as important but for me personally I see it as being critical. Manager 1 interview

The manager's all had very different ideas about what their formal job role was in relation to HIs. However, a consistent story through all of their interviews was that they all felt personally driven to tackle HIs and therefore they would continue to think about them within their jobs even if it was not part of their formal role. Site one is situated within a deprived area and it may be that this motivation drove these managers to seek a role in such an area. There are clear differences between the managers and the GPs when they talk about their HI roles. Consistently, managers believe that they are personally motivated about HIs even if it is not specifically related to their formal job role. GPs, on the other hand, did not discuss HIs as a personal motivator, but perceived their HI roles very differently. One GP thought their role related to being a GP and ensuring that their patients received the best from healthcare whereas a senior GP focused a more strategic and organisational role for dealing with quality and HIs. This formal CCG approach is consistent with the explanation provided in the Manager 3's interview. None of the managers expressed that they had no HIs role unlike one of the CCG GPs. Thus, it would seem that those in the most senior managerial roles (both GPs and managers) in site one are beginning to formulate an idea about the overall strategic role for the CCG in HIs. However, GPs and managers below the most senior level have a less clearly defined view, and see the problem in a more personal (or, in the case of the GPs, clinical role-related) way.

An interview was carried out with the Public Health Consultant (PHC) who was working with the CCG. The PHC believed that, because they work in PH, they should have an answer ready for a question that focused on HIs. No other CCG members when asked this question responded in a similar way. The PHC demonstrated a diverse and quite comprehensive view of HIs, referring to the inverse care law, access issues and the quality of primary care. In terms of the latter, the PHC focused upon the supply of GPs. This was in contrast to Manager 1, who explicitly referred to poorly performing practices. Thus, although the PHC and the manager both referred to quality of primary care and its impact on HIs, they appeared to be considering the issue differently. It is not clear, however, whether the failure of the PHC to explicitly consider poor GP performance was because they felt that this was a politically difficult issue to address, or whether they genuinely believed that all practices were performing adequately. The PHC also discussed the wider determinants of health and the wider issues that impact on health (Dahlgren and Whitehead 1992, The Black Report 1980 and The Acheson Report 1998). This had been referred to by Manager 1, but the PHC covered the area in more depth. The PHC spoke of much wider influences on health in addition to poverty; education and employment were referred to as an influence on HIs.

*'Oh, **I should have an off pat answer shouldn't I working in Public Health?** For me health inequality is about… essentially it's about **the gap in health and length of life and well-being between… all evidence would suggest between people who are in the 1ˢᵗ and the 5ᵗʰ quintile.** And so health inequalities can relate to a number of things. It certainly relates to inequality around **access to services and the inverse care law is alive and well in this city**. Things have improved a bit over time but XXX was always traditionally one of the areas that was under-doctored**. People have less doctors per head of population. I know that's improved a bit but it can be as simple as that. Quality of primary care, and people actually getting awareness of health issues amongst the population and people having the skills and confidence to get their care early enough for something to be done about it. And then it's all the socio and economic elements of health inequalities. People's access to good education, training and employment - good employment is good for health.** But by and large most people who have got a job are in much better health, partly because they've got more money, partly because they're out there, they've got social worth. They've got a network of people they communicate with, but it also relates to things like housing and… a whole range of things that really are under the umbrella of the local authority. But what we need to do as a city – and this is where, I guess, the hope is for the Health and Well-Being Board – is to bring all those elements that work together to create those inequalities and think through what are the best strategies to tackle those jointly'. PHC 2 interview [emphasis added in bold]*

The interview with the PHC on their HIs role was very different to the discussions with other CCG members. The PHC had a clear view of her role in tackling HIs role, focusing upon the programmes of work that PH were undertaking. Essentially, she perceived the PHCs role is to ensure that resources are coming into the city to ensure that people receive the greatest chance of improving their health.

'Well, I mean I think in public health it's pretty clear, because our programmes… I mean to some extent now, our programmes are dictated, and will be dictated, to the local authority. There are things we must work around. But I think our health inequalities' role around all those areas is to really work to ensure that the resources that we manage are spent effectively, based on the evidence, but also, where possible, in partnership, so that we get better value for the total resource coming into the city, and that we spend those resources where we are going to have the greatest impact on individuals, where we have got the greatest chance of improving their health inequalities'. PHC 2 interview

In summary, individuals in site one had no consistent view either of what HIs are or of what their own or the CCG's role in tackling them might be. The GPs referred either to the inverse care law, or to differences in health outcomes related to income levels. Where the inverse care law was seen as an issue, this led to a focus upon the individual advocacy role of GPs, supporting individuals to make the best use of the care available to them. Where the problem was seen as one related to income or deprivation, this appeared to lead to a sense of personal impotence, with 'no role' in tackling HIs. The more senior GP, however, discussed a more strategic role that they could play at the CCG level, using their CCG role to mitigate the impacts of the developing funding crisis. The more senior manager also

85

suggested that the CCG as a whole was in a position to tackle HIs at the population level, but interestingly commented that their own job description did not contain any formal mention of the issue. The other managers interviewed referred to access to services and patchy quality in general practices as key HI issues. Neither of these problems were mentioned by GPs. The managers consistently described tackling HIs as a personal motivation, but not as a formal part of their role. The PHC, by contrast, demonstrated a comprehensive understanding of the issues relating to HIs, including the wider social determinants of health and the inverse care law. Tackling these problems appeared to be seen as very much a PH issue, referring to city wide programmes rather than to anything being done by the CCG.

7.2.2   Health inequalities in practice

In addition to the exploration of beliefs about HIs in interviews, observations focused on the way in which issues associated with HIs emerged in practice. The main elements of HIs discussed by CCG members and affiliates in site one during meetings related to access. This was because of a local political issue surrounding plans to close a local Walk in Centre (WIC). The LA was not supportive of the closure of the WIC and to overcome this site one carried out a 'mystery shopper' exercise intended to demonstrate that access for patients was not an issue. However, the results of the exercise, demonstrated to the CCG that same day primary care access was in fact quite poor.

> *Manager 2: for Urgent Care we agreed a mystery shopper test for access issues. Interim results give a picture, same day appointment 38.1%, triage 15% signposted and call back most responses and are not typical. They are not results that we can be immensely proud of. To be honest this is an issue that we need to deal with quickly.*
> *(April governing body meeting)*

Examples of the conversations that were held in CCG meetings demonstrate that access was spoken about by both managers and GPs. However, in interviews, GPs spoke very little about the problems of access and HIs.

A consistent area that managers spoke about during interviews was poorly performing practices and HIs. This understanding of HIs was referred to in governing body meetings. However, it was clear that their main objective was to ensure that NHSE was aware of their efforts to try and deal with the issue. Therefore, whilst poor practice performance might be a component of HIs, in practice their approach was focused pragmatically on showing the regulator what they were doing.

> *Manager 11: you will know which are the heart sink practices, have a plan with how to deal with them. Even if no improvement is shown you will be able to show NHSCB what you have tried to do.*
> *(May governing body meeting)*

In interviews CCG members all spoke of their understandings of HIs and their perceived roles. The PHC portrayed HIs as a PH issue; this view was supported in practice by a variety of CCG members. At a locality meeting, GP 13 referred to obesity as a PH issue outside of the control of the CCG.

> *GP 13: although you are saying it is the parents' fault if you have children once they have reached a certain age they have their own mind-set. Look at schools in deprived areas they are surrounded by snack shops and takeaways. This relates to peer pressure and is a wider PH issue.*
>
> *(Locality 3 meeting)*

7.2.3   Summary

In site one HI conceptualisation is varied across different professions working within the CCG. Individual interviews identified how people thought about HIs and observations were used as a tool to see what was happening in practice. It is clear from the PHC interview and wider observations that HIs in site one are perceived to be an area of concern for PH. Although managers and clinicians spoke about the inverse care law in interviews no reference was made to the problem during CCG meetings. The main area of concern addressed in CCG meetings was access to services, in particular GP services. This was an issue that was politically contentious between the CCG and the LA and therefore time, effort and resource was focused on this problem; its potential impact on HIs appeared to be a secondary consideration.

7.3   Site Two

7.3.1   Expressed views about health inequalities

Site two GPs spoke broadly about the different influences on HIs. Examples included social deprivation; focusing on the wider influences on health (Dahlgren and Whitehead 1992, Marmot 2010, The Black Report 1980 and The Acheson Report 1998), access to health care (Acheson Report 1998, Goddard and Smith 2001 and Van Doorslaer, Koolman and Puffer 2002) and HIs and race (Smaje and Le Grand, 1997). GPs spoke of their awareness of the health disparities within their population, acknowledging that different areas people reside in influence their health. GP1 spoke about men's health and HIs explaining that it was a personal concern to ensure that men attended their appointments.

'*I guess as a GP its, it comes alongside deprivation in a big way. So social deprivation but then it is also hard to reach groups that might not be people living in the poorest areas it might be people who are too busy to get into the doctors for whatever reason. One of my little bug bears is men of a certain*

age that don't come in and therefore receive unequal healthcare, they don't get what they are entitled to. There are not tapping into their health screens there not tapping into or know they are entitled to smoking cessation support in the practices. Whatever, you know they are drinking and they don't know what to do about it. They are depressed and don't know what to do about it, whatever. I think where the public aren't aware of what's available there at risk of inequality or of not getting. GP 1 interview

GP 7 explained a number of issues that the CCG had to focus on in terms of HIs. Prescribing and the relationship with the LA were two mechanisms described as ways the CCG could try and overcome HIs. GP 7 referred to the polarisation of health experienced by residents dependent upon where individuals lived. The geographical area the CCG serve is a contributing factor for how HIs are conceptualised by GPs.

*'**Well in XXX, I'm not 100 per cent certain but I think we're the fifth or sixth most polarised PCT in the country. So what we have is a pocket of very high deprivation of more than 90 per cent in certain areas like XXX, and we have exceptionally affluent areas like XXX and XXX, and affluent also is XXX I think.** So what we end up with is a discrepancy in life expectancy of more than ten years based on the most deprived to the least deprived areas. And really that has to be addressed. Now we know health is not a single...**we know just what we prescribe and what we refer is not the single most determinant in health, housing has a massive determinant on whether people have good health outcomes, employment has a huge determinant. So there's some things that are beyond our scope with regards to trying to address health inequalities.** And there's a lot more to it with regards to lifestyle and access to Lifestyle Services. So in tackling health inequalities in those deprived areas, you know, it's really more around managing patients' emotional state because emotion is a key factor and if you have deprivation, you know, you have higher rates of depression, you have higher rates of smoking, you have higher rates of alcoholism, you have poorer educational outcomes, and it becomes a kind of self-fulfilling perpetuating cycle. **So it does require greater investment, but we also find that patients who are in the very affluent areas tend to not only live longer but tend to demand the more higher cost drugs, tend to have more hospital referrals because they want to see more specialists, and they can navigate the healthcare system better and more effectively because they tend to be better educated.** And I think we as a CCG are absolutely signed up to try to tackle that sort of level of thing, and that's where I talk about Practice variation and reducing Practice variation. So it's supporting the Practices in affluent areas to try and negotiate and ensure that they're prescribing the same sort of choice of drugs that we would expect patients in every area to get. GP 7 interview [emphasis in bold]*

Like other GPs in site two, GP 8 referred to the disparities in health across different areas. Unlike other GPs, GP 8 acknowledged that certain causes of HIs are out of the CCG's control and relate to the Government and funding.

If we look at mortality data, disability data and compare different areas there is a big disparity. It is partly the duty of health care to reduce the disparity of outcomes. Some things are out of our control and relate to government money and it is up to GPs to mediate. In terms of the flu vaccine there were high levels of variation of uptake so it was suggested that it should be provided in a local church at a coffee morning. There are also women's groups that are set up to target deprivation. My area of paediatrics the community nurse is used well in XXX as they support families there. Social inequalities impact on health outcomes. GP 8 interview

GP 9, a senior GP explained that deprivation is a large issue for people's health. However, GP 9 said that there are a number of additional factors that contribute to ill health. Access was viewed as influencing HIs; this is consistent with how managers in site one spoke about HIs.

'As I say, health inequalities is not just inequalities in deprivation, it's inequalities in access to health, from all sorts of perspective, about age, gender, race et cetera, et cetera…so there are inequalities all over the place. XXX has particular issues around deprivation, but that's not to say we haven't got inequalities in health in terms of other groups…so we've got a growing population of patients who are from Pakistan for example. We need to be thinking about making sure that services are appropriate for them, but actually I think we need to be thinking about, not just skewing the NHS to just that, but actually a reciprocal relationship, so we need to be playing with the local authority around access to language classes, we need to be promoting greater independence…you know, you have to be culturally sensitive, sure, but that doesn't mean to say we should be culturally insensitive either, to the concept of equality between genders, between…all the issues around self-care, self-management, apply there too, and we know that…I'm focusing on that population just as an example. And promoting concepts of prevention and screening and early intervention there too. So, health inequalities is multi-faceted'. GP 9 interview

The GPs explanations of HIs are multifaceted and take into account a variety of different explanations of what influence HIs including deprivation, social influences on health, ethnicity and prescribing habits (Public Health England, 2013). These different explanations of HIs show how complex HI conceptualisation is for individuals working within an organisation. In site two, throughout all explanations of HIs, GPs held a collective conceptualisation referring to place and health disparities. This was very much in contrast to site one where there was not one identifiable theme in GP explanations of HIs.

GPs in site two were asked what they thought their HIs role to be within the CCG. All GPs identified that they had a HIs role, whether they believed it to be formal or informal. GP HI roles were very varied; they were closely related to GPs' individual job roles. GP 1 discussed her HIs role as a CCG GP. Thus, the focus on HIs was at a CCG level rather than at individual GP level.

'I think my member relation role is part of that is to sell to practices the importance looking at health inequalities and looking at the bigger picture. So I think it comes in there. It comes from all of us working in the organisation and for GPs to sell that to patients'. GP 1 interview

GP 7 explained that her HIs role is not formal but it is to ensure that people are thinking of HIs within their decision making processes. Again, this HIs role, although informal is to ensure that HIs are being thought of as a CCG when making decisions and are always remain on the agenda. Similarly to GP 1, this role is a reflection of the organisation rather than the individual GP.

'No it's not a formal role but I think it's everybody's role to make sure that they consider it in their decision making process'. GP 7 interview

Unlike GP's 6 and 7, GP 8 did not focus on the organisation role alone but described a multifaceted HIs role, illustrating his roles as a GP, CCG GP and a locality chair. This demonstrates the complexities of HIs work; it is cross cutting both the different levels in the organisation and individual job roles.

As a GP I advocate for the patients and deal with the government when patients feel powerless in areas like benefit medicals and support with documents. I address small inequalities. I also help run the diabetic clinic which helps deal with health. There are also issues around smoking and alcohol misuse. As a locality chair there are plans to reduce A&E attendance and promote same day access and better triaging. In terms of elective care for XXX the hospital is XXX which is 2-3 buses away which is very tiring for patients so we need more community care in the local community. This is not such an issue in the more wealthy areas where they have cars. Community services disproportionally benefits areas of deprivation. From the CCG side it is spending time with the HWB and looking at the priorities of smoking, alcohol and the health inequalities there. For the CCG the public health role tackles health inequalities and ties in with the local authority. This is a formal role included in my job. GP 8 interview

The senior GP, GP 9 referred to a CCG level role for HIs, whereby he ensures that they are being thought of by the CCG.

'It is to make sure that our systems, processes and governance capture the need to reorientate our services, reorientate our spend, and ensure that the various stakeholders we have…hospitals, local authority, XXX, the public…are plugged into the need to address that as one our first priorities, and that we as a CCG have got a comprehensive set of commissioned pathways that actively address inequalities in the various manifestations' GP 9 interview

Overall, GPs in site two expressed a similar organisational level role for tackling HIs. Only GP 8 described the different elements of his GP role for tackling HIs, this shows how people can hold HI roles as an individual, within the CCG and across the organisation.

Similar explanations of HIs were provided by the managers in site two, again demonstrating a consistency of HI conceptualisations across GPs and managers. Manager 4, a senior manager, conceptualised HIs as the differences in health outcomes across different areas the CCG serve.

'My personal understanding of health inequalities? I suppose is the gap in, health outcomes between one area and another'. Manager 4 interview

Manager 5, like other CCG members, conceptualised HIs as the disparities in health across different geographical areas. In addition Manager 5 also said that individual freedoms and responsibilities were a contributing factor of HIs. This aspect of individual responsibility and HIs was not expressed by other CCG members.

'My own understanding I suppose is the disparity of health really between deprived and affluent individuals, obviously there should be no health gap. In an ideal world everybody would be of the same... would have the same health benefits, enjoy the same sort of health benefits. And a lot of that... a lot of that will come from the freedoms that individuals have to keep themselves fit and healthy whether that be going to a gymnasium or those sorts of issues where individuals do actually help themselves to keep themselves fit. And I think it's about... for us it's about promotion and awareness of letting individuals know that they should take care of themselves through healthy activities, healthy eating'. Manager 5 interview

Manager 6 focused on the measures used to monitor HIs in some detail; measures were described to explain the polarisation across the area served by the CCG. The influence of resource allocation on HIs was also discussed. This understanding of HIs was described by a number of CCG members in site one (see page 74). Manager 6 explained that within the borough affluent areas are overspent on healthcare whereas deprived areas are under spent demonstrating the HIs in healthcare across the area. Whilst not directly referring to the inverse care law this description demonstrates that those in most need are not receiving as many resources as affluent groups. This explanation corresponds with site one's explanations of the inverse care law and the literature (Tudor-Hart 1971, Payne and Saul 1997).

'So there's something about what are we measuring here? ***We're measuring an outcome in health, in life expectancy, and at XXX that's about 10 to 12 years across the wards, so it's big.*** *Our most deprived ward has only just got men's average age to 70 in the last report. Whereas I think some other places it's 82 or 84.* ***The other level outcome I suppose is healthy life expectancy, and that's even bigger in XXX. The last time I looked at it, it was a 16 year gap.*** *So they might be getting to 70 but start feeling quite ill at 54, and whereas if you're in XXX you start feeling a bit less able at 78 to 82, so it's that sort of difference.* ***Another way of looking at it is well then does the resource really follow that, and it doesn't. Which is why locally the most affluent areas of the borough are over spent and the more deprived areas of the borough health wise are under spent, which just mirrors***

what happens in the NHS generally, which is why more affluent PCTs tended to be over spent than more deprived ones. Then the issue is well, okay, what's causing that? A large proportion of that are going to be things I guess that have been outside health control around poverty and education and those sorts of things, housing, but then there's quite a large part that aren't, like lifestyle choices and, I guess, early years and those kind of things, and that's where I think the CCG can make the biggest difference, particularly in the lifestyle work. I think that's seen as not that important in primary care in some places and very important in other places, and I suspect lifestyle factors like ones around smoking and healthy eating and exercise and alcohol'. Manager 6 interview [emphasis in bold]

Overall, within site two there was a consistent conceptualisation of HIs across GPs and managers. They offer multifaceted explanations of HIs but they all speak of the differences in health outcomes across different geographical areas.

CCG managers were also asked whether they had any specific HIs roles. Manager 4 explained that she has a formal role to ensure that the CCG are addressing HIs and meeting their targets. This role is very different than what was described by the CCG GPs who seemed to have a less formal structure of work with regards to HIs. Wider comparisons across sites one and two identify that formal roles are being carried out by a variety of CCG staff. In site two the formal monitoring and accountability responsibility is held by a senior manager (manager 4), whereas in site one a senior GP (GP 4) carries out this role.

'Yeah, my role is to, make sure that we address, you know understand health inequalities. Look to address health inequalities in our planning processes. Have it very high up on the agenda. Then from a performance point of view, making sure, you know if we have said that we are obsessed with quality and that we've said we are going to reduce inequalities, then I need to, as someone who is doing the day to day organisation, I need to be saying are we doing that, are those things on track, are we looking at those types of things, are we putting resources in the right place, are we putting you know, the staff in the right place, are we putting the effort into the right place, are we asking those communities enough when we are planning services, are they meeting their needs. So, things like being an active member of the health and wellbeing board, making sure we can understand the part we can play but probably more importantly actually the part that other people can play really, in addressing health inequalities and improving people's health outcomes'. Manager 4 interview

Manager 5's description of his HIs role is consistent with GPs understandings of their HIs role. There was an awareness that they need to meet the health needs of the population however, this is not necessarily a formal responsibility on the individual.

'I do, I think it is about making sure that we serve the health needs of the population and within that definition that to me is part of what health inequalities is. And we're very, very... we want to make sure that everybody has access to the health services that they need and to make sure they can have a full

and healthy life and give them the opportunity to have that healthy life either by advice, promotion, treatment, follow-up treatment and all those activities. And I think that's really what I see it as and I think it's for me it's making sure we can stretch the resources as far as we can to make sure that people live longer, healthier happy lives'. Manager 5 interview

Manager 6, like the GPs, explained that his HI role was specifically related to his job in helping set the strategy. HIs needed to be thought of and included in the writing of future CCG plans.

'I think there are a number of areas. Some are very clear, some are just in the back of my head as things I think we need to think about going forward. So an obvious one will be well, I write the plans, so bring the JSNA and make sure that we've got clear plans in place to deliver and address some of the health inequalities and meet the health and wellbeing strategy, and I get involved in writing that as well, so that's where an obvious connection is'. Manager 6 interview

Managers, like the GPs, all clearly believed they had a HIs role, however, this was dependent upon their individual job roles. Both managers and GPs mainly referred to their HIs role at an organisational level rather than focusing on individual elements of their jobs. A clear difference across manager and GP HI roles is that managers hold more formal roles within the organisation, which are written in their job descriptions.

The PHC, in site two explained her understandings of HIs very clearly, defining HIs in two different ways, referring to outcomes and access to healthcare. The PHC said that people within the CCG frequently talk about the geographical health differences that are experienced by the local population. In addition to the CCGs explanation of HIs, the PHC described the wider influences that impact upon the health differences experienced by the population.

*'Well, I think you need to divide **between inequalities in terms of access to healthcare, and inequalities in terms of outcome. And I think most people, when they're talking about inequalities, are looking at geographical inequalities,** so, for example, as I've described for, the XXX/XXX problem, where we've got a stark difference in terms of life expectancy, healthy life expectancy, probably being 10 to 12 years different in those two areas. So what it means is, that people living in those areas don't have an equal chance to good health. **But actually, behind that is a whole host of things that, you know, govern the health inequality. Some of it's around income, some of it's around employment, and some of it's around risky lifestyles, in terms of alcohol and tobacco. There's inequalities in terms of access to services, that we've probably not completely considered in the past. And then you've got things like geographical issues and ethnicity and, for example, chronic disease in a lot of the Asian communities.** They don't like taking preventative medicines, because it's culturally not appropriate. Or that they wouldn't put their mother in a nursing home because that's, again, culturally not appropriate, and so the carers, much more burden on the carers. So all of those issues, for me, are quite important. But I think that it's*

around making sure that everybody has an equal chance for, you know, to good health as everybody else'. PHC 1 interview [emphasis in bold]

The interview with the PHC on roles brought different issues to the discussions with other CCG members. The CCG has put specific responsibilities in place to ensure that the PHC thinks about HIs. The PHC is there to ensure that a population level assessment is being carried out to inform the CCG of what work they need to do. In addition to this, the PHC explained that she has a responsibility to influence the CCG on HIs work. The role that the PHC describes in site two is very proactive in comparison to the description of the PHCs role in site one. This could be accounted for by the differences in the relationship and role the PHCs hold with each CCG.

'No, it's definitely formal. And in terms of the new governing body, I've got particular responsibilities in the Constitution around health and wellbeing strategy, and the JSNA, which is the Joint Strategic Needs Assessment. And that's really about our formal assessment of both health and health inequalities across XXX. And what that allows us to do is look at different age groups, different localities, and different disadvantaged groups, in terms of health and outcome. So that's very much my formal role within the board. And my deputy director role within XXX. I mean, it's about, really, it's about influencing, it's about on Place…I mean, actually, when you go to Place Board, which is the board that oversees the four priority neighbourhood management boards, you realise that health inequalities is everybody's day job within the local authority, in that they know exactly what the issues are, what some of the solutions are, and what the challenges are'. PHC 1 interview

In summary, site two had a consistent conceptualisation of HIs across GPs, managers and the PHC, referring to the disparities in health across different geographical areas. Although there was a consistent conceptualisation of HIs, HI roles across CCG members were spoken of differently. Managers and GPs all stated that they had a HIs role, their explanations slightly differed dependent upon individual job roles. The senior manager and the PHC hold the formal role and accountability for HIs work. The senior manager's role is to ensure that HI targets are being met whereas the PHC is there to assess population need and to ensure that the CCG are aware of the issues surrounding HIs. No other members of the CCG, who were interviewed, described their role formally, they spoke of a more informative role, ensuring that HIs were being included within CCG processes. The consistent conceptualisation of HIs and the acceptance that they all have a role in tackling HIs is starkly different from the CCG members in site one.

7.3.2   Health inequalities in practice

In practice what I found was that site two had a shared organisational conceptualisation of HIs that supported the findings from the interviews with CCG members. When HIs were discussed in CCG meetings, the disparities of health across different areas were referred to and discussed. The PHC, in

the annual planning event and governing body meetings explained that different priorities for different geographical areas needed to be thought about.

> *PHC 1: we should have a statement about health inequalities and issues in localities…practices in deprived versus non deprived have different priorities i.e. deprived have issues with alcohol and screening.*
> *(Annual Planning Event)*

> *PHC 1: We know that working in different localities will need different work as we know there is a disparity between XXX and XXX in health seeking behaviours. We have tried to develop a strategy that includes everyone's day jobs.*
> *(July governing body meeting)*

GPs during engagement events also spoke about the disparities in health explaining that to move forward as an organisation they needed to tackle HIs. This again demonstrates the CCGs overall conceptualisation of health inequalities focusing on locality deprivation differences relating to HIs.

> *GP 1: We have quality targets for GPs and local hospital targets, we want to deliver more services in the community where appropriate, reduce health inequalities due to polarisation look at meeting the needs of people using the locality model, developing personal responsibilities, delivering a surplus to invest in innovation and improve. My role is to encourage practices to innovate.*
> *(Engagement Event)*

> *GP 9: To get more freedom we need to reduce HI. Does anyone know what they are? If a man lives in XXX average life expectancy is 70 for XXX it is 82 these figures of death show HIs. It is not just that in XXX that you are richer, it is partly wealth but predominantly it is self-care and lifestyle, employment, smoking and exercise. XXX has not managed to narrow this gap even though everyone is living longer the gap still remains. Until we reduce HIs we will struggle with a finite budget and quality of services. For us it is important for us to help people understand to look after themselves.*
> *(Engagement Event)*

Manager 6 during a locality meeting reflected on the locality model explaining that localities may be able to have two GP chairs in place to take into account the different needs of the population across the locality. Although, the locality approach is embedded in the governing body's methodology to tackle HIs, this conversation was not held within a context relating to HIs. It was remarked on to encourage GPs to take on the chairing role. At the current time there was a clear lack of interest in chairing roles

for two of the localities. Therefore, a joint role was used to incentivise GPs to take on the responsibility (as they were already signed up to the HIs agenda locally).

> *Manager 6: I think that this would be possible in terms of the locality. In some areas this would work better when localities have both deprived and non-deprived areas as they will need different influences.*
> *(January Locality Event)*

7.3.3   Summary

Site two had a strong individual and organisational conceptualisation of HIs which was clearly referred to in interviews and demonstrated in practice at a variety of different CCG meetings. The collective conceptualisation of HIs was apparent in both interviews and in practice. This collective conceptualisation of HIs has been adopted by the organisation and is being put into practice.

7.4   Site Three

7.4.1   Expressed views on health inequalities

In site three, there was not a consistent conceptualisation of HIs; a more individualistic understanding of HIs was provided by each GP. GP 10, a senior GP, explained that HIs exist and can never fully disappear. There is a common acceptance within the literature that some inequalities and inequities are natural and cannot be eradicated (Klein, 2010). However, this description of HIs is very different from any other explanation provided by GPs, managers and PHCs across the sites that were being researched. GP 10 explained that HIs relate to information provision, people need to be more informed to help them care for themselves and access the correct services. The responsibility on individuals to take control of their own health has been a common ideology within different political parties' overtime (Baggott, 2004). GP 10 was clear that if people are unwilling to engage and help themselves there is very little that can be done. This understanding of HIs places the responsibility of health on the individual; there is no focus on the wider influences on health which have been raised by respondents in both sites one and two.

*'I mean they exist don't they, and they will always exist and it's very difficult... I mean you'll never get rid of them, you just need to flatten them would be ideal. If you took health inequalities as a spikey graph it needs to be a flatter graph. There's always going to be people who will not be helped, who do not want to be helped for whatever reason, **and I don't see it as our job to ram healthcare down people's throats that don't want it. I think we need to use as many possible channels as we can to inform people about services available and ways to make themselves healthier.** But then at the top end I think that we have to be able to rationalise as well because there are people who get too much health care, and that's not fair either, and unnecessary demands on the health service. Now if it*

was as easy to just pinch from those that have got loads and give it to those at the bottom then the health inequalities wouldn't exist, but that's not going to happen is it? **But I think it's important that we do that, but as I say you're never going to get rid of them, and there are always going to be people from, you know, poorer backgrounds with poorer health but you've just got to keep, as I say, trying to get the message out there about simple things; smoking cessation, alcohol, you know trying to reduce and minimise and keep these things, and that will improve people's health. But if they don't want it and they don't engage there's not a lot you can do**'. *GP 10 interview [emphasis added in bold]*

GP 2, referred to HIs as the gap in health between the deprived and affluent members of society. This was not consistently referred to as the way of conceptualising HIs within site three but similarities can be identified between this CCG GP and the GPs, managers and PHC in site two.

'My understanding of health inequalities? The gap between the affluent, the less affluent, whatever the technical term for that is these days…would have been social class years ago, but you can't say that anymore…which is actually getting worse'. GP 2 interview

Within their interview GP 12 explicitly said that her understandings of HIs would be very different to PHs interpretation of HIs. This comment identifies differences in the HIs agenda between PH and general practice. GP 12 focused on the clinical aspects of HIs; access, quality and appropriate care. Similarly to GP 10, there is an understanding that effort needs to be placed on information provision to ensure that patients are aware of the services that are available to them.

'It won't be the public health understanding, because it's about using language differently, isn't it? So for me it's about inequality…yes if you have diabetes, then you would expect to have quality of care no matter where in the patch you lived. And I would expect to be able to go to my GP, see them in a timely way and have all the appropriate stuff that I should need for care of my diabetes. However, we know that there are some parts of the community who have disproportionately large numbers with diabetes; they have language issues so they don't access services as effectively. There are dietary issues that aren't always addresses appropriately. Or they simply just don't know the way round the service and they're lost, they're not chased up. So I…you know, I'm on the phone to them, "Where are you? It's time you came in," you know, "Where have you been?" You know? So for me it's about we all have health needs, we all want and need it, we should have a quality service, but it's making sure that everybody knows exactly how to do that'. GP 12 interview

In site three, the GPs do not hold a consistent understanding of HIs. GP 10 and GP 12 place prominence on information provision and self care, emphasising the importance of individuals for tackling HIs (Beaglehole and Bonita, 2004 p145). The focus on individual responsibility was not heavily mentioned by other GPs or managers within sites one and two; this level of conceptualisation fails to

take into account the wider influences on health which are beyond an individual's control (Dahlgren and Whitehead, 1992). It removes the responsibility for tackling HIs away from the CCG.

As in sites one and two all CCG members who were interviewed were asked what they believed their HIs role to be. The GPs all had very different opinions on what their roles were. GP 10 said that although it was the role of PH to ensure that HIs were high on the agenda, this was also part of his clinical role.

'To keep it high on everybody's thoughts, do you know what I mean? Obviously the public health person does that as well, but it's my job as well, you know, when we're thinking about changing things or implementing a pathway or a new system or whatever, we have to be thinking is this fair, is this equitable, is this available to everybody and we can't just think 'Right let's go and put this fantastic service there' you know it's got to be... well firstly is there any point in putting it there? GP 10 interview

Interestingly, GP 2, the lead for HIs, was unable to provide a clear description of what his role entailed. The role had been assigned by the CCG without any formal structure being put in place.

'I think now that I'm the lead, it's probably a formal role, but it hasn't been formalised. I think it says in some Board minutes that I'm the lead, but nobody has actually given me a description of what it is I'm supposed to do. And I'm not sure that it will be forthcoming either! Unless I ask for it, yes'. GP 2 interview

GP 12 believed her HIs role to be a clinical one, focusing on disease prevalence. There was an awareness that this role focused on the population rather than just the individuals.

'I suppose for me with my diabetes and stroke hat on, it's about being aware of that population, because the South Asian population have a high level of diabetes and unfortunately often present with their diabetes already with complications, and I think we probably need to increase the awareness of everybody who deals with people with diabetes to look particularly hard at this group, because they often present very young as well, and not to miss them. And again, help them go through the system and understand why it's important and the…the care planning approach, you know, the self-care where they have the information that they need and that. So for me, it's about being aware of it and knowing that what works with my patients won't necessarily work down the road'. GP 12 interview

The GPs roles within site three were varied focusing on both clinical and population aspects of HIs. The clinical lead for HIs was the one that had the least awareness on what his formal role entailed. Site three managers explained that certain aspects of HIs were natural and out of the control of the health service. This conceptualisation of HIs reiterates GP 10's understandings of HIs. GP 10 spends more time with the CCG managers than other CCG GPs and therefore this may have influenced how they collectively conceptualised HIs. Manager 7 when discussing HIs, referred to the PCTs PHC and

how they would describe HIs. This demonstrates the influence the PHC had on the managers within the PCT.

'When we worked on this XXX PCT and when I think back to what our Director of Public Health always used to talk about, the definition we always worked on which I think is a good a one as any is the health inequalities are a difference in either experience or outcome or access that are changeable. So there will always be some inequalities in that some people's outcomes might be different for a whole range of valid reasons, so there might be a different outcome between someone having a procedure, well, IVF, let's use that as an example, someone having IVF at 44 will have potentially a different outcome or different success rate than someone having it at 30. That is not changeable, that is because of the age of the woman involved, health inequalities are things that actually can change because potentially if someone's education or income or, I don't know, other circumstances changed that could have a more positive impact on their health. So my understanding of that is that that's what inequality is, it's something that if another action was taken or things were different you do have the potential to change'. Manager 7 interview

Manager 8, like manager 7, divided HIs into those that could be changed and those that were naturally occurring and out of the control of the CCG.

'My understanding of health inequalities is that it is the avoidable variation in people's health; that is...that we could influence and change if people's life chances were more equal. So, you know, there are things that we can't influence such as people's...you know, I'm the genetic product of my parents, I can't influence that, but whether um...what housing I have, what education I have, what access I have to facilities, the opportunity I have to buy healthy food, to cook healthy food, to know how to cook healthy food; these are all things that are variable and can be addressed and the health service have a responsibility to address them'. Manager 8 interview

Comparatively, Manager 9 in the CCG explained HIs in a similar way to Manager 7 and Manager 8. However, Manager 9 explained that she believed HIs should not be a separate part of healthcare; it should be included in everyone's jobs.

'It's one of these phrases that's bandied about, that people hide behind. When I was at University, I did an ethics part of my degree, and one of the key things that stuck in my head is about the equality, that we're all equal, but some are more equal than others. And I think it's the same. You could reflect it the other way on inequalities. We're all individuals, we are all different, so I don't think there's any such thing as inequalities. It's about how we make things as equitable as we can, based on an individual set of needs. Personally. I think it's one of the things that got hyped up, and now people hide behind it. So, we do equality impact assessments, but we should do them anyway. We don't do it to identify the marginalised groups or whatever, we do an equality impact assessment about everybody's access to a service, or a re-design, or to a policy. Why do we then start having categories in it that says, have you

considered the one-legged man, or the gay lady, or whatever it is. Actually, no, shouldn't we be thinking that all the time. And I think that's back to what I was saying about culture, that if we embed the culture and it becomes the norm, part of my job then as a manager for doing some of the national returns and demonstrating it is, yes, I can do the play on language, but actually, it should be everybody's business. It isn't that we should have an equalities lead. Actually, everybody's business is equalities'. Manager 9 interview

The managers in site three all spoke of unavoidable HIs; this conceptualisation of HIs removes the responsibility of HIs away from the CCG. Unavoidable HIs conceptualisation was only discussed by GP 10 and therefore this understanding of HIs was not held by all CCG members.

All of the managers within site three believed that they had a HIs role. Manager 7, a senior manager explained that HIs needed to be a part of the planning process, believing that her HI role is to work with the LA across the health and social care economy. The senior manager's role in site three is a planning role. Comparatively, in site two the role is formal, focusing on performance and measures.

'Well, I think my role as chief officer is to make sure that that is not ignored and that addressing health inequalities is actually picked up as part of our planning, and I would see myself as a governing body member being one of the people who should put that challenge in when proposals are brought to the governing body or we have discussions about things, about properly considering the impact on health inequalities and what we can do. I think I also have a role because I'm part of things like the Health and Wellbeing Board, so I have a role in feeding into those conversations with other partners and potentially influencing others like the local authority where actions that they take might have an impact on health inequalities'. Manager 7 interview

Manager 8 explained that everyone has a HIs role, clarifying two elements of her job that included HIs. Firstly, there was a corporate responsibility to ensure that HIs are included in the planning process. This corresponds with the Manager 7's and GP 10's accounts of their roles. Secondly, manager 8 discussed the inverse care law and how this impacted on poor practices. This manager's interpretation of HIs is consistent with managers in site one who refer to the inverse care law and the quality of primary care.

'I think we all have a role in relation to health inequalities. I think one of the things that, you know, is well known is the inverse care law; that the people who need services the most are very often the ones who are least likely to get them. So I think firstly in terms of my corporate role as a, you know, as a senior manager and working with the governing body for the CCG, in terms of where we put investment, where we are prioritising, I think there's a corporate responsibility there. And I think in my role as Head of Practice Support and Development, there is a role to make sure that practices in the more deprived areas, particularly those who are struggling perhaps, have more emphasis on them and

are supported perhaps more than some of the practices out in the leafy suburbs where they're very able to get on and do it themselves'. Manager 8 interview

Manager 9 explained that she was the manager for HIs who linked with the clinical lead, GP 2 and therefore it was a formal responsibility. Additionally, Manager 9 explained that she had an informal role to try and change behaviours and approaches chosen to tackle HIs. Behaviour change approaches were not mentioned by any clinicians or other managers across the three sites. This role is something that has been informally introduced by the manager.

'I suppose, within my job, I would have to say formal, because if I'm the strategic lead, and I'm supporting, I'm the manager to GP 2's clinical role, well, then it's got to be formal, hasn't it? I would also say that it's very informal, that a lot of what I need to do is back about the ethos and the culture, and that's done outside. So that isn't done in formal arenas. There is some of it that I do in one to ones, there's some of it I'll do by process, like business case templates, but that's then just about the informal, so it's my behaviour and my approach, and the drip, drip, drip part of it, to be perfectly honest. Manager 9 interview

The PHC in site three described HIs as the avoidable differences in health outcomes and access for patients. Although avoidable health differences are spoken about there is a clear understanding that deprivation, ethnicity and the wider societal influences can impact upon health (Public Health England, 2013). This was not as widely acknowledged by other members of the CCG.

'That health inequalities are differences in people's health outcome and health status that are avoidable. So they might be based on your - where you sit in the deprivation - the spectrum of deprivation, where you sit in that. It might be about particular vulnerabilities you have, so learning disability or ethnicity or - and when I say ethnicity I don't mean the unavoidable things like because you're a particular ethnicity you're more prone to a particular disease. It's more about you're less likely to be able to access services appropriately and that there may well be cultural aspects that are related to your ethnicity that make you more prone. So African/Caribbean community very high salt diet, for example'. PHC 3 interview

The PHC in site three did not distinguish between two different roles like the PHC in site two. Here the PHC explained that her role was to ensure that the CCG were aware of the joint opportunities across the LA and the CCG and how they could become actively involved. The PHC had adopted a relationship manager function between the CCG and the LA. One important finding was that the PHC was becoming more aware that to ensure that HIs are on the table that she needed to ensure that the information was being presented in the right way to the CCG. This is something that had obviously proved difficult for the PHC and the CCG in the past. This role highlights the challenges that the CCG and the PHC have faced when trying to work on the HIs agenda as two separate organisations.

'I think my role is to remind people that they exist to try to make the joint health and wellbeing strategy really come alive for the CCG and to see how they can have ownership of it and contribute to it. So I guess my role is to provide the information and I think one of the things I'm learning is I've got to provide the information in a way they can relate to better than I am at the moment. So I need to go back and say, okay, you know if you want facts and data, let's start with the facts and the data and then move on to the big picture. I'm going to change my approach'. PHC 3 interview

Within site three, two managers spoke of the unavoidable inequalities and differentiated between HIs that could be tackled and those that couldn't be changed. This was also expressed by GP 10 and the PHC. Other GPs within the site spoke of HIs very differently. Although this is documented within the literature (Klein, 2010) there was little mention of unavoidable differences in health in sites one and two. Another finding from site three is that a number of the GPs reflect on HIs as an area where people have an individual level of responsibility to care for themselves. Site one and two did not reflect on the individual responsibility on HIs, they tended to focus on wider societal influences on health such as place and government funding models.

In summary, individuals in site three discuss HIs differently. GPs hold varied conceptualisations on HIs. GP 10 focuses on unavoidable HIs, HIs that are out of the control of healthcare. Comparatively, GP 2 recognises HIs at a population level. GP 12 on the other hand purely focuses on the clinical aspect of HIs and disease prevalence. Managers all hold similar understandings of HIs which are consistent with GP10s understandings of HIs. This focus on unavoidable HIs, takes the control and responsibility away from the CCG when trying to tackle the issue. Although the managers believed that some HIs were unavoidable they all recognised that they had a role to ensure that HIs were on the agenda and part of CCG work. Thus, they must acknowledge that there are certain areas that they are able to influence. The PHC focused on the wider influences on HIs and therefore her conceptualisation of HIs was very different to the clinicians and managers. The PHC, when discussing her role, clarifies that she is trying to get the CCG to think about HIs and be aware of the problems the local population face.

7.4.2   Health inequalities in practice

The timing of fieldwork commencing in site three, five months before their authorisation submission date, makes it difficult to know how or whether the CCG were thinking about HIs prior to the authorisation process commencing. All observations that were conducted in site three demonstrate that HIs were discussed and regarded in relation to authorisation (e.g. strategic plans, case study development and the overall vision of the CCG). HIs were an official element of the authorisation process, and CCGs were required to provide evidence about their approach. Site three initially was unable to adequately provide this evidence, and therefore received outstanding conditions regarding HIs in their authorisation. This led to further discussions about HIs in CCG meetings. These discussions focused on the processes of authorisation rather than the wider conceptualisation and understandings of HIs.

> *Manager 8: When the governing body last met we had received our site report highlighting two*
> *red areas. There have been two more stages since then with a moderation panel being held for*
> *all wave two CCGs to look at consistency. Our reds remain the same on health inequalities. On*
> *Monday a conditions panel met to rate the reds and develop input from the Commissioning Board*
> *to support you. Our two red areas have been rated at 1 and 2 which is low.*
> *(December governing body meeting)*

In practice, individual member's conceptualisation of HIs was not carried through to CCG meetings. HIs seemed to be viewed as something that needed to be overcome to ensure authorisation was met for the CCG. Therefore the wider influences on health, the responsibility and future HIs were not articulated in meetings by CCG members.

7.5   Overall Summary

This chapter supports the findings that were presented in the literature review (chapter 2), HIs can be conceptualised in a number of different ways. This chapter answers question one (see section 5.2), the chapter explored how individual conceptualisations of HIs across CCG staff and those working with the CCG could influence organisational interpretations of HIs in practice. Overall, HIs were conceptualised differently across the three sites (see figure 17). The table demonstrates how conceptualisations of HIs are varied across the three sites, no single academic understanding of HIs has been adopted locally. However, a collective conceptualisation of HIs was only evident in site two; where HIs were referred to as variations in health across different groups of people. This collective conceptualisation of HIs was not only discussed during interviews but was also evident in practice. Observations highlighted that HIs were referred to and discussed with reference to different groups of people that the CCG served. For sites one and three there was no collective conceptualisation of HIs, there was a lack of clear interpretation of the problem, with reference being made to wider influences on health (e.g. funding formulas), therefore removing the responsibility of tackling the issue away from the CCG. The conceptualisations of HIs across all three sites failed to take into consideration the work of Marmot (2010) which offered guidance on how HIs could be challenged, providing information for healthcare, Local Government and Central Government. This review takes into account the wider determinants of health but also places emphasis on the role of health care. The invisibility of Marmot is surprising as it has been seen as a key document of focus within the LA when thinking about HIs (Dhesi, Forthcoming). In the next chapter, I go on to investigate if these different conceptualisations within and between the three sites impacts on how they are beginning to tackle HIs (or not).

Data from sites		Different health outcomes for different people	Inverse Care Law	Access	Wider influences on health	Inequalities as a PH problem (rather than CCG)	Prescribing	Responsibility of the individual	Gap in health	Health needs/service	Inequalities as an authorisation issue	Disparities in Health	Health Experience
Site 1	Observation			I		I							
	GP interviews	II	I										
	Manager interviews	I	I	I									
	PHC interviews		I		I	I							
Site 2	Observation				I							I	
	GP interviews				II	I						II	
	Manager interviews			I								III	
	PHC interviews				I	I						I	
Site 3	Observation									I	I		
	GP interviews						I	I	I				
	Manager interviews									I			
	PHC interviews				I					I			I

Chapter 8: Tackling Health Inequalities

8.1　Introduction

In the previous chapter I have demonstrated that HIs are conceptualised differently, not only by CCGs as organisations but also by individuals within them. Not all CCG members hold a collective understanding of HIs; this could impact on the way CCG members attempt to tackle HIs in their area. This chapter addresses the second research question (see section 5.2), focusing on how CCGs have chosen to tackle HIs, if at all, during their year of establishment. This) is important to understand as CCGs have been given an explicit duty to work to reduce HIs. Interviews with CCG members were used to establish what managers and GPs associated with the CCG perceived was being done to tackle HIs and observation data was used to see what was happening in practice. The results are individually presented for each site with comparisons being drawn throughout the chapter, again perceptions of individuals was sought via interviews and actual practice observed in meetings.

8.2　Site One

8.2.1　Initiatives to Tackle Health Inequalities

When GPs were asked how they were planning to tackle HIs as a CCG, GP 3 explained that they had done nothing to tackle HIs because they were spending their time trying to establish themselves as an organisation.

'*It's been done three of four times so you know then thing that you are talking about today which is addressing health inequalities I think we have hardly touched upon it as we are trying to form ourselves as an organisation'. GP 3 interview*

GP 3 explained that the CCGs intention was to try and improve the health outcomes of the population. However, other surrounding geographical areas were also improving the health of their local population and therefore it becomes difficult to make a difference when comparisons are being drawn (i.e. it is impossible to reduce the differentials). GP 3 was unable to discuss what they were doing as an organisation to tackle HIs. Overall GP 3 seemed distant from the HIs agenda.

'*I mean anything we do should be to improve the health of our local population but how that relates specifically to reducing health inequalities I'm not sure. I find that difficult to answer. I mean if we were to improve the outcomes for our population in terms of cardiovascular mortality then that would give our population a boost up the league table so to speak. But that will probably be happening in other areas so it is difficult to pin down isn't it?' GP 3 interview*

GP 5 was also unable to provide an answer of how the CCG was going to attempt to tackle HIs. GP 5 explained that they wanted to be more responsive to HIs as an organisation ensuring that GPs feedback their perceptions of local need to the CCG. GP 5 hoped that in two years' time he would be able to contribute a full answer and plan of how the CCG were tackling HIs. This GP, explicitly privileges GPs' non systematic experiential knowledge above the systematic knowledge of PH.

'I can't give you a sort of full; I think what it should be doing goes back to what we said before. It should be that the CCG should be responsive to what GPs are saying about local need and that should mean then that they, that we fight our corner, we try to ensure that services are responsive and that services are developed. I mean I don't know that there's a more formal answer to that. I'd hope, again because of this period, I'd hope that in two years time we've developed some services that are actually helping to tackling some of these inequalities'. GP 5 interview

The senior GP, GP 4 provided practical examples of where he believed they were trying to tackle HIs as an organisation. GP 4 said that it was important to tackle the 'perception' of HIs and access, although whose perception was not explicitly discussed. This could be interpreted as the patients accessing their GPs or how the LA perceives access across the area. The CCG was running training exercises to ensure that GP practices were better at providing same day access for patients. Additionally, GP 4 explained that the CCG had introduced a planned care referral gateway to control the access to planned care. This access, was not necessarily seen to be a way of improving health outcomes, rather it was seen as a general need to be met.

'I mean, **to look at that from a basic perspective, that was to do with perception, this was to do with access and the way in which practices dealt with demands for on the day access for the client.** *You have this suspicion that something's going wrong, you develop an objective system to check whether it's going wrong, or not, ideally your benchmark is against somewhere else, but that's impossible, because no-one ever publishes these results, and then* **you put an educational intervention in place in order to try and modify your system, and the educational intervention we're putting in place is some involvement for practices in training...both in their front end training, their telephone techniques, not only to their telephone techniques for their receptionist, but also for their doctors in triage, and also some education for practices in terms of managing their demand, and when they have to, and matching their supply of staff and resources to their demand patterns, so, it's some basic stuff about how to run your business better...** *I guess, some of the other things is to do with effective use of resources, and there are many examples about effective use of resources, so, for example, the planned care referral gateway is an example of how you control access to planned care based on need, we used to use waiting lists to manage healthcare, ration healthcare, but that's not done these days, so, nowadays what you have to do is use evidence based medicine to manage healthcare...So,* **the conclusion, therefore, must be that if you try and regularise referral patterns, you won't get any, you won't be a damage to those patients who would have been over referred, in fact, it's their benefit, because they're**

making, they're life is made simpler because they don't have to go to multiple appointments, *and get investigated for things they don't really need investigating for, so, not only are we trying to make a more effective use of resources in a purely monetary way, we're also trying to reduce over referring, as well as improve under referring, and that's a way of tackling health inequality between practices', GP 4 interview [emphasis added in bold]*

Only one of the GPs, GP 4, was able to provide a concrete example of how they were tackling HIs as an organisation. GP 4's explanation of tackling perceived HIs, demonstrates that CCG members aren't focusing on specific HIs but trying to ensure that GP practices are keeping their patients happy with the service. Access in this context refers to a number of different ways that GP practice staff can talk to patients including face to face visits and telephone triage. GPs 3 and 5 believed that it would take time to tackle HIs and their time at the moment was invested in developing the CGG as an organisation within the NHS reorganisation; concentrating on managing a shrinking resource and establishing a new governing body for authorisation.

Managers within the CCG were also asked how they thought they were tackling HIs as an organisation. Manager 1 explained that she thought they were concentrating on the prevention agenda, this links with the work of Marmot (2010). The Public and Patient Advisory Group (PPAG) were portrayed as a way that CCG members were able to meet people from different communities and access their views. PPAG was a group formed by the CCG to engage with patients and the public. This group meets monthly, providing comments and feedback to the CCG on their proposals. The overall purpose of the group is to ensure that wider engagement is taking place.

'I suppose, that is the subgroup that I have forgotten, we have a patient and public advisory group. So I'd say something like that is one of our tools because we meet people from our different communities and different groups who are speaking out. As I have said patients and groups don't speak out. So that is one of the things as I say the CVD work is, I suppose it is not preventing health inequalities but it is mindful that due to health inequalities we have a level of higher need, a greater risk and presence of cardiovascular disease. I think preventing health inequalities, I think continuing to fight to improve our local hospitals rather than saying go somewhere else'. Manager 1 interview

Manager 3 referred to the PH programmes of work and their attempt to tackle HIs. Little explanation was provided and, it was clear the PH was seen separately, rather than being a core CCG responsibility. CCG members are focused on the complex family work, working alongside the LA as well as general practice to try and improve quality and reduce variation.

'The complex families work is probably one thing that we're working with the Council on. Is there anything else…well, clearly, there's nothing that runs immediately to mind. There's a lot of Public Health work goes on with, you know, local people, but that's in the Public Health arena, not mine. Yeah. In that sense, yeah, that's that Z stuff we talked about. So that's working with those practices

who are outliers. So that, I suppose, that's health inequalities in that sense, yeah, that was about improving the quality of primary care to improve the health of the population, which would help our variation, so Z score the variation stuff that's going on, referral patterns, that sort of thing, you know'. Manager 3 interview

The PHC responded in a similar way to manager 3 explaining what were the PH programmes of work for tackling HIs, concentrating on what could be achieved by the move of PH into LA. There was no mention of what the CCG programmes of work were.

'I think the public health programmes are pretty self-explanatory, so for example, although screening is going to the National Commissioning Board, I think we'll still have a role in communicating important public health messages to populations that traditionally don't engage; the screening, the immunisation, the people who don't maybe access information around drinking at a healthy level or looking after themselves or whatever. And I think a lot of the work is broader than lifestyle. Now we're in the local authority we've got an opportunity to think more about healthy planning, how are we going to create an environment that is health-promoting, rather than promoting obesity by not giving people opportunities to…? If you're in an urban environment that is not conducive to walking and cycling, if you're in an environment where the crime rate is high and people are frightened to walk. If we keep giving planning permission to more and more and more takeaways and people can't access good quality fresh food in their local environment. It's about trying to work on that broader strategic level to create an environment where people can improve their health and have better access to the things that make you healthy'. PHC 2 interview

Managers did not provide the same examples as GPs of how HIs were being tackled. Some examples related to the individual roles that CCG members are involved in, however GPs were still unclear whether any work was being carried out on the HIs agenda. Manager 3, a senior manager explained that tackling HIs was an element of the PH agenda rather than CCG work, which was supported by the PHCs interview.

8.2.2   Governing Body Papers

At each governing body meeting, papers would be submitted for discussion or approval. In site one, all papers were submitted with a cover sheet, asking the author key questions regarding the purpose of the paper, the relevance to the CCG and how the proposed paper impacted upon access and HIs (see figure 18). The boxes were completed with text and filled out individually by each author of the paper. Whilst site two and three also had cover sheets, these did not include reference to HIs.

NHS
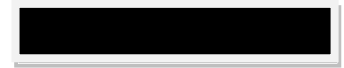
XXX CCG Board Meeting – 11 April 2011

Report of:	
Paper prepared by:	
Signed off by:	
Date of paper:	
Subject:	
Background papers and links to priorities/objectives:	
Purpose of the paper:	
Relevance of the paper to delivery of XXX Commissioning Strategic Plan:	
Implications for access and inclusion:	
How does the proposal contribute to reducing health inequalities?	
How does the paper evidence XXX Clinical Commissioning Group competencies and governance for authorisation?	
How does the paper evidence Use of Resources?	
How does this paper contribute to 2012/13 NHS Operating Framework areas of Quality, Reform and Finance	
Action/decision required:	

GPs and managers were asked whether they found this section of the governing body papers useful and were questioned about the purpose of the cover sheets. GP 3 said that the sections were there to act as an aide memoir to remind people about areas the governing body would be interested in for any future plans, it was implied that the cover sheet had become a tick box exercise for CCG members. Whilst manager 2 explained that the process was a waste of time.

'No it's just a tick box. It doesn't dictate which papers come. It is just on the front there to as a memoir and I suppose the theory is if it doesn't tick any of those boxes why is it coming to the board. You know…it could be a paper about the audit committee which doesn't tick any of those boxes on the front but they still come to the board because they have to'. GP 3 interview

'Complete waste of time, nobody bothers with it. I could elaborate but it just doesn't like..'. Manager 2 interview

It is clear from the interviews with the GPs and managers that the governing body cover sheets are not viewed positively or used well. The PHC explained that they had previously been used by the PCT to ensure that different departments were able to feed into the planning process; however this was not the case anymore. Several participants explained that the cover sheets are ignored by CCG members. However, others believed that the cover sheets were there to remind people to think about important issues when submitting papers to the governing body. The cover sheets did not have a clear function and weren't necessarily used well by the CCG. One explanation of the cover sheets becoming a tick box exercise could be that they were established and embedded by the PCT and therefore as time has progressed, they have not been utilised well, influencing individual's perceptions of them. Finally, I checked the governing body papers every month, comparing the access and HI sections on the cover sheets. The information in these sections was put into a spreadsheet and compared monthly. This revealed that the information on each section was copied and pasted on the cover sheets of monthly papers and supports CCG member claims that the cover sheets were a waste of time and ill-used (see Appendix one).

8.2.3   Relationships to Tackle Health Inequalities

Partnership working is portrayed within the literature as a clear example of how organisations can work together and tackle HIs (see section 2.4.3). Previous policy initiatives have encouraged partnership working between health and social care, however partnership working is not necessarily easy to establish and sustain across different organisations (Glendinning and Coleman, 2000, Glendinning and Coleman, 2004). During the interviews GPs were asked which other organisations they perceived the CCG needed to work with in order to tackle HIs. GP 3 and GP 4 both believed that they needed to work alongside the LA and their Foundation Trust (FT) when tackling HIs.

'Yeah I think local authority probably. Local authority and our local hospitals…yeah I mean the two I mentioned I mean the relationships with the local authority are probably as good as they have ever been because we are tasked to bring in neighbourhood teams and look at long term conditions. So the relationships are pretty good on the back of that. That's not to say the task is easy but the relationship is good. And the relationships with the local trust are probably as good as they have ever been, because we meet them on a regular basis with the commissioning agenda. So again those relationships are good that again that doesn't necessarily equate to you know better commissioning or better care. But certainly the relationships are good because the changes are focusing people's minds'. GP 3 interview

'Definitely the local authority. In terms of making services work more efficiently, which, sort of, tackles health inequalities, although it doesn't move resources around specifically to tackle health inequalities, but you can't, you've got to change services, there's two sets of relationships for XXX CCG, and those were the XXX sector, which is where most of our aging care and reduced length of stay is going to come from, and with the other two XXX CCGs, which have, we jointly have the relationship with the local authority, but also, we join the commission of mental health services, so, there's significant, a relationship there, and those are the big players, and then, of course, the Acute Trust, my main concern, I think, XXX [FT], who is responsible for, sort of, seventy five per cent, eighty per cent of our activity, I think, you can have a sensible conversation with them, and they're not, touch wood, a referral centre, apart from a very small part of their activity, so, they're focused on secondary care, and just do general type services, I think, our major issue is with our relationship with XXX Foundation Trust'. GP 4 interview

GP 5 believed that they needed to work with the LA but also placed emphasis upon the GPs that worked within the CCG and joint working with PH. From April 2013 joint working between the CCG and PH became the responsibility of the LA (Department of Health, 2010b, Department of Health, 2011d). GP 5 said that health is influenced by wider issues including benefits, therefore directly linking CCG work with the LA. Additionally, the role of GPs and the quality of general practice was viewed as a way to overcome access issues.

*'Probably **public health and the local authority really. Local GPs, I mean I kind of just looking from a GP perspective, I think a good GP service can do an awful lot for you know an area really.** So, I think if you could really bring up primary care in this area for example it could really do an awful lot. There are a lot **of patients that don't get access to services that they should be getting. So I think general practice is kind of fundamental and I think a lot would come from there.** I think if you would improve primary care that would be an easy way to do that…**I think the local authority view; I mean so much of this is tied up in national stuff like poverty.** I have mentioned that we work with the homeless the factors that influence homelessness will be around poverty and again without sounding very vague if this country becomes much poorer and austerity kicks in. If people's housing benefit gets cut that will have a massive impact on health really. So, national policy in terms of,*

one of the big issues we have at the moment is people having their benefits cut, that will have a more profound influence on what happens. So our patients seem to be getting poorer from that respect really and again that is a relatively new process. ***We have a number of patients who are being told they are fit to work and their benefits are being cut which is impacting quite forcibly really and that then affects everything else. They become depressed, their health becomes jeopardised and health tends to become, it slips down on their own personal agenda really'****. GP 5 interview [emphasis added in bold]*

All of the GPs recognised the importance of relationships with the LA for tackling HIs. Overall, when GPs were asked about the importance of organisational relationships, they acknowledged that wider / external relationships helped focus CCG member's minds on HIs, reminding them that the CCG and health issues are part of a bigger picture, including poverty and resources.

All managers commented on the importance of the LA for tackling HIs; similarly to the GPs. In relation to developing working relations with other organisations, manager 2 explained that the LA should be front and centre for tackling HIs alongside the FT.

'Organisations, obviously local authority, right up there front and centre. The acute trusts are right up there too but for different reasons. I am…everything's political, everything. The acute trusts are key to it in the sense that they have A&E which on a quiet day, if you were cynical you might say that on a quiet day people coming into A&E might just get x-rayed randomly or…bit of patient churn just to keep the motor running but the flip side of that is on a cold winter's day you end up breaching four hour waits, things like that'. Manager 2 interview

The senior manager commented on the role of the LA and local FT in tackling HIs, whilst expanding further by explaining that PH and the GPs within the CCG were also partners in trying to overcome HIs. A whole system approach was recognised as the way to tackle HIs.

'Well, Local Authority, Public Health, our GPs and our Acute Trust and Community Services, because, you know, it's the whole system this, we've all got to do our bit and the problem, I think, in the Health Service has been, we have too many priorities are targets each year to deal with, far better to say, over the next few years we just focus on, say, CHD, diabetes, get those sorted, because that will help, you know, and then the two years after, we focus on this, this and this, whereas, rather than having 10 things every year, we should do a little bit out and then do enough of, so it keeps continuing, I think, we're overloaded with priority and targets'. Manager 3 interview

When the PHC was asked who she thought were the CCGs main partners in tackling HIs, she explained that she thought it was PH, the LA and GPs. These partners were also mentioned by GPs and managers in the CCG. The main difference was that the PHC explained that GPs were ideally situated to give people the right start in life, this role is stipulated in (Marmot, 2010). The use of

Marmot's ideas and recommendations to tackle HIs is something that is heavily referenced in PH. Marmot's ideas were seen as important when setting HIs agendas in LAs (Dhesi, Forthcoming).

'Public health / local authority. And I think at the moment they… their local authority contact inevitably has been a lot around social care and who the social care needs of patients and their health needs could be worked together a bit more. So the key one, top of the list probably is the local authority – and public health is a developing part of local authority - I think they need to think about the other elements of local authority rather than just social care, and that might be helped by the fact that the local authority may be developing a more internal integrated approach to children and adults as well; because I think that young people's health and child health is going to be absolutely key to this agenda. I mean if you look at all the Marmot stuff: giving people a good start in life is going to be so important, and GPs have such a lot to do with that'. PHC 2 interview

8.2.4   Tackling Health Inequalities in Practice

In practice I found that the areas CCG members spoke about regarding tackling HIs during interviews were also mentioned in CCG meetings without any reference being made to HIs. For example, primary care access was heavily referenced during CCG governing body meetings; however the overarching issue for the CCG was their relationship with the LA and the closure of a local Walk in centre (WIC) (see chapter 9).

Manager 10: for Urgent Care we agreed a mystery shopper test for access issues.

Manager 2: interim results however not complete give a picture same day appointment 38.1%, triage 15% signposted and call back most responses and are not atypical. They are not results that we can be immensely proud of. To be honest this is an issue that we need to deal with quickly…

Manager 10: Primary Care Foundation are coming in to work with us over the next couple of months. The initial target is PM and primary care access. The results of this exercise help focus this.

GP 5: this highlights the issue what GPs think walk in centres are for.

Manager 2: there was considerable variance across the practices.

PHC: have you shared with councillors?

Manager 2: we have to it is just the way in which we do it.

Manager 3: it is clear from the data that we have an issue.

GP 3: as a board what are we going to do with the information?

 (April governing body meeting)

Managers, during interviews, spoke about the CCGs public engagement panel, explaining that the purpose of it was to ensure that hard to reach members of the population for example a representative

from the Lesbian and Gay Foundation was being included in the decision making processes of the CCG. During a CCG governing body meeting the recruitment of members to the panel was questioned, demonstrating that CCG members have thought about which groups should be included in the engagement process. However, no direct links were made to HIs during the meeting.

> *Rep 1: how were people appointed? Are organisations represented?*
> *Manager 2: there is a little tick in column a tick and a little in column B there is only one appointment from LGB T as one of the members is representative of the LGF organisation.*
> *Rep 1: it is about being clear and making sure that the issues are spoken about widely.*
> *Manager 2: that potential issue is it being just about them will only happen with one of them.*
> *(May governing body meeting)*

Overall, the HI initiatives that CCG members discussed in their interviews were mentioned during a number of CCG meetings but were never raised within the context of HIs. The focus was placed on other areas. There were few identifiable HIs initiatives that were discussed during site one CCG meetings.

8.2.5   Summary

In summary, there was no clear strategy of how this CCG was intending to tackle HIs. However, both clinicians and managers were able to provide examples of small programmes that the CCG were leading or involved with that would impact on HIs. Two clinicians explained that they were concentrating on developing as an organisation and therefore the HIs agenda had slipped. Parallels can be drawn with past work on Patient and Public Involvement (PPI). Coleman et al. (2011) explains that although there have been mechanisms to encourage PPI work over a number of years in the NHS, there has been a lack of evidence to prove the effectiveness of PPI work (Harrison et al., 2002, Coleman et al., 2009). Therefore they often become knocked off of the agenda. The PHC working alongside the CCG could only provide PH examples of how HIs were being tackled in the area; there was no reflection on CCG work. All CCG members believed that as the organisation moved forward they needed to work alongside the LA and the local FT to tackle HIs. It was evident from interviews that PH and CCG work were viewed separately, thus it could be argued that there is a lack of joined up thinking in site one focusing on the HIs agenda. The CCG governing body cover sheets were an example of how the HIs agenda being overlooked by site one, rather than focusing on how CCG work could impact on the HIs agenda, it was being used as a tool for authorisation, again reflecting the lack of an HIs strategy in site one.

8.3   Site Two

8.3.1   Initiatives to Tackle Health Inequalities

In site two GPs provided different examples of how they were tackling HIs as a CCG. Two of the GPs said that they were working jointly with the LA on the HIs agenda. GP 7 said that they were focusing on access to lifestyle services for their population whilst working alongside the LA. The PHC working with the CCG was seen as a facilitator of the relationship as she had worked with people from the CCG and the LA for a number of years.

'There's the access to Lifestyle Services is a key part. There's many initiatives that are Local Authority involved, there used to be Sure Start but I think there's an alternative now. I can't remember the names of all these things. There's lots of work going on in schools around healthy eating, lifestyle choices etc. So I think there is quite a lot of work being done. Some will be joint, because we have a Public Health person who obviously works here and also works with the Local Authority, so a lot of it is joined up, the children's services, the adult social care services is joined up, there are regular meetings, there's section 75 where there's shared care arrangements. So there's actually lots of things that enable joint working to take place'. GP 7 interview

GP 9 also commented on the relationship with the LA explaining that the LA and the CCG were trying to rebalance the relationship with the public, making the public aware of their own role in their health. Individual responsibility for health reflects the Thatcher Governments ideology of individual responsibility that surrounded health, whereby health facts could be provided to the population, however individual choice and behaviour was perceived as an individual responsibility (Baggott 2004 p 339).

The main focus between the CCG and the LA was the complex elderly, trying to overcome the inefficiencies in the system and prevent recurring hospital visits for patients with multiple health conditions. The aim was to try and create an integrated team to case manage and anticipate care for complex individuals in the health and social care system. GP 9 said that by working with this group they would be able to make space to concentrate on other areas of health.

'Well we are looking at…as I say, the main programme for us, our main plank in addressing health inequalities, is firstly to give ourselves some headroom by constructing this new model for complex elderly…complex people, mainly elderly. Because we know that there's a huge inefficiency in that system, that drives the hospital to struggle with performance, drives the economy to spend more than it should, and therefore doesn't give us the resource to reinvest, differentially reinvest in addressing health inequalities. So, that's one facet…And then working with the local authority, I think we need to look at how we can start to rebalance that relationship with the public through our health and wellbeing strategy, to address people directly about their role in this'. GP 9 interview

GP 9 reflected on the budgets explaining that they were trying to allocate money to different areas reflecting the inequalities experienced by different population groups.

'We are waiting…budgets, more to look at inequalities in health, both in terms of age and deprivation…prescribing projects for example, commissioning budgets that we want to delegate…we are thinking about how we can weight those to accurately reflect inequalities in each area'. GP 9 interview

GP 8 also spoke about the different areas the CCG serve and said that they were aware that different localities had different needs e.g. screening attendance and therefore they needed to run schemes that reflected the need in those areas appropriately.

For each locality there are slightly different health inequalities. We have spoken about a potential scheme where we email patients relating to the coil and contraceptive implants focusing on teenage pregnancies. It depends on the area as for us it is more of an issue than XXX which has an elderly population. More family planning access would benefit patient's more than wealthy areas. GP 8 interview

GP 1 recognised that the plans the CCG had for tackling HIs were still evolving and being developed. Similarly to site one, public engagement was being used to approach HIs; however in site two it was used as a method to ensure that people knew what healthcare was available to them.

'I guess most of that at the minute is building and evolving and I think at the minute it is mostly the public engagement side of things that is addressing that more than anything else. If I was thinking health inequality is a result of people not knowing what is available, not seeing the doctor and not knowing how they can shape health services around public engagement'. GP 1 interview

The managers in site two focused on the prevention agenda when discussing how the CCG were tackling HIs, this was similar to the managers responses in site one, again reflecting the Marmot agenda. The senior manager, manager 4, said that there were a gamut of things that the CCG were doing, specifically mentioning the importance of lifestyle services and screening.

'Things like trying to improve uptake of screening rates. Looking at lifestyle services, there's a whole gamut of different examples really'. Manager 4 interview

Manager 5 again focused on screening and alcohol explaining that CCG members had invested lots of money into the prevention agenda. This interview demonstrated how the CCG was already making plans to pool budgets with the LA across a number of areas (this is a legacy of PCT work), supporting previous GP statements.

'We are throwing money into prevention especially around cancer, there have been many promotion campaigns I can't off the top of me head actually remember individual schemes, but there are promotion campaigns, but this is one that we are working quite close with the council in terms of alcohol. I think it's the alcohol and the drug addiction, that's another area where we are looking to pool budgets'. Manager 5 interview

Unlike managers 4 and 5, manager 6 reflected on the CCGs role for tackling HIs as an employer. Manager 6 discussed the importance of understanding how they work as an organisation, reflecting on staff recruitment, service and how this could impact on the HIs agenda i.e. thinking about what geographical area staff are being recruited from. This CCG work was still being thought out; manager 6 believed that this was one way the CCG could focus on tackling HIs much closer to home.

'If you're in charge of HR and recruitment what's the recruitment policy, because you can impact, you can say we will almost target more deprived areas for recruitment. So I know there's a start up job effectively, a lower grade admin job, and you could say well, as part of our responsibility to the economy we will recruit that from only two areas in this town. Now, I don't think we've thought about that. I've got it in my mind, but I've not really put that into the system yet to say well, we haven't got anybody at that level in the organisation currently, and it's a younger person's job most likely…But you could target it to those sort of areas and say it's a career opportunity in the NHS. And I think we need to be a bit cleverer at that kind of thing. Even down to where do you get your sandwiches from. There's loads of places you could start to think about that kind of issue. And then your own staff anyway, are you really tackling some of the drivers behind inequalities in terms of health causes? But that I don't think would have that big an impact on health inequalities because I don't think most of our staff are part of the population. They tend to be part of the population that's got quite good health' Manager 6 interview

The PHC during her interview said she was able to distinguish the CCG programmes of work for HIs from other key organisation's work. The CCG had decided to focus on screening in deprived communities and health checks; this had been agreed through the HWB. Other HI priorities in the area are dealt with by the Place Board and the HWB. The Place Board oversees neighbourhood management boards that focus on four priority areas focusing on local issues, challenges and solutions. The PHC was very specific about what targets the CCG were trying to improve and how this would help tackle HIs.

'Yes. I suppose, specifically in the CCG, there's a project around improving screening uptake in deprived communities, that's particularly focusing on our deprived communities. And there's two bits to that. One is the breast screening van is going to go, or be sited near, and call patients from XXX and XXX, which is one of our priority areas. So we're doing some particular work with that community to try and improve access. And the target is to improve by 3% on last time, the deprived community's access to breast screening. The other one is around health checks. We've done XXX, and we're now going to

117

XXX. And that's around working with the practice systems, to try and identify high risk patients, who haven't yet been assessed or seen, in terms of their risk… And the health checks really covers a whole range of things, because as well as the CVD, it also picks up risk factors for cancer. And it's a sort of hook on which to hang an awful lot of improving access to individuals, and therefore reducing inequalities that way. In terms of the rest of the actions, most of those are outside of the CCG, driven through both Place and Health and Wellbeing Boards'. PHC 1 interview

The explanations for tackling HIs were varied, like in site one. GPs and managers reflected on areas they were aware of. Interestingly, GP 8 and GP 9 spoke about budgets and the resource needing to reflect the different needs within their population. This planned strategy to tackle HIs reflects the organisational conceptualisation of HIs, focusing on the disparities of health within the area (see chapter 7). However, no weighted budgets (budgets based on the need in that area) had been allocated at the time of data collection. There is much discourse surrounding the HIs agenda in site two; however because of the timing of the research it is difficult to see whether this discussion would be implemented into action. This discourse poses the question, could talking be perceived as doing? There is no formal guidance surrounding the duty to tackle HIs for CCGs, thus talking about the issue could be perceived as a method in which to think and tackle HIs.

8.3.2   Relationships to Tackle Health Inequalities

It was apparent from several of the initiatives mentioned by GPs that the relationship with the LA was important for tackling HIs. GP 1 was the only one that did not claim the LA was a key partner for tackling HIs, focusing on the importance of charitable organisations for tackling HIs.

'I guess I keep finding things along the way so, and I guess charitable organisations so things like Age UK or probably lots of other organisations within XXX are more closely in line with the public or more closely in line with specific needs'. GP 1 interview

GP's 7, 8 and 9 thought the FT and the LA were the right organisations to work with for tackling HIs. The LA was specified as being the most important relationship.

'Our main partners are the local authority at number one. I am debating the FT but probably the nature of acute care they won't see health inequalities like us. There are also connections with the Third Sector and charities working with us, like the mental health team working with Mind'. GP 8 interview

'The local authority, the foundation trust…actually I haven't mentioned, and it's remiss of me, local mental health foundation trust as well. They're a significant partner, and we need to think about how we can address the significant mental health issues that often drive inequalities'. GP 9 interview

'To be honest I think it's the Local Authority and the Foundation Trust and Primary Care'. GP 7 interview

The majority of GPs believed that they needed to work alongside the LA to tackle HIs, from some GP interviews; it was clear that joint working had already been established across the LA and the CCG (from the legacy of the PCT) for example the integrated team across health and social care managing complex patients. Site two members also referred to section 75 which is a shared care agreement across the CCG and the LA, again evidencing the joint working arrangements.

The LA and the FT were all agreed, by managers, to be the main partners for tackling HIs.

'Well I think to me it's going to be the council really key one with the council and XXX Foundation Trust or local hospital, especially now they've got the health visitors and district nurses'. Manager 5 interview

Manager 4 believed that the LA would enable opportunities for the CCG to work across a larger footprint, outside of health. The third sector was seen to have a place for tackling HIs; they were perceived to be able to target areas that were not attainable in the statutory sector and therefore they could access wider community groups.

'Obviously the local authority. Local providers. The local authority covers huge areas, you know schools, you know it's that whole gamut really in terms of making sure you reach out to the whole community. Third sector as well are always very, very good at reaching into areas that the statutory sector isn't terribly good at reaching into really'. Manager 4 interview

Similarly to managers 4 and 5, manager 6 explained the importance of the LA and the FT for tackling HIs. However, manager 6 said that there was still some work to be done with the voluntary sector; it was acknowledged that this relationship was not strong enough; further work was needed in this area. Manager 6 suggested that the PCT, prior to the CCG had not established a good relationship with the voluntary sector without providing any reasons why the relationship had not been developed.

'Clearly the local authority. That's good. We've done a lot of work with them, and we all do a lot of work as well. I don't know whether they're partners, but I do think some of our GP practices, particularly in the more deprived areas, are key to this… reason for the FT is actually the community health services are all in there. I knew there was another reason, not just the contracts and that sort of thing. So yeah, clearly they're key partners in community health type health visitors, the district nurses and others that work in those communities all the time, and we underestimate what they could achieve I think. Then there's the voluntary sector, and I just don't get much impression that we've got anywhere with that in our heads. I don't think the PCT ever did more than pay lip service to them, and CCG, I'm not quite sure it even does that yet'. Manager 6 interview

It was clear from the way that the managers spoke about the LA that this was a key relationship for tackling HIs in their local area; the interviews reiterated CCG GPs opinions on wider organisational relationships. Although other organisations were mentioned the relationship with the LA was seen as the key one for tackling HIs.

Like other CCG members, the PHC said that the main partner for the CCG for tackling HIs was the LA.

'Well, clearly, the local authority is our main partner. I mean, obviously, our GPs, and our schools, and our councillors, but local authority is the clear'. PHC 1 interview

In summary, there was not one clear description of how the CCG were tackling HIs. However, GPs, managers and the PHC all spoke about the prevention agenda and screening. GPs and managers spoke about the allocation of money and specific schemes being directed to specific areas of need, reflecting the CCGs conceptualisation of HIs. All CCG members spoke about the importance of the LA and their joint agenda for tackling HIs within the local area.

8.3.3 Tackling Health Inequalities in Practice

In practice I found that in site two HIs were spoken about in practical terms. The majority of initiatives that CCG members referred to during their interviews were discussed in detail in their CCG meetings. Locality initiatives and funding models were discussed at July's governing body meeting. Although HIs weren't mentioned it was explained that they needed to be doing different things across different localities; to address the differences in health need.

> *Manager 5: the £20,000 budget is fine but we need to plan how we will use the money and get good outcomes. We don't want the same thing happening in all of the four localities, the money needs to be used effectively.*
> *GP 1: it was made clear to me that the 20,000 was just for meetings and education and that more money would be available for other things. There is the complex elderly pilot in XXX which has two sides as it aligns with our vision and it is encouraging different things.*
> *Manager 4: rather than pilot I would call it phase one.*
> *(July governing body meeting)*

Additionally to this during an operational meeting, the PHC encouraged CCG members to allocate additional funding over a short period of time for screening in specific deprived areas. Although not explicitly mentioned in this meeting, interviews illustrated that CCG members believed that screening was a way that they could tackle HIs.

> *PHC 1: this is just so that all GPs are aware and to check that you are happy to go forward. We have had a slight underspend on health checks. Therefore if practices in our 4 key areas do screening in these deprived areas will get extra money.*
>
> *GP 9: there is a differential uptake of income across areas.*
>
> *PHC 1: it is short term and only for 1 year.*
>
> *GP 14: this does not include all deprived areas.*
>
> *PHC 1: no this is in our specific areas.*
>
> *GP 9: I am happy to go forward. How much extra do you pay?*
>
> *PHC 1: around £6 per screening.*
>
> *(March Op Exec)*

Further to this, a LA representative attended the CCG governing body meetings demonstrating the ongoing relationship with the LA. Although this is not directly linked with HIs it enables the LA and the CCG to manage their relationships and communicate individual organisation initiatives and further opportunities for joint working. The different schemes (e.g. screening) that were mentioned by CCG members were spoken about in detail during CCG meetings. The main focus of the schemes was not necessarily HIs however there is a consistent approach of locality need being taken into consideration. This underlying understanding of HIs is represented by the CCG organisation and individual CCG members during interviews, observations and initiatives trying to tackle HIs.

8.4   Site Three

8.4.1   Initiatives to Tackle Health Inequalities

In site three the GPs were aware that the CCG had a lot more work to do on tackling HIs. GP 12 said she was listening to PH colleagues so that she could get to grips with the HIs agenda. GP 12 acknowledged that HIs work was in its infancy and that CCG members still had a lot to learn. HIs were seen to be derailed by other issues the CCG were dealing with for example the authorisation process; GP 12 said that PH needed a stronger voice to ensure that the HIs did not fall off of the agenda.

'I think we are listening closely to our public health colleagues. I think we're getting to grips with the equality and diversity agenda and realising how important it is and I really am hoping that it will be at the very beginning of the SR stuff…I think the JSNA, the health inequalities agenda, I think over the next 12 to 18 months we'll have a much clearer view of how we work that in to our commissioning process. Which is why I was saying I don't think public health is a strong enough voice at the moment. I think it's very easy to be derailed by all the other things that we have to deal with and it needs to be really strong'. GP 12 interview

The senior GP, GP 10 said that CCG members had been involved with the JSNA and were trying to develop a new public engagement strategy. The strategy was trying to involve the public more,

ensuring that public opinion was being fed back to the governing body and into the developing plans. However, GP 10 acknowledged that the CCG could be doing a lot more on the HIs agenda.

'Well being involved in the next JSNA is a fairly big one which we are involved in. I think our patient and public involvement strategy is far and above anything that's been done before. We are talking far more to patients and getting patient opinion, getting the actual views on the streets I think, far more than we've ever done before, which must be beneficial, you know, because these messages are getting back to board level, and we can't just sit and ignore them can we. So I think that's a bit thing we're doing, but I think we could do a lot more'. GP 10 interview

GP 2, the HIs lead for the CCG, provided what he referred to as the rehearsed answer for how the CCG were tackling HIs. The pain tender service was an example used by CCG members during the authorisation process to try and demonstrate how the CCG had tackled HIs. The pain management tender refers to a two tiered service that was previously only available in one area the CCG provided care to. The CCG discovered from the JSNA that the service would be beneficial if it was provided to the whole population. GP 2 explained that the pain tender example of HIs work was not adequate enough for them to pass that section of authorisation. This could be interpreted as the CCG not having a coherent answer for how they were tackling HIs. As explained earlier (policy context chapter 3), the authorisation process was how CCGs were examined to see if they were prepared as an organisation to commission local health care services. One of the criteria of authorisation was HIs; this was initially left outstanding (the evidence was not perceived as sufficient by the assessors to pass that criterion of authorisation) as they had not provided sufficient evidence of how they were thinking about HIs.

'I think probably the rehearsed answer would be the pain tender, the pain service tender, which…I mean that was certainly a JSNA priority, the number of people living in chronic pain and the lack of holistic service to deal with that…so there's a service tender gone out…I think, well the contract's been awarded, I guess the service has been mobilised now…I think that's the most tangible example. We fell down…well we didn't fall down, that was our missing information for the authorisation day, so I'm not surprised not to have a coherent answer on that'. GP 2 interview

The GP's responses highlighted that the CCG as a whole did not have a clear plan of how they were tackling HIs. CCG members were thinking about the future of the CCG, and were aware that they still have work to do on the HIs agenda.

When CCG managers were asked how they were tackling HIs there was a mixed response. Manager 7, the senior manager, explained that the CCG had some projects in place but they were aware that they needed to pay more attention to the HIs agenda. This response supports GP 10's comments that HIs are not at the forefront of CCG plans. Manager 7 provided the pain management tender as an example of how the CCG had tackled HIs, the example that GP 2 said was rehearsed by the CCG. Manager 7 also discussed future CCG plans and the relationship with the HWB for tackling HIs.

'I think there have been some specific projects but I think it's an area we need to pay more attention to…So I think part of that is an ongoing part of our development to make sure that people have that broader thinking and they concern themselves with those issues. In terms of what we've done so far, we have identified some areas, so things like the commissioning of the pain service that arose partly from a pilot project that was put in place to address a need that developed from the JSNA. So there were particular issues in certain localities with access to services with the numbers of people reporting issues around limiting illness and management of chronic pain, so that service was delivered in relation to that…But I have to say I think we've got an awful lot more to do, I don't think we've done a huge amount. We are at a strategic level, we're feeding into things like the joint health and wellbeing strategy, we're part of the Health and Wellbeing Board, we're part of the discussions at that level but for me the real test is going to be when we sign off our 13, 14 plans and our five year strategic plan about whether we've fundamentally really started to address that and we've got that sign up'. Manager 7 interview

Manager 8 also referred to the pain management tender as the way the CCG had addressed HIs.

'I think one example of that would be the development of the pain management service, the tier two pain management service; so previously we had a pilot project that was running just in…the area of pain management tier two level service, and when we looked at the Joint Strategic Needs Assessment we realised there was a need for this type of service across the whole of XXX, so we went out to procurement to procure a new tier two pain management service for the whole of XXX'. Manager 8 interview

It was clear in the interview with manager 9 that her opinions of tackling HIs differed from other CCG members. Manager 9 explained that the CCG had initiatives in place to tackle HIs but she did not agree with them. She suggested that by identifying areas that suffer from inequalities she believed that the CCG were causing further potential inequalities.

'Well, the answer to the question is yes, right. However, I also think, personally, that they're negative. Okay. So there are areas where inequalities are identified, so we've got as areas, there's highly deprived areas, and we might target that. And I'm not saying it's the wrong thing to do, but I think that then, in itself, creates either further inequalities, or a dependent culture, so I'm not always sure it's the right thing to do. And that's where I'm back to policy. I think that probably from the right place and the right reasons, people identified that things were not equitable, but by making policy, they create another problem'. Manager 9 interview

Two of the managers including the senior manager referred to the pain management tender as the main way the CCG were tackling HIs. The most prominent finding in site three is that manager 9 does not agree with the methods used to try and overcome inequalities, believing that such initiatives lead to

further inequality issues. This outlook was not reflected by any other CCG members in site three or the other two CCGs in this study.

The PHC stated that the CCG had not been overtly involved with tackling HIs. PHC 3 explained that certain members of the CCG had been involved in smaller projects focusing on HIs, for example one GP had looked at smoking quitter rates in deprived practices. However, there was not a clear amount of work that had been carried out in this area. The PHC's response was not unexpected, both clinicians and managers explained that they were aware that they needed to do a lot more work on the HIs agenda.

'It's had a role in some of these things. Oh now that actually – XXX has been doing some stuff around smoking, but it's still about practice quitter rates and although they've been offered information about practice deprivations scores and it's been suggested that they combine those two and look at which are the practices that are likely to have the highest smoking rates because of the deprivation levels and which are the ones that are lowest performing on the smoking quitter because actually those are the ones we should target first. That's the sort of thing they don't pick up and they don't get. So I would say nothing overt if I'm absolutely honest'. PHC 3 interview

8.4.2   Relationships to Tackle Health Inequalities

When the GPs were asked who they thought their main partners for tackling HIs should be, GP 10 focused on internal members of their organisation rather than reflecting on the wider health economy. This is the only CCG member in and across the CCGs that spoke about their HIs partners in this way. GP 10 said that these members of staff were HIs champions and therefore they needed to make people aware of the agenda.

'Dr. XXX who is our inequalities lead. I think XXX, our Consultant in Public Health, and XXX who is obviously the Head of Strategy, and then just the general culture that we're trying to... so that everybody thinks about it, you know. I'm not trying to say we all do it, we're not, but you know, the first ones I've mentioned are some of the champions of it, and then the rest, you know, it's my job to kind of, as I said before, keep everybody aware of it'. GP 10 interview

GP 12 focused on the prevention agenda within primary care, therefore PH was seen to be the main partner for tackling HIs within this area (Department of Health, 2012b, Orme et al., 2007).

'It's got to be public health, hasn't it. Because primary care is about prevention, a lot of it. And if you look at any general practice LES's, half of them are public health based. So public health, yeah'. GP 12 interview

HIs partnerships were discussed differently by the CCG GPs. There was a focus on prevention and the internal relationships within the organisation. Data collection illustrated that tackling HIs was not high on the CCG agenda and therefore the importance placed on internal relationships by GPs 10 and 12, could be an example of how the CCG are trying to get HIs on the CCG agenda by placing HIs responsibility on individual CCG members.

Managers referred to strategies they had in place which took into account partnership working on HIs. Manager 7 explained that she believed that the third sector were important organisations for the CCG to work with to overcome HIs. The CCG has a matrix of organisations which enables them to access certain organisations when representation of specific groups is required i.e. people with specific diseases. The matrix is a database that holds information on all communication and special interest groups. Individual groups are characterised against the equality and diversity strategy, formulating a plan of how to make contact with the groups. Additionally, manager 7 mentioned that at a strategic level the CCG needed to work with PH and the LA.

'It depends what you mean by relationships because we have a number of relationships with third sector organisations, for example, and health inequalities will be part of those conversations. So we've got a whole engagement matrix of organisations that we work with and who might represent particular population groups or groups of particular disease groups and things, so we have those kind of relationships. I suppose at a more strategic level we have relationships with people like the public health observatories and other institutions who will provide us with information that is relevant around health inequalities. But that's more about informing the strategic position. I think the main important relationship is with public health and the local authority because that's where the bulk of the discussions happen locally about our position'. Manager 7 interview

Manager 9 referred to a transformational programme of work the CCG was actively involved with, focusing on the health and social care agenda. It was explained that all partner organisations involved with the programme are the right ones to help tackle HIs. These organisations include neighbouring CCGs, HWBs, LA and the function of PH.

'I suppose, at the top level, I would say, it's got to be the seven partners from the strategic review. And equally, the Health and Wellbeing Board partnerships'. Manager 9 interview

Manager 8, like the other managers believed that the key partnerships for tackling HIs included the LA, the voluntary sector, the FT and other providers.

'So I suppose the most major partner is XXX Council. And then alongside that, the other providers within the health system, so what influence we can have on XXX Trust and XXX, XXX Foundation Partnership Trust. And then the one thing that we're going to be looking at next week is working with

the voluntary sector; so we've got an event with the voluntary sector organisations to see how they and we can work together'. Manager 8 interview

All managers acknowledged the importance of the LA for tacking HIs; this differs from the CCG GPs responses, who concentrated on internal relationships. Site three has clear relationship matrixes and programmes of work which allows opportunities for partnership working. Site three also acknowledged the importance of the relationship that they held with the HWB. CCG GPs and managers in sites one and two did not specifically mention the HWB or the JHWS when speaking about their main partners for tackling HIs. Although, this was surprising, one explanation for the lack of clarity on the HWB and the JHWS could be related to the timing of the project. Data collection was conducted when CCGs were in shadow form and establishing their relationships with their local HWBs. At the time of interviews the JHWS and HWB may not have been fully developed. CCG GPs and managers spoke broadly about the HWB and JHWS but did not specifically refer to them as their main partners for tackling HIs when asked.

When talking about HIs partnership work, the PHC said that the CCG needed to work alongside the LA, HWB and the third sector; these relationships were useful to help CCG members understand the wider determinants of health. All of these organisations were mentioned by other CCG members.

'The local authority and the Health and Wellbeing Board, the third sector… I think the involvement with Health and Wellbeing Board and the strategic review potentially have really good links with Public Health, and helping them to understand the wider determinants of health'. PHC 3 interview

In summary, similar to sites one and two, site three GPs and managers provided a variety of different examples of how they tackled HIs. The consistent example quoted was the pain management tender which was viewed positively by all CCG members other than the HIs lead, who said that it was a rehearsed answer for authorisation. The majority of CCG members recognise that they have done very little in this area and need to focus more attention on the HIs agenda. All managers and the PHC believed that a key partner for tackling HIs was the LA but GPs did not focus on external partnerships. GPs were more reflective of relationships within the CCG.

8.4.3   Tackling Health Inequalities in Practice

In practice I found that HIs were only spoken about during CCG meetings in the context of authorisation. There was no mention of specific initiatives around how the CCG had tackled or planned to tackle HIs. This is very different to individual interviews where CCG members spoke about the pain management initiative. CCG meetings concentrated on the process of authorisation and how to overcome outstanding criteria they had for HIs. During a governing body meeting, CCG members discussed how this research project could be submitted as evidence that they were thinking about HIs.

Manager 8: when the CCE last met we had received our site report highlighting two red areas. There have been two more stages since then with a moderation panel being held for all wave two CCGs to look at consistency. Our reds remain the same on health inequalities. On Monday a conditions panel met to rate the reds and develop input from the Commissioning Board to support you. Our two red areas have been rated at 1 and 2 which is low. We have a meeting on the 11th December about what is to be done. On the 18th January the NHSCB will make a decision whether the things are in place. This is very good news with a low rating level on our reds.

PHC 3: you mentioned that we are rated 1 and 2 but that we are having a meeting for both.

Manager 8: they are on the same subject.

Manager 9: the evidence is the same to cover both things.

GP 13: for level one do we just google? (laughter)

GP 10: only if we had an expert of health inequalities? I am not saying anything (people looked at me in the room).

Manager 9: that is part of our evidence, we originally submitted that but we are re-signposting.

PA: she is on all of the minutes.

(December governing body meeting)

In one particular CCG meeting, CCG members discussed that their outstanding authorisation areas were a subjective topic. Therefore CCG members believed that they had not passed the HIs element of authorisation because of the assessor. This perception led the CCG to resubmit the same evidence, with 'better' signposting to the HIs agenda. This strategy enabled site three to be fully authorised by April 2013 without any outstanding conditions.

Manager 7: in domains two and four there is an evidence gap, we need to turn these green in my view and maybe focus on them in SMT. A lot of this is subjective and therefore we need to strengthen what we have got.

Manager 8: we need to add further cross references as not everyone saw all of the information.

Manager 7: the JSNA is broken down into locality and is reflected.

Manager 13: we need the complete report bringing here to be reviewed so we can show our evidence. I worry that from additional actions we would be held to account for delivery.

GP 12: did XXX have different reds? Could we learn from them?

Manager 13: there is so much subjectivity in the panels.

GP 10: there are inherent inconsistencies because different people are doing things. I went to one where they got green but had nothing in their plan on health inequalities.

(November governing body meeting)

Further to this CCG members during meetings made it clear that they were thinking about HIs when they carried out Equality Impact Assessments (EIA). This became obvious when CCG members would draw my attention to the EIA during meetings so that I was aware what they had done previously. This

is not a key initiative that was mentioned be CCG members during their interviews; however it was clear during meetings that this was how they thought they could think about tackling HIs as an organisation.

> GP 13: We had a really good equality impact assessment, see here (there was laughter in the room as GP13 pointed to the assessment for me to look at).
> (October governing body meeting)

> GP 12: Just for Lynsey an equality and diversity strategy is done at the beginning and this information has all come from the JSNA. This is where we have got all our information together.
> (strategy group)

From interviews it was evident that CCG members were aware that they needed to do more work on the HIs agenda, this was evident through the use of observations. Site three focused on HIs as a process, a criteria to do well for authorisation. Additionally to this, the use of EIA was seen as the way the CCG were thinking about HIs, these are commonly used by all CCGs and are not seen as a way of tackling HIs but as an examination of how service change will impact on the population. This is not an accepted strategy to tackle HIs.

8.5   Overall summary

In summary, across all three sites, managers and GPs associated with the CCG provided a variety of different examples of how each CCG was tackling HIs. There was no clear conceptualisation of HIs in site one and three (see chapter 7) and although it was evident that there were some programmes of work which might impact on HIs, this was not their primary function. For sites one and three, there was evidence of box ticking for authorisation. Site one used the CCG governing body sheets as authorisation evidence, whilst interviews highlighted that CCG governing body members did not find the sheets useful. Site three had a prepared answer when asked how they were tackling HIs, GP 2 explicitly stated when asked the question, that he would provide the authorisation rehearsed answer, again showing how the HIs agenda was closely linked to the authorisation of the organisation. Only site two spent time explicitly considering how to tackle HIs, CCG members gave examples of a variety of programmes of work the CCG were focusing on, they mainly discussed the prevention agenda and budget allocation based on need. All of these initiatives were referenced during CCG meetings, the common theme being that different areas require different funding and provision based on need, reflecting the organisations conceptualisation of HIs.

This chapter illustrates that HIs are conceptualised and tackled differently across each CCG sampled and therefore the duty placed on CCGs to tackle HIs can be interpreted and enacted differently based on individual CCG members understandings of the policy. At the time of data collection CCGs were establishing themselves whilst working alongside their PCT, this meant that the CCG had little

influence over tackling HIs; they still had to run any ideas past the PCT. If the Kingdon's (2003) policy window model is taken into consideration (chapter 3), it seems that the HIs window has been opened at central government level, however there was still uncertainty and a lack of action taking place locally to enact the policy because of other competing factors. Now that CCGs are fully functioning organisations it would be interesting to see if these initiatives or programmes of work are being fully established.

Chapter 9: Understanding the findings: sensemaking in practice

9.1 Introduction

Previous chapters have demonstrated that two out of three CCGs have no clear conceptualisation or programmes of work relating to HIs (addressing research questions 1 and 2). This chapter will explore the wider contextual influences on the HI's agenda, including the role of history and the impact of wider relationships (addressing research question 3). As demonstrated in chapter 4, sensemaking provides a lens to examine the findings from this research, exploring possible explanations of why and how the HI's agenda is conceptualised and enacted upon at a local level. This chapter will explore possible explanations for these findings using sensemaking as a lens. In this section the role of PH is touched upon, however it was found to be such a significant issue, sensemaking in relation to PH is discussed in chapter 10.

9.2 Collective and organisational history

9.2.1 Site One

Data collected in both observation and interviews highlighted the importance of the collective history shared by the organisational members in determining their current behaviour. Site one had a shared organisational history, having worked together as both a PCG and a PBC group within a PCT, with a larger footprint in the past. This shared history has had an impact on their current understanding of what HIs are; however, in this case what had been learnt from that history was something which appeared to be analogous to the psychological concept of 'learned helplessness' (Miller and Norman, 1979). This theory asserts that humans exposed to adverse situations which they cannot control develop feelings of impotence and lack motivation to try to bring about change. Observation and interviews suggested that both GPs and managers in site one were keenly aware of the deprivation affecting the population that they served. GP 3 explained that it was impossible to miss the fact that the population they served suffered from poor health.

'I mean you would have to be blind and deaf to work in XXX and not see that you are working with a population that has poor health. I think the problem is you know that you are running to a standstill just to serve it you know. On a busy wet Tuesday you are seeing people come through the door as a GP and probably the same if you are a doctor in the accident and emergency department….I mean the board is the place where it should be reflected upon and we should be coming up with ideas of how we can deal with that'. GP 3 interview

GP 3's reflection on HIs illustrates the difficulties GPs face with the HIs agenda in site one: they are 'running at a standstill' trying to carry out their daily duties, treating their patients' needs and therefore

unable to focus upon the wider influences of health or the HIs agenda. They are treating the health needs as they arise rather than focusing on prevention. Faced with what appears to be an overwhelming volume of need, the GPs individually and the CCG as a whole appeared to be unable to move beyond meeting those immediate needs. This manager expressed puzzlement as to why they had historically been unable to articulate their needs and tackle the problems that they faced:

'I think it is to do with how much people articulate their need partly. Although it is interesting as places like XXX, the PCT seem to be awash with cash, been in surplus etc. I know that they get quite a good resource from the government that is partly to do with the socioeconomic need of that area. Whereas that doesn't seem to happen here in XXX and I am not sure why that is and I'm not sure if it is because you have a range of different areas and affluent areas but yeah I think it is how the funding flows. But I think it is also because I don't think XXX articulates on an individual basis its need enough. I don't think there are enough people kind of shouting out that the care people are getting isn't good enough'.
Manager 1 interview

For GPs and managers in site one, their collective historical experience of dealing with seemingly intractable health problems appeared to have generated a feeling of helplessness, which was reflected in their approach to tackling HIs. Access to services was portrayed as a continuous problem for the CCG and previously for the PCT. At a governing body meeting CCG members discussed how access had been a problem previously and needed to be improved by the CCG. Initiatives locally that had been implemented were part of the historical Health Action Zone scheme (HAZ). HAZs were a pilot scheme that initially comprised of 26 zones around England which were implemented to explore and tackle HIs enabling a better provision of services; they were introduced in 1998 and were supposed to last for seven years (Benzeval, 2003).

> *GP 5: historically that's how the budget was set had variation and GP input. As a GP it is difficult to get access for patients to come services i.e. bereavement for children who have lost a parent, the waiting list is so long they are adults by the time they have made access. If we rationalise and make choices it makes the process more objective.*
> *Manager 12: quite a lot of services came from old funding bids, if you remember HAZ's many schemes have carried on from there.*
> *(February governing body meeting)*

The depth of need present in the population could be said to have almost provided an excuse for the CCG to accept their inability to make any difference. This was reflected in their discussion about HIs in meetings, where the focus was upon access and equity. Provision of services was an ongoing problem for CCG members, they were aware that historically people in certain areas were unwilling to travel for their treatment, thus impacting on equity. It was articulated that although patients were unwilling to travel, GPs were also not referring patients adequately.

> *Manager 12: here was a problem with people of XXX not wanting to leave XXX and travel outside of the area.*
>
> *GP 5: I have concerns with equity.*
>
> *GP 3: the problem was that GPs don't know that a service is available through CATs.*
>
> *Manager 3: we are aiming to get information out to practices and handed two documents around the room.*
>
> *(February governing body Meeting)*

Interestingly, CCG governing body members wanted to try and address the 'perception' of lack of access (see chapter 8). It was believed that by making GPs more efficient it would improve individual's perceptions of access. Trying to overcome access problems was not straightforward, it was clear that they wanted to improve efficiency without annoying their member GPs by creating more work.

> *GP 4: There needs to be a stress on the approach that patients are dealt with over the phone and face to face. We need to teach GPs how to triage patients especially on the telephone and in terms of the front desk they need to spin no access into a positive rather than a negative by helping patients through the maze. We may need to look outside of the NHS for training in this area.*
>
> *Manager 10: I met with someone but we were not happy with the provider hence we are thinking that training is the best option forward.*
>
> *GP 5: the patch was a good way to deal with the situation. I have raised it as GPs should not just sit back they need to be more efficient and therefore they would not need to necessarily have to add extra hours.*
>
> *(February governing body)*

In Weick's terms, experience of the problems facing the local population had generated a shared schemata of helplessness in the face of overwhelming need. Their personal experiences as providers of trying to meet what felt like unlimited demand informed their focus on the concept of improving access as a way of improving population health. This problem of helplessness has been evidenced by Chew-Graham. et al. (2002) when researching the management of depression in primary care, this research suggests that GPs working in deprived areas are less likely to see depression as a 'treatable disease'. There was a reluctance to respond to depression as an illness because of the wider influences that were affecting health e.g. social and wider factors.

9.2.2 Site Two

Site two formed a clear contrast to site one. Site two held a positive view of their collective organisational history, GPs said that working within the CCG and previous iterations of primary care commissioning had influenced the way they thought about HIs. Coleman et al (2010) illustrate this through the use of empirical research describing how past organisations have helped shape newly

forming organisations, highlighting how past organisational practice can continue into new organisations. This effect was clearly visible in site two:

'…Working as part of this organisation and PBC before has gotten me certainly thinking of the bigger picture and I think certainly we need to get through to practices really that it isn't just about working in your practice; you need to think at locality level and you need to think at population and what we can do'. GP 1 interview

GP 1 said that HIs were on everyone's agenda, claiming that discussions that were held by the CCG and the previous PBC group have ensured that HIs are always considered, leading to a clear organisational view of HIs.

'I think it is on everyone's radar within governing body and within PBC before that really and through those types of discussions. There are the things that have helped it'. GP 1 interview

The senior clinician, GP 9, referred to PBC explaining that before the CCG came into fruition they had recognised within PBC that they needed to reduce HIs to sustain the health economy. As they developed as an organisation into the CCG they wanted to ensure that the HIs agenda was moved forward with them. GP 9 explained that to be successful with the HIs agenda they needed PH expertise within the CCG.

'We started out in practice based commissioning with a recognition that until we narrowed health inequalities, we wouldn't really have a sustainable health system…XXX has a very hospital orientated system at the moment, with XXX Hospital's admission…60 per cent being acute, and significantly from those parts of town which are more deprived. And so, the root cause of that, partly is XXX health inequalities. So we have to have expertise in public health to help us deal with that issue'. GP 9 interview

Managers in site two did not reflect as heavily on the history of PBC commissioning but referred to the influence of working in the local PCT. Manager 4 spoke broadly about the NHS, saying that working in the NHS for a long time had developed her understanding of HIs.

'Having worked in the NHS for twenty odd years. You know, looked at health stats and the planning of things, doing a masters in health service management. I suppose that's where you build up, you know that understanding'. Manager 4 interview

Manager 6 said that working within the PCT had influenced how he conceptualised HIs. The PCT had previously written joint strategic plans with PH, incorporating HIs. Manager 6 helped formulate the plans and now continues to do this work within the CCG. Joint strategic plans are now part of the CCG agenda; therefore a continuation of PCT work can be identified.

'No, it's come from working in the NHS. It's come from the planning function really, because PCTs have had to write strategic commissioning plans for the last four or five years, four years, and you did do that as PCTs jointly with your public health department, so the JSNA and all those sorts of things were core documents to doing that kind of planning. I think that's new to a lot of parts of CCGs. They weren't that involved in that'. Manager 6 interview

Thus, it is clear that both managers and GPs in site two believed that their experiences of working in both the PBC group and the associated PCT had had a strong influence on their current approach to thinking about and trying to tackle HIs. Within both the PBC group and the wider PCT, HIs had been historically seen as an important issue that they had to try and overcome. These beliefs were carried over into the new organisation, whereby historical understandings of HIs were incorporated into the CCG agenda.

In the wider context of the CCG, not focusing on HIs alone it was clear that the CCG were adopting previous working ways of the PCT and PBC group. This was evidenced during observations of different CCG meetings. Manager 6 explained that they were keeping some of the structures of the PCT but wanted to try and move it forward as a CCG and potentially adapt to take into account the needs of their population.

Manager 6: localities are based on a number of things; they are based on history and the old PBC organisation. All localities are also close if not identical to local authority boundaries [boundaries that were stipulated by the Place Board within the LA]. They are well understood populations. In terms of the localities they are listed below in terms of populations. In the past they were bigger but PCTs wanted a move towards local communities and this is where the split arose from. There is still a lot of work that needs to be done here as we want them to become more independent, to do this we need a business manager to turn it around as it is a mind-set change. Some will go much more quickly than others towards independence. They have to meet a minimum of four times a year although this will be debated in March and the meetings are normally held on a Wednesday afternoon.
(February op exec meeting)

Some of the formal roles that the CCG needed to have in place were continued on from the PCT. The PHC explained that she had been a Caldicott Guardian previously and therefore the role should just continue. The role of the Caldicott Guardian is to ensure that the NHS, LA and other organisations have high standards when handling patient identifiable information (NHS Connecting for Health, 2013). Thus illustrating how the CCG had evolved from the PBC group and the PCT.

PHC 1: We need to identify a Caldicott Guardian and a deputy which we can do when the governing body is sorted. I am one in the PCT so I could carry on.
(May op exec meeting)

In practice, CCG members were aware of where they had come from but wanted to ensure that they were distinguishing themselves from the PCT and becoming their own separate organisation (Coleman et al., in press). This was illustrated in a variety of CCG meetings across a number of different contexts the CCG were focusing on. Manager 6 when discussing patients with complex needs explained to CCG members that they needed to stop copying the PCT and focus on what work plans they wanted to develop.

Manager 6: we need to stop copying the PCT and be absolutely focused and ruthless was what is the most important thing.
(July op exec meeting)

One explanation of why the CCG wanted to ensure their plans were different from the PCT was to distinguish themselves as a new organisation to member practices that were a part of the CCG. Across several meetings the vision and plans of the CCG were discussed. GP 1 and GP 9 suggested that a survey needed to be sent to GPs to see if they were able to identify what made the CCG different to the PCT. For site two it was important to be able to try and show some of the differences between themselves and previous iterations of primary care commissioning organisations.

GP 9: in terms of items five and the development of issues that were identified at the initial bilateral meeting which looked at communicating our vision, showing a clear difference between the PCT and CCGs which I think we capture in our vision
GP 1: we have set up a survey with the GPs to see what differences they can see from us before and now as the CCG and how it affects them. We could feed this in.
(May op exec meeting)

Weick's concept of sensemaking helps examine how new working practices and understandings within an organisation can be reconciled through the use of past identities. For site two, the past identity of PBC and the PCT and the recognition of the HIs agenda within that, influenced the way the newly forming CCG thought about the HIs policy agenda. The CCG made sense of the HIs agenda (an imposed duty from the Government) through the old organisational interpretation of HIs when they previously existed as a PBC organisation. GPs and managers all referred to the influence of working in the NHS or the PBC group in their individual understandings of HIs. Being part of a previous iteration of primary care led commissioning had helped establish the CCG's interpretation of HIs. Weick (1979) describes schema as standards and ideas that are derived from the past and placed against the current organisational change. Site two held a strong and positive schema about the role of commissioners in tackling HIs and the previous, PBC and PCT identity and ideology surrounding HIs had been wholly adopted and carried forward into the new organisation.

9.2.3   Site Three

Site three is very different to sites one and two; they are a newly formed organisation established under the current NHS changes. Therefore, there is no collective history that has shaped CCG members understandings of HIs. The CCG is not based on a previous geographical footprint and therefore not only are they a new organisation; they are also commissioning health for a different population. However, although the CCG was a new organisation, an informal meeting with a manager suggested that past history had helped shape the development of the new organisation. Manager 8 explained that they had intentionally targeted GPs to join the board who did not take part in PBC. This demonstrates how specific sensemakers reflected on their past organisational experiences, noticed 'cues' about problems that they wanted to avoid when developing the CCG, and acted in order to avoid those problems.

Interviews with CCG members illustrated that being a new organisation had enabled them to focus on their development as an organisation and think differently. Further to this, the CCG had to develop their organisation for authorisation; this could have forced CCG governing body members to concentrate on their development as an organisation at the detriment of other areas the CCG needed to focus on. The development of GPs with no commissioning experience, developing wider organisational relationships and encouraging clinical conversations were all seen as big strengths of being a completely new organisation.

'But I think the development, we've put a lot of time into developing ourselves as an organisation and that was fed back to us actually at the site visits as a positive, but it's something we've done a lot of'. Manager 7 interview

Manager 9 explained that an advantage of being a new organisation was that they were able to develop the norms and culture of the organisation. Therefore, there weren't any pre-existing conditions being placed on the organisation's development.

'…then you've got a number of us that are comers in, for want of a better word, really. And that's…they've decided what their structure needed to look like, what is the workforce and establishment that they needed, and then started drawing people into those posts…So it's been about developing those types of things, as opposed to expectations and culture and… And I know it's in and amongst, but it doesn't feel as clear-cut as that to me, so I think that's still got to be worked through'. Manager 9 interview

This lack of shared history was illustrated in manager 8's interview. It is clear that there were no preconceived ideas about the CCG and therefore people are unable to make comparisons to the past.

'I think it's been…I think what's been good about it is that people haven't come with a lot of preconceived ideas. People haven't come along and said, you know, 'Oh, we did that in PCG days', or 'We did that when we were a Practice Based Commissioning Consortium'. So that hasn't happened, so people have come at it with fresh eyes and that's been really good'. Manager 8 interview

This manager clearly feels that this lack of a shared history is strength, as it is allowing them to start afresh and avoid past problems. However, this also means that items will only reach the agenda if there is some external push or impetus to put them there. In the case of HIs, no such push existed, and site three therefore showed limited appreciation of the HI agenda. It was apparent from interviews with CCG members that a lack of organisational history had enabled previous fractious relationships to be eradicated, providing an opportunity for the organisation to move forward with no preconceived ideas of what the organisation should be based on and how it should be developed.

9.2.4   Summary

History across the three sites has helped influence the development of the CCGs very differently. For sites one and two history has played an important role in influencing organisational understandings of HIs. History has led to the development of learned helplessness in site one, with concentration being placed on daily healthcare and dealing with the direct health needs of the population. In site two, organisational history has helped develop a strong HIs agenda for the CCG. Staff members coming from PBC and the PCT have brought skills they have developed to try and encourage a HIs agenda in the CCG. Comparatively, no collective history in site three has enabled them to start from the beginning on the HIs agenda with no influence from previous iterations of the health system and a new population to serve and understand further. Coleman et al (2010) suggested that to understand how current policies are enacted on the ground local histories have to be taken into account. This has been corroborated by this project whereby history is clearly influential on individual and organisational understandings of HIs.

9.3   Wider Past Relationships (Local Authority)

Relationships and partnership working have been identified as a key way to try and tackle HIs both nationally and locally (Sullivan et al., 2004, Benzeval, 2003, Acheson, 1998, Department of Health, 1998a). However, research suggests that relationships can impact upon policy initiatives differently. For example when different professions work together, they often have different working practices which can impact on the way that they work (Evans and Killoran, 2000). Exworthy and Frosini (2008) previously found that social networks and organisational relationships form an important basis for the enactment of local policies. Interviews with CCG GPs and managers in all sites illustrated the importance of the relationships the CCG held with the LA.

The aim of this section is to explore how relationships were established, the overall purpose of the relationships, what impacts upon the relationships and where the HIs agenda is situated within the relationships. Relationships are a key area of policy initiatives in health (see section 2.4.3). However, this section demonstrates that joint working and external relationships are not easily established. They are influenced by key individuals and the historical context that organisations are developed within. Although, the LA were described as the main partners for tackling HIs in each CCG, this chapter explains how HIs are one of many factors impacting upon organisational relationships. The relationship with the LA for all CCGs is a functional one; it requires good practical relationships, allowing work to be carried out on the ground. When exploring relationships between the CCG and LA it is important to focus on the type of relationship that is required to ensure that work is carried out. Thus, if CCGs perceive that their relationship with the LA is a good one, they are more likely to be practical and perform the agreed functions across the organisations.

9.3.1 Site one

In site one, the relationship with the LA did not seem as cohesive as in site two. Although the relationship was established historically, the LA in that area was linked to three separate CCGs which had previously been PCTs and PBC organisations. One explanation of a distant relationship between the CCG and the LA could be the influence of external organisations or previous commissioning arrangements i.e. the PCT.

Sensemaking provides a framework that allows local contexts and history to be explored when examining the management of organisations. In site one, it was evident that the relationship with the LA was historical and therefore it was examined retrospectively by the CCG. The PHC associated with site one CCG explained that they were working with a large LA which held a lot of political power and therefore the local CCGs needed to learn how to manage the relationship and ensure that their views about local health and the purpose of PH were heard. It was apparent that the power of the LA was a 'cue' of how the CCG made sense of their relationship. They were aware that they needed to have a strong voice to ensure that their views and plans were heard.

'I mean the local authority XXX… it's a big city. They're a big player. They're strong. They've got very strong political… it's a strong, almost one party Council, and they're a force to be reckoned with, and the CCGs need to rise to that challenge and come along, because they have got a huge amount of power and a huge amount of investment in this city, and actually be clear about what they want to achieve and what they want to happen for their patients and the local population, and really get in there and really argue the case, and from our point of view, to really have their say about the way they think the public health ring-fenced budget should be spent; because if they don't say it, the local authority will say it' PHC 2 interview

Data from observations illustrates the differences in views and practice across the two organisations when local discussions were taking place around the closure of a local Walk in Centre (WIC). The CCG wanted to close a WIC because of staffing issues but the LA Overview and Scrutiny Committee (OSC) wouldn't agree to it until they were sure that primary care access could cover the demand if the WIC was closed. The OSC is a specific part of the LA and is composed of elected councillors who are not part of the executive decision making body of the council. They perform an oversight function of the council executive and / or external bodies e.g. the NHS (Coleman, 2006). The potential closure of the WIC took a lot of CCG governing body time and demonstrated the complexities of the relationship between the CCG and the LA. It was an on-going process where an agreement between the two organisations seemed unlikely at the time of data collection. CCG governing body members discussed that they did not have the resource to keep the WIC open and believed that local access needs could be met by local GPs. In contrast, the LA did not feel that there was adequate primary care access in the area and therefore opposed the closure.

'The walk in centre, yeah, we've been to overview scrutiny three times now and, I think, we should have been very honest the first time and said, actually, we're closing it in financial terms and, I think, there's a lot of confusion, because we're not closing the actual centre, there's two general practices and the treatment centre is still there, so all that daily activity, people going for dressings, it's going to be there'. Manager 3 interview

Further to this, during a governing body meeting the PHC raised her concerns that the data the CCG had acquired, on access from the mystery shopper exercise would cause further tensions between the LA and the CCG. In essence, the evidence from the exercise supported the views of the LA OSC, that local primary care access was not sufficient. Therefore, the results gave the LA OSC more ammunition against the CCG. During meetings it was apparent that the relationship was not functional, there was little focus on practical working on the ground; the issues they were facing were strategic. Therefore, the situation surrounding the closure of the local WIC could be viewed as an effort to try and mitigate the power dynamics between the two organisations.

PHC: To pick up on the political situation. We are all committed to change the situation I don't want to see this exercise back fire. I feel protective of the board.
(April governing body meeting)

Although interview and observational data illustrated that the relationship between the LA and the CCG was fractious, CCG GPs and managers all acknowledged that they needed the relationship with the LA to focus on the HIs agenda (see chapter 8). CCG governing body members hold a shared schemata on the HIs agenda, they know that healthcare is one small element of the work that is required and therefore acknowledge the need for a good relationship with the LA. Manager 1 said that she was aware that to tackle HIs, the CCG really needed to work alongside the LA as they were dealing with the wider influences on health. Manager 1's explanation gives the LA and CCG relationship purpose, this

understanding of the relationship could stem from a number of policy partnership initiatives that were introduced by government (Department of Health 1998; The Acheson Report 1998; Sullivan et al 2004).

'But I think we are still conscious of that and conscious of the need, the east side often gets left out a lot. They can go to XXX hospital but there's maybe not as many clinics about, so I think we are conscious of access to services in that sense. On a more fundamental level, I think that's where we need to work with the city council but I think the CCG's just one piece of the wider thing. I think if we are genuinely going to tackle health inequalities, it has to start from a young age; it has to start from housing, employment and lots of other things'. Manager 1 interview

Marks et al. (2011) claimed that policy commitments for the NHS emphasise the importance of working across health and local government to prevent ill health and reduce inequalities. On a practical level, GP 5 explained that for the CCG to tackle HIs they needed to improve their relationship with the LA because the responsibility for PH would be transferring to the LA from PCTs. This highlights how the relationship is on-going, the CCG need to work on their relationship with the LA so that PH support isn't lost.

'I'd hope, again because of this period, I'd hope that in two years time we've developed some services that are actually helping to tackle some of these inequalities. I mean Public Health is an issue as well, but I think that's important now with its link and merging with the local authority really. But, these things take time'. GP 5 interview

The relationship between the LA and the CCG in site one was complex. Through the use of Weick's (1995) sensemaking concept it is apparent that site one perceives itself to have a separate identity from the LA. The historical context that that CCG and LA relationship has developed in has influenced how the relationship functions and has made them aware of ongoing problems that they are likely to face i.e. politics surrounding health. In essence, there is still the mentality of 'them' and 'us' between the organisations with a lack of joint focus to bring the organisations together. However, there is still an acceptance by CCG GPs and managers that they need to continue to work with the LA to tackle the issue of HIs, they have a mutual dependence on each other to be successful on the HIs agenda. In both observations and interviews, CCG members discussed why they needed a relationship with the LA but they struggled to identify the practicalities of the relationship. They acknowledge that they need to work together but they do not seem to have grasped quite how to do that yet.

9.3.2   Site Two

The relationship with the LA in site two was well established, the CCG had been formed across the same geographical footprint as the PBC group and the PCT before them. Therefore, historical relationships with the LA had already been established. This enabled a joint working agenda to be

formulated by the two organisations facilitated by the PHC. In comparison to site one, the relationship with the LA in site two was not as fractious and therefore they had managed to develop a stronger working relationship whereby practical joint working was already well established and in place.

'Some will be joint, because we have a Public Health person who obviously works here and also works with the Local Authority, so a lot of it is joined up, the children's services, the adult social care services is joined up, there are regular meetings, there's section 75 where there's shared care arrangements. So there's actually lots of things that enable joint working to take place'. GP 7 interview

The senior manager, manager 4, explained that their relationship with the LA was held in high regard based on previous commissioning strategies that they had been involved in. Therefore, a positive historical context had influenced how the CCG and the LA worked together.

'We've got very good relationships with the local authority. That was always ranked and rated quite highly for them. So, you know, sort of it's always been one of the big areas that's been in there, all you have to do is look at our stats [statistics] really through things like World Class Commissioning'. Manager 4 interview

During interviews CCG GPs and managers all spoke about the purpose of the relationship. The organisational relationship with the LA was portrayed by clinicians, managers and the PHC as being the key organisational relationship for tackling HIs. The majority of the managers in the CCG discussed the importance of the LA for the CCG. Manager 5 explained that they had a very good relationship with the LA and PH which was useful for creating health and wellbeing strategies and within this commissioning. This demonstrates how previously strong working relationships across the two organisations have helped influence the implementation of current policy. Thus, historical relationships have helped determine how new policy initiatives are implemented at a local level.

'So again... and that coming back to the point I made earlier about having good relationships and I think you build up good relationships from trust and honesty… We've got very strong relationships with the council in terms of health and wellbeing strategies so we've got to adapt on there as well. And on the board is the director of adult social care. So I think that really squares off the whole joint commissioning approach that we have with ourselves and the council. So you've got XXX on there as Public Health and she'll shortly be going to the council as we know and obviously XXX is director of adult social care. So it feels... it feels right to have that approach'. Manager 5 interview

Manager 6 spoke of the good relationships that they had with PH and the LA explaining that it was a useful relationship for the CCG to have. CCGs have been given a duty to tackle HIs and these relationships are believed to be influential on the agenda.

'CCG has a duty to narrow inequalities and work with local areas around doing that, and we think that GP practices can have quite a big impact on that. We don't think it's just the local authority services. So what we try to do is make a really strong connection between public health in the local authority and the CCG'. Manager 6 interview

Both manager 5 and 6 spoke about the benefits of the relationship between the CCG and the LA for future work. Manager 4 explained that through previously working with the LA the CCG had been able to develop an understanding of HIs.

'I suppose that's where you build up, you know that understanding but obviously here it is about working very closely with the local authority and people out in the communities to understand the needs of local people, their experiences of health services and experiences of health outcomes'. Manager 4 interview

In site two, there was a shared schemata surrounding the CCG and LA relationship. The relationship with the LA was held in high esteem, they had moved beyond strategic thinking and were developing a practical working relationship, and therefore the relationship had become functional. Interviews illustrated the importance of the PHC working in the CCG; this key figure had clearly influenced the relationship and acted as a liaison between the two organisations. Similarly, to site one, the historical context was an important factor for the development of the LA and the CCG relationship. The health service / LA relationship had historically been a positive one for site two, which had enabled a strong working relationship between the LA and the CCG. Joint working arrangements were already established and therefore under a new policy initiative they have been able to continue their joint working. The LA and the health service has a shared experience of 'doing things together', therefore the CCG and the LA were able to establish their expectations of how they should work together, and what they could achieve by carrying out partnership working. In Weick's terms, their experience of successful shared action in the past has provided material which informs their current sensemaking; action has enabled them to clarify their understanding about what 'partnership' means. Thus, the success of new policy initiatives are embedded in relations between previous iterations of the NHS and local government.

9.3.3   Site Three

Relationships for site three weren't as well established in comparison to the other CCGs. Site three was a newly forming organisation and therefore the relationships weren't based on a lengthy history. However, certain CCG governing body members may have previously worked with the LA. Interestingly, CCG GPs and managers recognised that they needed a relationship with the LA to ensure that the PH and CCG relationship was maintained. As described in chapter 8, site three has not grasped the HIs agenda and therefore may have chosen to make 'sense' of HIs internally as an

organisation before developing any wider relationships to challenge the issue. If an understanding of HIs has not been grasped there is little purpose to a practical working relationship with the LA.

'They've been struggling to get their head round what their terms of reference are like and what their offer on the table is going to look like, and I can understand that absolutely, because they are torn between local authority and health and as I said, they've got a huge agenda. But what we mustn't do is lose them. We need more of it, not less of it, yeah'. GP 12 interview

When CCG members were discussing their organisational relationships and HIs, it was clear that there was not one coherent story coming from CCG members. Manager 8 did not believe that the CCG had established any relationships that particularly focused on HIs.

'No, not that I can think of that relate specifically to health inequalities'. Manager 8 interview

Manager 9 did not talk about specific organisations and individuals but said that everyone that the CCG worked with helped them focus on the HIs. This answer is arguably broad and therefore it could have been given because there is a clear lack of relationships that are influencing the HIs agenda.

'Well, everyone that we work with'. Manager 9 interview

Overall, in site three it is clear that external relationships were not as well established with other organisations as they were with sites one and two. There is an acknowledgement that they need to work on their external relationships and they are aware of who they should be working with to tackle HIs (see chapter 8) but they have been unable as yet to put that into practice. Neither history nor relationships have had a strong organisational influence on HI conceptualisation in site three. When comparing all three sites, it could be argued that site three have an opportunity to develop their relationships with the LA without the influence of history. If developed well, they would be able to construct a relationship without any expectations on either organisation and formulate a working plan to suit both organisations. However, it must be acknowledged that partnership working is much easier in theory rather than practice (Humphries, 2013).

9.4   Wider Implications

Weick's concept of sensemaking has provided a framework to examine the importance of local histories in the establishment of CCGs whilst they begin to tackle their HIs agenda. Both organisational and individual histories have been influential in the development of the three CCGs. Sites one and two formed their CCG based on past iterations of primary care commissioning e.g. PBC and previous geographical boundaries. Site three is a new organisation; however the decision to form the CCG was influenced by the historical context in the area. Specific CCG members had worked as part of the PBC group and were aware of the conflicts that they would not overcome unless geographical boundaries

and working relationships were changed. National policy may continue to change the structure of the health system in the UK; however this project indicates that historical contexts will shape how policy is interpreted and implemented locally. CCGs have been introduced by Government with the intention to improve the commissioning of health care for patients; however they have been developed against existing relationships, structures and ideologies.

The application of sensemaking has demonstrated how the wider relationship with the LA is underpinned by history. Thus, history not only shapes the development of organisations but also influences how working relationships are formed and/or sustained. Policy may change at a national level but the local context and practicalities on the ground will shape how relationships are formed or maintained. This has implications in the current health care system, as part of authorisation CCGs have been examined on their wider working relationships, once each CCG has passed the authorisation phase and has become an operational organisation there is a risk that old problems will continue to affect relationships. Overtime, these different relationships will shape the local health contexts which could lead to variation of services based upon relationship development.

Previously, HIs have been portrayed in the policy arena as a joint PH and LA issue, with little guidance being provided to healthcare of how they can tackle HIs. A new duty has now been placed on all CCGs to tackle HIs and this project has demonstrated how HIs are conceptualised (chapter 7) based on history and wider organisational relationships. Therefore, national policy may be placing a duty on each CCG to tackle HIs but this will be defined by each CCG, using their existing knowledge of HIs and working with other organisations in their area. There is a risk with this policy initiative that very little will change on the ground; similar people will often still be working in the CCGs and therefore practice may not change. This area is worth exploring further once all organisations are fully operational, to see how they incorporate the duty and try to tackle HIs (if at all) once they become functional organisations.

In the next chapter, I go on to explore the relationship that each CCG holds with their PHC and the wider local PH team, explaining how this key relationship is influential on the HIs agenda.

Chapter 10: The Role of Public Health

10.1 Introduction

Fieldwork took place when local polices were being implemented, PH was moving into the LA and the working relationship with PH was in development (see chapter 3). This chapter discusses the role of PH in CCGs, a finding that was not originally addressed in the literature and the initial research questions. It has been included in the thesis because whilst conducting this research it was found to have an influence on the HIs agenda. Further analysis suggested that three types of PH role could be discerned in the three sites. These were PH as a 'service provider', a 'co-owner' and a 'critical friend'. The aim of this chapter is to explore these three key roles of PH, define each role, examine the roles in practice and their influences on both the HIs agenda and wider organisational relationships.

10.2 Site One Public Health as a 'Service Provider'

10.2.1 Definition

In site one; the data suggests that the PHC is performing the role of '*service provider'*. In this context service provision can be described as a role that enables a transactional relationship between organisations. The relationship is defined by structure, rules, trust and communication. Day and Barksdale (1992) in the marketing literature define four conditions outlining how organisations select their service providers and the importance of certain criteria in the selection process. They stated that experience, expertise and competence were important in addition to the overall understanding formed between the two organisations. The understanding was based on the need for the relationship, communication skills and the likelihood that contractual arrangements will be maintained. A service provision role can work in a number of different ways; either the service provider can offer a list of services that they can provide, from which the purchaser can pick and choose or the purchaser could contact the provider with their specific requests when required. In site one, the service provision agreement with PH seemed to function within both categories. In a CCG governing body meeting the Director of PH referred to the relationship between PH and the CCG as being a mandated responsibility. Thus, the PH team was aware that they had to provide support to the local CCGs.

> *DPH: Local Authorities have been mandated to provide a PH core offer to CCGs which is one of our five mandated responsibilities…I manage the core PH team which we are lifting and integrating into the local authority. I want to make sure that we support the CCGs because it is a huge PH role that shouldn't be diminished but strengthened. We have adopted a temporary MOU based on a template from XXX between PH and the CCG. It is an interim document to test out our way of working. We will formally agree it with the 3 CCGs from next April.*
> *(September governing body meeting)*

In individual CCG meetings, CCG governing body members used their PHC as a key contact with other members of the PH team to gain access to the expertise they required. This was illustrated when CCG members were confused with the gateway system that was being used locally to access an obesity service. In this situation they utilised their PHC to access the key individuals or information that they required, ensuring that communication was managed and maintained by the PHC.

> *GP 5: it is still not clear on gateway and bariatrics.*
>
> *Manager 3: it is the NCB not us.*
>
> *GP 5: I know about the panel but there are some muddy areas with GPs not knowing what to do.*
>
> *Manager 1: I am disappointed as they were there to do that.*
>
> *GP 5: there were lots of presentations and I think that was the problem.*
>
> *PHC 2: I will get XX to contact you as I am unsure on obesity.*
>
> *(April governing body meeting)*

During individual interviews the role of the PHC as a service provider was reaffirmed when manager 3 explained that the PHC was their contact to PH, again illustrating how the CCG perceived the role of their PHC. The PHC was there to offer support and access to others when the CCG deemed it necessary.

'Well, they're our link to Public Health, but I don't think…we could put them on [the governing body], or we could not, the plan is not to'. Manager 3 interview

This type of relationship, whereby organisations and individuals are portrayed as service providers is an increasingly important type of relationship structure in the NHS. There is now a clear focus on procurement and contracting between organisations. This is visible in the CCG and Commissioning Support Units (CSU) relationship; the CSU are a standalone organisation that has the function of providing contractual support to CCGs (Checkland et al., 2012), the specifics of the relationships are outlined and agreed between each CCG, any qualified provider and CSU. As the NHS moves forward, the service provision relationship reflects the developing structures within the NHS (relating to contracting and service provision by external organisations) and therefore is relevant to wider relationships that are in existence within the NHS.

10.2.3 Service Provider Role in Practice

The PHC is a member of the operational committee and attends governing body meetings to provide support. A PH team, including the PHC provides a service from the LA to the CCG from 1st April 2013, offering support and advice when needed. An interview with the PHC illustrated that prior to this PH was situated in a combined team across the LA and the NHS. However, it was clear that the PHC's

CCG role was part of her workload and only a small section of the work that she was employed to do. Hence, the PHC provides support and information when necessary.

'I'm a consultant in public health with Public Health XXX. Public Health XXX is a combined team now between NHS XXX and the local authority in preparation for the move of public health to the local authorities in 2013. And one part of my portfolio is providing some public health input to XXX CCG'. PHC 2 interview

The relationship with PH and the PHC is an historical one, based on previous configurations of the NHS; the PHC previously worked with the local PCT and the PBC group. The way the PHC describes her role it is apparent that she is the designated link person for the CCG within PH. Thus, the PHC is a key person in linking the CCG and the LA together.

'It's historical really. Before the last re-organisation I used to be public health consultant in XXX PCT. And when the PCT or what is now NHS XXX became city-wide I transferred into that but retained my link with XXX, what was a practice-based commissioning group at the time. And I've just been the nominated person ever since'. PHC 2 interview

The PHC explained that she did not have a formal voting role within the CCG. However, the voting status was not seen as important. The PHC reflected that she felt comfortable to contribute during meetings as she was welcome around the table.

'Although I suppose if push came to shove I wouldn't have voting rights, but I've always felt that I am able to say what I want to say or to comment on things. And I know in some areas the people that are in attendance don't even sit at the big table. They sit in the cheap seats at the back. Sometimes they are allowed to say things and so on, but actually being welcomed at the table makes a big difference I think to your feeling about being included and part of the agenda'. PHC 2 interview

The interview took place with the PHC whilst the CCG were still holding their governing body meetings in private (meetings were held in public from July 2012). However, once the meetings went public, all non-voting members no longer sat around the table with the other CCG members. Therefore, this change in dynamic could have affected the contribution of the PHC during public meetings.

Further exploration of the PHCs role within the CCG was carried out through interviews. A senior manager, manager 3, explained that PH information was fed into the CCG via an operational committee rather than at governing body level. Therefore PH and the PHC are not as involved at the governing body level of the organisation other than the PHC attending the governing body meetings.

'Well, they're our link to Public Health, but I don't think…we'll keep them at the executive committee level to feed into that, so that if the board say we need more Public Health involvement, we'll get the executive management team here which will involve XXX'. Manager 3 interview

The wider relationship with PH was viewed negatively. Manager 1 discussed GPs perception of PH, explaining that PH was not held in high esteem; GPs did not see the importance of PH because of a lack of outcomes in the past. This could explain how the CCG were using their PHC as they developed as an organisation.

'Public health is probably an area where there's not friction but I think that GPs don't necessarily respect it as much as they possibly should. I think some of that comes back to, if I am being really honest the public team are perceived as talking the good talk but they don't really see them doing actions. But, so it's a difficult one, it's going to be interesting as time goes on'. Manager 1 interview

In practice, observation data made it evident that the PHC was clearly viewed as part of the LA (they were not really until 1st April 2013) rather than the CCG, this was apparent at a CCG governing body meeting. GP 4 was discussing HIs and the need for the CCG to have a designated lead. The PHC contributed to this discussion by requesting that the HIs lead be renamed a PH champion. This is an example of how the PHC was trying to incorporate PH into the CCG agenda.

> *PHC 2: On the paper it mentions identifying a health inequality lead member, can we broaden this to a champion of public health?*
> *GP 4: That does fit nicely with the public health remit, I agree.*
> *(July governing body meeting)*

The HIs agenda could be influenced by the relationship that the CCG has adopted with their PHC. The service provider role enables PH experience and knowledge to be obtained when the CCG feel it necessary or when it is volunteered by the PHC at meetings they attend. This means that PH is not included in all areas of CCG work. Therefore, there is a risk that the CCG and PH will not be working on the same HIs agenda.

10.3 Site Two Public Health as a 'Co-owner'

10.3.1 Definition

In site two, the data suggests that the PHC is a *'co-owner'* of the PH agenda within the CCG. The PHC is deeply involved with CCG work, linking the PH and CCG agenda together. Links can be drawn between the term co-owner and responsible partnerships that are discussed by Cornwall et al. (2000). Responsible partnerships are referred to as the relationship between service providers and service users. Responsible partnerships are defined as the way in which co-ownership is felt by the service

providers and service users (Jalal, 1999). Work by Fowler (1997) describes the co-owner relationship as independent, whilst having shared intentions, enabling the relationship to be well defined. All these characteristics of a responsible partnership and co-ownership are visible in the PH and CCG relationship in site two. The function of PH is now a part of CCG work, regularly appearing on the CCG agenda alongside HIs. Co-ownership of the agenda means that the PHC is working to the same agenda as the CCG. The PHC and the CCG construct jointly their shared agendas and shared outcomes. This joint working also means that the CCG and PH have adopted a shared risk model of working.

10.3.2 Evidence

The embedded PH role enables the CCG to demonstrate how highly PH is viewed by the CCG and opens up wider opportunities for collaboration. The relationship with PH has been held in high esteem and enabled a constructive working relationship between the PHC and the CCG. The co-ownership of the PH agenda can be seen throughout the whole of the CCG. The PHC is a voting member on the board and members of her PH team have been allocated to localities to ensure that PH support and influence is continuous throughout the whole organisation. PH can be viewed as being integrated into the organisation; it is visible on a number of different levels. The continuity of PH running throughout the CCG illustrates the strong working relationship the CCG has with PH. Although the PHC is viewed positively by CCG governing body members, the developed structure has allowed the PH / CCG relationship to be developed beyond one person. This will be useful in the future for the success of the relationship and succession planning; there are people already working in the CCG to ensure that the relationship is maintained over time.

'But what I'm at the moment building, is a public health team to support each of the localities. So we'll have a senior consultant on each locality, and then some senior strategic public health specialists as well, because we want to just get out into that, you know, into the localities and work much more closely with the chairs in terms of public health, particularly around the Marmot work, which is trying to find people who haven't been screened, who are at high risk of disease, and the early cancer work, in terms of presenting early for cancer. So that's our real priority this year'. PHC 1 interview

This working relationship between the CCG and PH is formed on a memorandum of understanding; this is a business document which outlines the duties of each organisation. This was part of the authorisation process and was completed by all CCGs. However, the PHC in site two explained that although specific guidelines had been produced, outlining the support required of PH for CCGs, they had chosen to work towards what they thought was needed for the LA, PH and the CCG to succeed. Thus, staff were working across all organisations to ensure that adequate work was being carried out.

'So I've built a little team, some of whom will be core members, and basically, 90% of what they do will be for the CCG and with the CCG, and some will be, people like xxx, who is looking after the new

integrated lifestyle service, clearly needs to work closely with the CCG around some of that. But the majority of her work is sort of XXX wide within the local authority. So I think we're probably quite good, in that we don't say, this is 40% of your job, or this is…we just do what needs to be done, and we've sort of allocated it according to the functions so. I suppose the difference will be, some of my team will spend a lot of their time physically in the CCG, and some will be physically in the local authority, and we've just got to make sure those working relationships work'. PHC 1 interview

The co-owner relationship that was established between the PHC and the CCG in site two has enabled the HIs agenda to be jointly understood and embedded throughout the organisation.

10.3.3 Co-owner in Practice

In site two, the PHC is an active member of the CCG; this was observed in CCG meetings and reflected in interviews. The PHC plays an active role in the decision making processes of the CCG. The senior GP (GP 9) explained that in the CCG organisation the role of PH was not even questioned. The CCG were aware from past iterations of the NHS and primary care that for the CCG to succeed they needed PH on board.

'We started out in practice based commissioning with a recognition that until we narrowed health inequalities, we wouldn't really have a sustainable health system, and so we wanted a significant public health involvement from the outset, and we wanted to carry that over into a CCG so that we would be a public health commissioning organisation, so we would make efforts…will make efforts…to commission services that directly address health inequalities agenda, because that drives a lot of the unbalanced system that we have at the moment' GP 9 interview

Interviews with CCG members illustrated how integral the PHC was to the CCG. It was clear that the CCG wanted to ensure a formal PH place was included in the CCG to ensure that PH support was not lost during the current reconfiguration of the health service. GP 1 spoke about the relationship the CCG had with the PHC explaining that she was already embedded within the organisation previously (the PHC worked in the PBC group and with the PCT) and therefore CCG members wanted to carry the PHC into the new organisation.

'I mean I think the Public Health Consultant has been integral to the commissioning organisation and it felt wrong to lose that. The big risk of public health coming out and going into LA means that there is a real need for that input. And because XXX has been integral to clinical policy and all sorts of parts of the organisation it feels not right to lose her as part of the advisory position that she is in, she has been so active in that it felt right to have her as an active member of the governing body'. GP 1 interview

The senior manager, manager 4, viewed the PHC positively when reflecting on the work the CCG undertakes for the population they serve. Manager 4 emphasised that by placing the PHC in the CCG

they were aiming to try and improve the health of their population and really make a difference on HIs. The expertise of the PHC was respected not only by CCG members but also local GPs. This again illustrates how history has reinforced the positive relationship between the PHC and primary care in this area.

'We really feel that CCGs have got a massive potential for really addressing inequalities and improving health and you know all of those things. So, we felt that it was really important to have a very strong Public Health presence within our organisation. XXX's worked with the CCG and before that PBC for a very, very long time. So she's got a lot of you know credibility with the general practices'. Manager 4 interview

The PHC in site two has an embedded role within the CCG and the LA. This allows the PHC to not only provide information to the CCG but also question the decisions that the CCG are making. This embedded role allows for a cohesive organisational approach to health across the LA and the CCG. This method of joint working proved useful when writing joint documents and plans across organisations. This was apparent during a governing body meeting when the JHWS (the proposed local joint health and wellbeing strategy) was presented to the CCG. It was obvious that the document had been jointly worked on and developed by the two organisations.

> *PHC 1: I would like to draw your attention to inequalities and the draw to us. Cancer now outweighs CVD deaths. After that it talks about our responsibility as a CCG and I think it is important to add knowledge to this formally in the strategy. The delivery plan outlines accountability so that we are aware of our responsibilities in terms of things like long-term conditions and cancer screening. It also mentions the mental well-being impact assessment tool that we should be using in all our reviews. There are other redesigns in drug and alcohol systems. In public health you have been allocated a senior and operational member to support localities so that we can work together more closely trying to join up the community issue*
> *(July governing body meeting)*

The co-owner role as evidenced above enables the CCG and PH to work jointly across a number of different areas. This approach allows both PH and the CCG to agree areas that they think require joint working. Therefore, joint responsibility is taken for different areas of work.

10.4 Site Three Public Health as a 'Critical Friend'

10.4.1 Definition

In site three, the PHC performs the same role as the PHC in site one; providing PH information to the CCG and liaising between the LA and the CCG. However, in practice, whilst providing elements of service, PHC 3 has adopted a role which can be described as a *'critical friend'* role. In the context of

this study, the role of critical friend can be defined as an individual who offers both comments and critique to the CCG on their plans and development. A critical friend is an external individual to the CCG who provides feedback to the organisation when it is required of them. Thus, they are not directly involved with the overall development and agenda setting of the organisation. The term 'critical friend' has been used in several different arenas including, local government overview and scrutiny committees as well as in educational governance (Coulson and Whiteman, 2012, Kember et al., 1997, Costa and Callick, 1993). For the purpose of this project a definition has been adopted from the governance literature whereby critical friends are defined as those who:

'Provides such feedback to an individual…or a group. A critical friend as the name suggests, is a trusted person who asks provocative questions, provides data to be examined through another lens, and offers critique of a person's work as a friend'. (Costa and Kallick 1993 p50)

10.4.2 Evidence

In site three, these characteristics can be identified of the PHC. PH input was requested and well received when the CCG were preparing for authorisation (see chapter 3). Each CCG needed to ensure that they were including PH in their plans; it was part of the authorisation process and therefore needed by each CCG.

> *GP 10: Our public health consultant also attends our development days and is always there when we are developing our strategies. She is very vocal which we welcome home, and is always talking about equality and diversity and how that fits in any plans within XXX.*
> *(OD Day)*

Interestingly, when PH information was not deemed as useful or necessary by CCG members it was not as well received. Thus, demonstrating how the critical friend role is enacted based on the request being initiated by the CCG. They are not embedded within the organisation and therefore struggle to impact on the agenda. This was illustrated when the PH team brought a multiple deprivation scale to show the differences in health across the geographical area the CCG served. There was much discussion about the item on the agenda but no decisions on outcomes. Overall it was decided that it was not the place of the CCG to be focusing on the wider influences on HIs.

> *GP 14: yes but we discuss these things and give them no power we cannot add health inequalities. These are bigger issues like housing and that is for the HWB we cannot change that.*
> *PH: you can influence.*
> *GP 14: we need to be realistic about what GPs will want to get involved with.*
> *PH: I meant relating to signposting.*
> *GP 15: there is no time in appointments.*
> *GP 14: I think that is unrealistic. I think we need to think carefully what the practices will do and what we want to do.*
> *(August strategy meeting)*

Site three, as established in other chapters (see chapter 8) did not initially perform well during the authorisation process when trying to illustrate how they were incorporating HIs into their agenda and plans. During an interview with the PHC, she explained that she was glad of the initial results as it was what she had always believed to be the case. This demonstrated the critical aspect of the critical friend role the PHC was performing. However, the CCG were seen to be complacent about the results and the expertise and influence of the PHC was not deemed necessary to overcome the issue. Thus, showing how the role of the critical friend was used to the advantage of the CCG when they thought it was necessary.

'I was delighted when they were red. Because this is what I've thought all along. The real weak links for them are this real grasp of the Health Inequalities Agendas…So I was delighted that those two were still red, in a way. Unfortunately I think and I've heard this perception this morning in this very room from two other people, that the perception is that they seem to think, oh well we had to have a red, so they've got to pick on something and our stuff was much better than XXX so really it's all there but they just didn't see it. So where I was hoping they'd say, oh XXX this is a real issue what are we going to do about it and I'd go well I'm so pleased you've asked. Instead it's oh well, it's just one of those things isn't it, we were going to get a red'. PHC 3 interview

The critical friend role the PHC has adopted within the CCG, allows her to be the link between the CCG and the wider PH team, however PH is not embedded within the CCGs day to day work. The PHC plays a peripheral role, whereby advice and support is offered when it is deemed necessary and of significance to the CCG. They are not included in the initial stages of CCG strategic planning but are able to offer insight at a later stage. Thus, PH is not as incorporated into CCG work as it could be.

10.4.3 Critical Friend role in Practice

This PHC offers challenge to the CCG; she tries to ensure that the CCG think about the wider influences on health e.g. ensuring that the Joint Health and Wellbeing Strategy (JHWS) is used by the CCG. During interviews CCG members explained that they believed their PHC was a critical friend to their organisation. The role of the PHC was to ensure that PH was being included in CCG work. Manager 8 reflected on the PHCs role as an inspector, scrutinising CCG work to ensure that they were concentrating on the right areas of health and remembering to include PH issues in health. There was still recognition, as in site one that the PHC worked for the LA and therefore some element of her work was service provision from the LA.

'Um…personally I would see them both as a critical friend, really to support and challenge - you know, are we getting the emphasis, are we thinking enough about health inequalities, you know, what is the public health issue in what we're trying to do - so I think definitely that, and I also think as a service provider'. Manager 8 interview

GP 2 said that the PHC has carried out a specific role of critical friend because of the situation the CCG has been working in. Data were collected during a period of transition; the CCG has needed a critical friend in their PHC to ensure that CCG members learnt about the PH agenda. GP 2 said that as an organisation they were unable to discuss HIs, however the PHC has been there to reinforce the HIs agenda. Interestingly, GP 2 believed that the role of the PHC would have to change again, adopting a more partnership approach to health. This reflects the relationship between the CCG and the PHC in site two which is based on a more solid and historical relationship including joint work when PBC was in place.

'I think she's focussing as a critical friend in this phase…and we needed that, because we needed to learn about public health thinking, we couldn't talk coherently, think coherently about health inequalities…we're not experts now, but we get basic principles. I think we needed that critical friend approach, but I think it needs to change now into a different relationship going forward, which is much more about partnership and co-production, and trusting us to work effectively, I think'. GP 2 interview

GP 12 said that the PHC had kept her on the 'straight and narrow' when thinking about HIs. It was clear from this interview that the PHC was trying to influence CCG members' understandings of HIs so that they could incorporate them into their CCG plans.

'I'm learning from XXX all the time. She keeps me on the straight and narrow. The rainbow. Which should be in colour, not grey'. GP 12 interview

The role of critical friend was important for site three, the senior GP; GP 10 explained that previously the relationship with PH had not been strong because of personality clashes, the PHC was there in the CCG to ensure that the CCG was reminded of the HIs agenda.

'Let's just say our working relationship with public health is not as good as it could be. Mainly due to personalities, would be my honest answer…But I think that their prime job is the critical friend, so that whenever we are discussing items of business or a possible project or whatever, they are always there to say 'What about health inequalities' for example. Yes, they are always there to prod appropriately' GP 10 interview

It is clear in site three that the CCG had not yet grasped the HIs agenda, illustrated by the authorisation process and their responses to their results. Their response to their initial authorisation outcome needs to be considered. If that is how the CCG focus on the HIs agenda and do not request any further support as the organisation develops, there is a risk that the HIs agenda may be lost in the CCG, consequently leading to PH and the CCG working separately.

10.5 Summary and Wider Implications

The role of PH has been constructed differently by each CCG, and this arises out of historical relationships, both organisational and individual. The concept of sensemaking (see chapter's 4 and 9) provides a framework to examine how the established role of PH has come into fruition over time in each CCG. In site one; the PHC has adopted the role of a 'service provider' to the organisation, therefore the CCG request information and help from the PHC when they believe that they require it. However, at governing body level there seems to be no formal place for the PHC to offer advice. An interview with a CCG manager explained the relationship between PH and local GPs had historically experienced friction. GPs did not view PH positively because they felt that they were able to provide information but lacked the ability to bring about outcomes.

'Public health is probably an area where there's not friction but I think that GPs don't necessarily respect it as much as they possibly should. I think some of that comes back to, if I am being really honest the public team are perceived as talking the good talk but they don't really see them doing actions. But, so it's a difficult one, it's going to be interesting as time goes on'. Manager 1 interview

If the relationship is examined using the concept of sensemaking, the 'service provider' role the CCG has given to the PHC has been defined by looking retrospectively at the relationship and examining what will be useful to the CCG. The CCG are aware of the knowledge that PH has and are able to use the resource when they think it is useful to them.

In site two, the PHC is embedded within the CCG and throughout the organisation. The PHC is viewed as the co-owner of the PH agenda within the CCG, jointly working with CCG members and the LA. In site two, it seemed that the CCG had previously developed the role of their PHC, as 'co-owner' of the organisation and made 'sense' of their working relationship when PBC was in place. All CCG GPs and managers acknowledged the importance of PH, for tackling HIs before the CCG was established. Therefore, during the establishment of the CCG members have been enacting and creating the environment that has allowed PH to become embedded throughout the whole organisation and take on the role of 'co-owner' of the organisation. By actively being a co-owner of the agenda within the CCG, the PHC refers to PH and the CCG as 'we' in meetings, co-authors papers and leads discussions, thus the PHC 'gives sense' to colleagues about the importance of HIs.

'We started out in practice based commissioning with a recognition that until we narrowed health inequalities, we wouldn't really have a sustainable health system, and so we wanted a significant public health involvement from the outset, and we wanted to carry that over into a CCG so that we would be a public health commissioning organisation, so we would make efforts…will make efforts…to commission services that directly address health inequalities agenda, because that drives a lot of the unbalanced system that we have at the moment'. GP 9 interview

The PHC in site three is perceived differently, although she officially performs much the same role as the PHC in site one, she is seen as a critical friend to the CCG, ensuring that PH isn't forgotten about. In site three a collective history was not established (see section 9.2.3); however as described earlier the formation of a new organisation had been influenced and shaped by history, allowing new people to work together in a different geographical setting. The role the PHC has adopted in site three is that of a 'critical friend', offering critique and challenge to the CCG where it is deemed necessary. When examining the concept of sensemaking it reflects on the importance of a positive identity that organisations hold. In essence, site three is a developing organisation that is establishing itself in a new context. The role critical friend could have been enacted because of the uncertainty surrounding the organisation and the lack of experience of the governing body members working together. The role of critical friend enables an external voice to offer critique in a social setting when it is necessary to ensure that the organisation constructed themselves and their future plans in a realistic framework.

The different roles that have been enacted in each CCG by the PHCs will have different implications for the way in which their relationships are managed and how HIs are tackled in the future. The strengths of the service provision role are that CCGs will have to think about and manage their external relationship with PH effectively, outlining their requirements of PH and their expectations of service provision. The danger of this role is that as time progresses CCGs adopting the PH service provision role will need to ensure that they are continually developing their ideas about local health and ensure that local service provision from PH reflects their vision. If this approach is not adopted there will be no challenge to the initial agreement of work that has been prepared, leaving little opportunity for the relationship to develop and reflect the changing needs of the population they serve. This in itself could have an impact upon the HIs agenda within the CCG, if there is no challenge there will be little opportunity to develop the HIs agenda alongside the organisation.

When comparing the service provider with the co-owner role there are potentially different outcomes and implications to the relationship. The strength of the 'co-owner' relationship is that it has enabled a strong working relationship between PH and the CCG, PH and the CCG are working together on the same agenda, PH is a part of the CCG, included in all plans, from the initial design phase of a strategy all the way through to delivery. The danger of this relationship is that it may lead to complacency across PH and the CCG. Thus, the HIs agenda may no longer be challenged or updated because of the co-ownership of the agenda. There is no external PH element that can offer critique or challenge to the CCG. This is where the oversight of the HWB may be useful, offering an external critique of how the CCG and PH are operating whilst developing agendas. Under the current structures of the health system, CCGs working with their PHCs in this way need to be aware that when contracting work out to other organisations e.g. Commissioning Support Unit (CSU), the HIs agenda may be lost. The current commissioning support offers a layer of complication, whereby CCG priorities may not be externally delivered.

The critical friend role provided by PH to the CCG is similar to the service provider role. The CCG request feedback and support from PH when they deem it necessary. The strength of this model of working is that PH is able to offer a critique to CCG work, offering PH insight where it is lacking within the CCG. A danger of this working model is that PH is now situated in the LA; there is the potential risk that the focus of PH may change from a health perspective into a local government one. Thus, PH may not provide what the CCG has requested. Under the current structure there are no alternative options for PH support for CCGs and therefore the relationship may not operate as the CCG and PH had originally agreed. In the long term, if PH is utilised as an advisory role HIs and how to tackle them, may not be viewed similarly across CCG and PH work.

When CCGs are constructing and developing their relationships with their local PHCs they need to be aware that their model of working can influence their wider relationship with PH in the area. There is not one clear way to construct a PH relationship, they are dependent upon history and wider working relationships (see chapter 9). However, if CCGs follow the co-ownership model as adopted in site two they will have a clear shared agenda. This means that targets are mutually dependent on the working relationship between the two organisations. HIs are likely to be jointly conceptualised, tackled and monitored, enabling joint strategies to tackle the issue.

This chapter has highlighted the importance of the relationship that CCGs hold with PH. Three different relationships were identified; 'service provider', 'co-owner' and 'critical friend'. Overall, PH was found to be influential on the HIs agenda and the relationships that CCGs held with other organisations. The next chapter will bring together the main findings from this piece of research and discuss their implications in more detail.

Chapter 11:   Discussion

11.1 Main Findings

The original aim of this project was to explore how CCGs were tackling HIs. However, because of the timing of the project and the on-going policy changes, there was little evidence of action relating to HIs. This project therefore focused upon how HIs were discussed, the wider influences on HIs and how these factors influenced CCG plans to tackle HIs. At the initial stage of this research project, time was spent exploring and examining previous studies and contributions that had been made to the health policy and HIs literature. This enabled me to understand what had been examined previously and the role that healthcare played in tackling HIs. As demonstrated in chapter's 2 and 3; health services were seen to have a minimal role in tackling HIs, their role concentrated on access to and equity of services (Acheson, 1998). HIs are regarded as a 'wicked issue' (Stewart, 1990), not amenable to simple solutions. Partnership working (with the involvement of health) was deemed important, although detailed prescriptions of how this can be achieved are lacking in the literature. In this study, individual and collective understandings of HIs, and the role of PH were additionally found to be influential on the HIs agenda within CCGs. The figure below; figure (19) is a visual representation of the main findings from this project. The three central circles represent the core factors that were explored in this project. All the other elements in the diagram are contextual and were found to have variable influence across the three CCG sites.
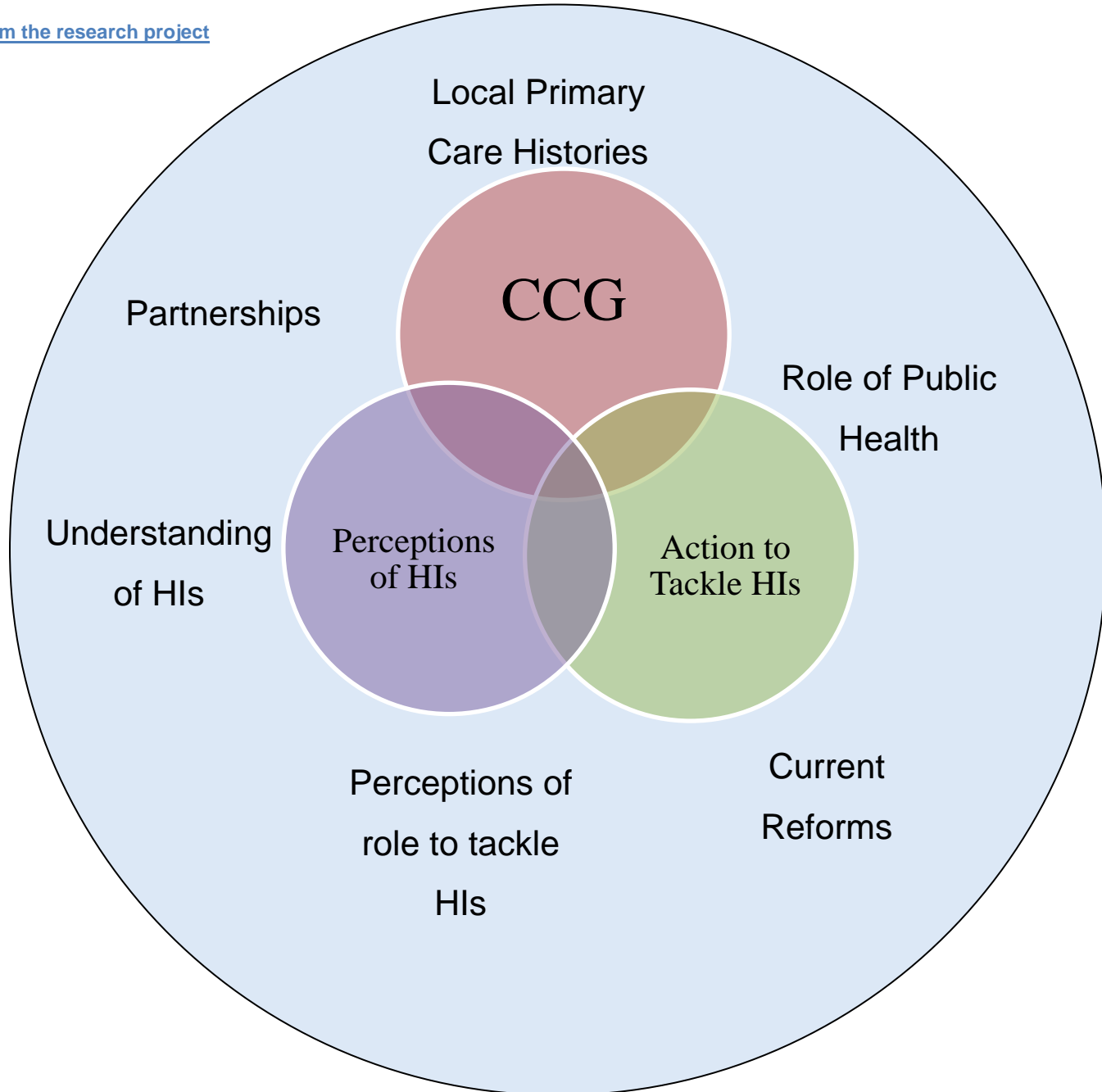
This chapter will discuss the main findings of this project, the wider implications of the research and possible future research.

11.1.1 Health inequalities conceptualisation

When exploring the literature surrounding this project it was clear that HIs is a complex field, with many different theories used to explain the inequalities which exist. These include: the individual behaviour model (Townsend and Davidson, 2002); the life course approach (Marmot, 2010); and access to services (Acheson, 1998) etc (refer back to section 2.3). Each different approach or theory implies a different set of potential 'solutions'; it was therefore clear that one of the first tasks of the research must be to understand how CCGs were conceptualising HIs. In order to explore this, CCG governing body members were asked about their understandings and interpretations of the HIs agenda, to see whether individual and organisational interpretations influenced how CCGs planned to tackle HIs. This was followed up in observations of meetings, looking for evidence of the ways in which these conceptualisations were manifested in the approach taken to tackle HIs.

This project found that across all three CCGs, HIs were thought about and discussed differently. In site one there was no clear shared conceptualisation of HIs, and they struggled to conceptualise HIs at a strategic level. Individuals mentioned the inverse care law (Tudor Hart, 1971) (the inverse care law hinges on the bigger picture and the influence of both social and economic factors of HIs), the implications of underfunding and the general deprivation in the area, but in practice the focus seemed to be on access to services, in particular GP services.

In site two there was a shared conceptualisation of HIs, influenced by the population that the CCG served. In this site, HIs were conceptualised as the differences in health between different area localities (Shaw et al., 2005, Gatrell et al., 2004, Davidson et al., 2008). In practice, the shared conceptualisation of HIs enabled site two to formulate a plan of how they were able to contribute to the HIs agenda locally, planning to try and tackle different health issues across different areas using differential investment and targeted schemes. This approach of tackling HIs has previously been supported at a national level by the policy agenda. Alan Milburn, set national HIs targets in 2001 attempting to overcome health differences across the population and introduced the Spearhead initiatives (Department of Health, 2005), to try and improve the health of specific populations by developing health trainers and improving school nurses (Adshead and Thorpe, 2007) (see chapter 3).

Site three had clear differences to sites one and two. Firstly, site three was a newly formed organisation, commissioning services on a new geographical footprint. Secondly, the population composition seemed to have no influence on how HIs were conceptualised, and as a result there were many different explanations provided by individual CCG governing body members when describing HIs. None of these explanations were explored further in practice by the CCG; HIs were only discussed within the context of the requirement to include the concept in their application for authorisation. Overall, the CCG treated HIs as a tick box exercise within the authorisation process. The implications of this were that no clear conceptualisations and plans were put in place to

examine and overcome HIs in the area. Similarities can be found between the way site three has focused on the HIs agenda and the performance management criteria of QOF. Gillam et al. (2012) conducted a literature review focusing upon the impact of QOF, and found evidence of gaming involved in the process. This evidence is reflected in the authorisation process of CCGs; CCGs had to demonstrate (with evidence) how they were looking at HIs. Site three used this research project as evidence that they were thinking about HIs, suggesting that, as with QOF, ticking boxes relating to authorisation may lead CCGs to be creative in their approach. In addition, Gillam et al found that QOF had acted to bring practices together, altering their organisation and routines in order to meet the targets. In a similar way it seemed that the authorisation process has impacted upon CCGs, bringing members together as they constructed documents and evidence. Finally, QOF has been viewed as a tick box exercise; this is also relevant to authorisation. Lester et al. (2011) examined unintended consequences of quality indicators in primary care. The implementation of QOF indicators was found to increase the fixation on measures, rather than trying to improve general quality of care. For authorisation, CCGs had to demonstrate that they were capable of functioning over 119 criteria and therefore producing evidence could become a tick box exercise, as timing did not allow full detail and evidence to be developed for each area. Although the main aim of authorisation was to ensure competency across many areas (see section 3.4), it became simply a task to accomplish for some CCGs, driving their agenda and forming the focus of their work.

11.1.2 Action to tackle health inequalities

This research suggests that, if there is no shared understanding of what HIs are or what the role of the CCG is in tackling HIs, it will become impossible for CCGs to plan organisational action to tackle HIs. The timing of data collection meant that there was little action regarding HIs (CCGs were not fully functional organisations), however it was clear that only site two had collectively conceptualised HIs and therefore were explicitly thinking about how to tackle HIs in relation to the problems that they were facing on a local level.

11.1.3 Impact of history and wider relationships

The concept of sensemaking (Weick, 1995) provided a framework to examine how past histories and wider relationships influenced how HIs were conceptualised and tackled (see chapter's 7 and 8). Past histories had helped shape how all three CCGs had defined themselves as organisations. Site one was formed during previous iterations of primary care commissioning, and the history of local commissioning had informed the CCG's understandings of the health of the population they served. They were aware of the effect of deprivation in their area and seemed to feel helpless in the face of these wider problems. Site two held a strong organisational history, characterised by good relationships with the LA and PH. CCG governing body members had previously actively worked to tackle HIs when they were part of the PBC group and therefore in the current reforms they were focusing on how to implement their strategies. In contrast, history was not as influential in site three, a newly formed organisation under the current reforms. However, it was clear from fieldwork that site three had been formed to avoid previous problems that had been experienced when PBC was in operation, such as personality differences. The development of a new

organisation has provided the CCG with an opportunity to establish the HIs agenda based on current population requirements rather than being predetermined by history, although there was little evidence at the time of data collection of them yet seizing this opportunity.

History was also found to be influential on how wider relationships were formed with the LA for sites one and two. This research found that a 'good' working relationship between the LA and the CCG could be described as a practical relationship on the ground. Whereby the two organisations moved beyond strategy and were able to agree how the two organisations would work together and implement joint programmes of work, enabling them to work towards the same goals. In site one, previous historical working had helped shape how the CCG thought about and referred to their relationship with their LA. They acknowledged that they needed a 'good' relationship with the CCG but were unable to define the meaning of 'good'. They suggested that they needed to maintain a relationship with the LA to ensure that PH support was not lost (as the PH function transferred to the LA). In site two the relationship with LA was based on 'good' working practices, previous work between the PCT, the PBC group and the LA had enabled working relationships to be constructed and developed, therefore the CCG wanted to continue previous working practices, ensuring that the positive working relationships weren't lost. This enabled site two and the LA to continue working on their shared agenda, offering expertise and skills when it was necessary.

Overall, wider relationships and history have helped shape how CCGs have been formed, how working practices have been instilled and how the HIs agenda has been formulated.

11.1.4   Sensemaking

Weick's concept of sensemaking provides a lens through which to view these findings, highlighting 'unreasoned' explanations which may help explain observed behaviour. In essence, Weick suggests that people do not consciously make sense of situations, but act automatically in ways that are partially entrenched in existing schemata and previous experiences. Thus, sensemaking helps us examine underlying assumptions in order to understand observed behaviour. This is valuable, as it could be used by CCGs, to provide a framework to help them 'explore' their actions and in turn disrupt entrenched patterns of poor behaviour or identify good practices to pursue.

Overall this study demonstrates how HIs conceptualisation, strategies to tackle HIs and relationships that CCG members hold with other organisations including LAs and PH (see chapters 9 and 10) are not necessarily consciously developed. This reflects Weick's emphasis on the instinctive nature of sensemaking, as organisational members notice (or fail to notice) cues based upon their previous experiences, and act based upon a perception of plausibility rather than careful assessment. This study highlights the relevance of history, local contexts, what is perceived as plausible by CCG members and previous ways of working. These factors underpin CCGs' generation of their local schematas, which in turn underpin action (or lack of action) to tackle HIs and respond to the central government duty that was imposed on them. In this section, I will discuss these factors in relation to CCGs, the usefulness of sensemaking and its significance for the HI's agenda.

The duty to tackle HIs imposed on CCGs was understood by members of CCGs within their local context. For example, there was an overall agreement in site one that many of the issues relating to HIs were out of the control of CCGs: HIs were seen as consequences of the wider determinants of health (Dahlgren and Whitehead, 1992). This demonstrates how even as national policies and the prominence placed on the Marmot review (2010) act to highlight the importance of HIs, local sensemaking may inhibit action. Site one conceptualised HIs as a PH issue, and this has locally shaped how the agenda has been formed and how local relationships function. Site one clearly believe that the HI's agenda is the responsibility of PH, and PH are viewed as belonging to a separate organisation, especially since the function has moved from PCTs to the LA. This has meant that local working practices in the CCG have left little regard for the HI's agenda, instead leaving the responsibility with PH. In site two, by contrast, the differences in health outcomes across the healthcare footprint provided them with not only clear 'cues' about the importance of HIs but also an opportunity to differentially intervene to try to change things. They conceptualised HIs as the disparities in health experienced across their local population, leading them to focus action on improving the health of those in deprived areas, to try and ensure that a good standard of health was being experienced by all, not just affluent members of the population. This demonstrates how local organisations conceptualise a problem / interpret a policy based on their local contexts and therefore, understand a national problem within a local setting.

Alongside these local interpretations, CCGs were also subject to other competing demands. The authorisation process was very time consuming, limiting the time available to consider other issues. This highlights the conflicts between competing policy agendas and how they can impact on local agendas. The authorisation process was mandatory, with a highly structured set of requirements, whereas the 'duty' to tackle HIs was vague and aspirational. It is unsurprising that the former prevailed over the latter. Successfully achieving authorisation (which includes providing evidence that they are thinking about HIs) was an important process for site three, as it enabled the CCG to begin to develop their identity as a new organisation and validated their existence. HIs were simply one of a number of issues that the CCG had to tick a box for in their authorisation submission, rather than being seen as a separate or important issue.

History was a key influence that was examined through the lens of sensemaking. History had shaped how all three organisations were formed, their wider relationships and for both sites one and two, how they conceptualised HIs. This study and the application of sensemaking reiterates what has been found in previous primary care commissioning studies, that history is a key component of how organisations locally understand and interpret change (Coleman et al, 2014). For site two, longstanding shared geographical boundaries, leading to relative stability of organisational forms over time has shaped local interactions and understandings, especially between previous primary care commissioners, the new CCG and the LA. In addition, the area is socially mixed, with areas of very high and very low deprivation. This has fed into a longstanding belief amongst primary care commissioners that they have a role to play in tackling HIs, as they have clear evidence visible in their day to day work of the impact that HIs have on comparative health of affluent versus deprived populations. This conceptualisation has influenced the approach

the CCG plans to take when tackling HIs, focused upon improving the health of those people residing in poorer areas. Their history of working alongside other organisations provides experience of action which feeds back into the sensemaking process and contributes to a relatively sophisticated conceptualisation of their role in tackling HIs. Furthermore, actors in this site are more likely to notice cues relating to HIs which arise in their ongoing work because they are sensitised to it by their previous experiences. The shared history of primary care commissioners and PH working together, has enabled a co-ownership of the PH agenda to evolve. This in turn has helped to embed PH and the HI agenda throughout the organisation.

What this research demonstrates is that new policy initiatives are interpreted in the light of previous experiences, as well as subject to other competing priorities. Together these factors influence how a policy is both understood and enacted.

11.1.5   Sensemaking, health inequalities and policy literature

Drawing on the HIs and policy literature (see chapters 2 and 3); I am able to demonstrate how local contexts, plausibility, history and previous ways of working (key aspects of the sensemaking process) impact on local HIs policy implementation. In chapter 3, I introduced Kingdon's (2003) model of policy windows. Exworthy and Powell (2004) take this concept further and suggest that Kingdon concentrates on the central level policy opportunities 'big windows', but that to understand policy implementation local level opportunities, which they call 'little windows' also need to be taken into consideration . Rather than just concentrating on the traditional policy pathway, whereby policies are disseminated from central agencies to their local counterparts (vertical dimension), influences across both central and local agencies also needs to be accounted for (horizontal dimensions). Policy can interact across agencies, meaning that competition and conflicts are introduced into the policy arena. Exworthy and Powell (2004) argue that for policy implementation to be successful a central policy window needs to be opened (Kingdon, 2003), but that account must also be taken of local implementation issues and inter-agency conflicts. I have applied these two models to my sensemaking findings, to further explore the complexity of the HIs policy arena

As I described in chapter 3, Kingdon (2003) helps us focus on the HI's policy agenda through the use of his policy window model. This model allows us to see how the duty imposed on CCGs to tackle HIs was introduced into the policy arena and how a policy window was opened at central government level (see figure 20). Marmot (2010) provided an authoritative account of the causes and consequences of HIs, pushing the issue onto the policy agenda. The re-organisation of the NHS provided an opportunity to get HIs onto the agenda of healthcare organisations, during the early development of CCGs.
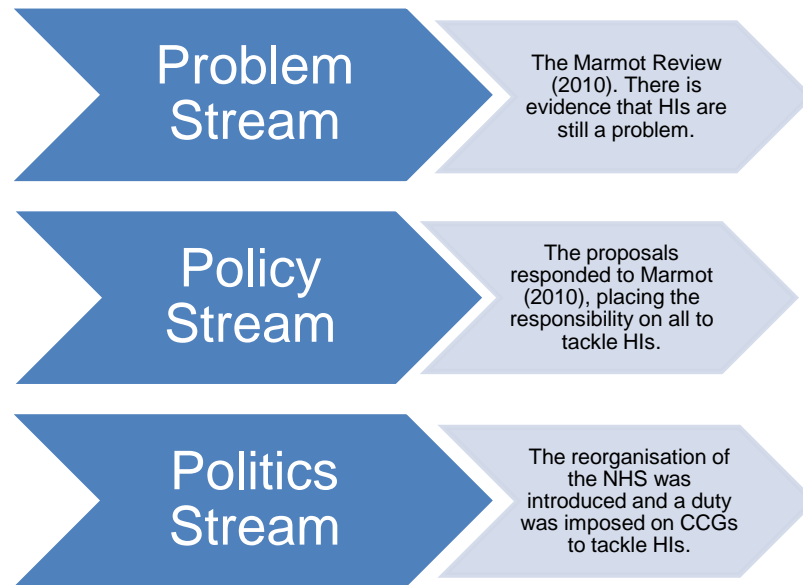
Powell and Exworthy (2004) have demonstrated with their work exploring HIs policy implementation, central policy initiatives are often difficult to enact locally. Policy, process and resources were found by Powell and Exworthy (2004) to be important influences on local HIs policy implementation. In this context (see figure 21), when the duty was imposed on CCGs to tackle HIs, authorisation, the reduction of budgets, changing responsibilities of organisations, the integration agenda and the reorganisation of the NHS were all competing elements in a time restricted agenda. CCGs were spending a large amount of their time trying to prepare for authorisation, whilst PH were moving back into the LA and HWBs were being established, resulting in changing local relationship dynamics and working practices (see section 3.4). This research found that even if both 'big windows' (central policy) and 'little windows' (local policy) are open, what happens on the ground is still influenced by embedded local factors (see figure 21). Using sensemaking as a theoretical lens highlighted the fact that, alongside these key organisational changes, CCGs were trying to make sense of the changing context by reflecting on the past successful ways of working and trying to fit central policies into their local contexts. Local actors may enact central policy i.e. accept changing responsibilities and budget cuts within the guidance provided, however HIs policy may not be fully enacted due to the influence of local dynamics, the plausibility of the specified policy and local histories.

'Big Windows' (Kingdon)		
Politics Stream	**Problem Stream**	**Policy Stream**
The reorganisation of the NHS was introduced and a duty was imposed on CCGs to tackle HIs.	The Marmot Review (2010). There is evidence that HIs are still a problem.	The proposals responded to Marmot (2010), placing the responsibility on numerous organisations (including healthcare) to tackle HIs.
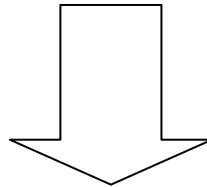
'Little Windows': Factors influencing local implementation (Powell and Exworthy)

- Local Authority and NHS undergoing major re-organisation
- Budget reductions
- Changing responsibilities
- Authorisation
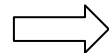
Local implementation

Sensemaking: Other factors influencing local implementation

- Plausibility-what can CCGs do to tackle HIs given the broad definition, no guidance, competing agendas and organisational change.
- History / Local contexts-current policy is viewed in the local context, focusing on what has happened before (successes / failures) and working on-going relationships.

These results demonstrate that to influence policy implementation it is important to understand and take into account micro level issues and factors that affect the sensemaking of people on the ground who have to interpret and enact policy. The approach taken for this research project, uncovering the conceptualisation of HIs and difficulties in local interpretations, demonstrates that the role of those involved with tackling HIs should start with a similar diagnostic approach, asking the questions what are HIs and how can we tackle them? This enables implementation to be contextually sensitive, allowing local sensemakers to recognise local problems, respond to the locally identified problem and drive policy implementation. Thus, local policy implementation is influenced by 'big windows', 'little windows' and embedded sensemaking practices.

11.2 Comparison with existing research

The timing of this project and the policy changes has meant that simple comparisons cannot be made with previous work, CCGs are new organisations, therefore there has been little research conducted in this area. However, Checkland et al (2012) when exploring the early workings of CCGs, found that CCGs serving diverse populations were beginning to grapple with issues surrounding the HIs agenda. Issues included national budget allocations and the impact it would have on their population. This reflects the discussions surrounding the HIs agenda in site one (see chapter 7).

11.2.1 Previous health service initiatives for tackling HIs

The NHS itself, when established in 1948, was supposed to eradicate HIs, with free healthcare being available to all, irrelevant of social position. However, from the 1970s onwards it was clear that health outcomes and healthcare access were disparate between different social groups and communities (Hudson, 2013). It is often difficult to reflect on the success of HIs initiatives because of the political influence that surrounds the NHS and Local Government. The policy context (chapter 3) alluded to the political challenges that have faced the HIs agenda surrounding both healthcare and LA initiatives. The ideology of those who are in power influences how the HIs agenda is defined (if at all) at both a national and local level. Baggott (2004) suggested that the Labour Government placed a higher priority on PH and HIs, an agenda which the Conservatives had largely ignored. Thus, for example, when the Conservatives were in power in the 1980s and 1990s, it was regarded as unacceptable to talk about 'health inequalities', with the term 'health variations' preferred instead (Allmark and Salway, 2009). When Governments change, initiatives or funding is often adapted to reflect the ideology of those in power, therefore success and evaluation of specific initiatives often becomes problematic. Both the literature review and the policy context (chapters 2 and 3) have discussed the journey of HIs, referring to understandings of HIs and initiatives that have been imposed on areas to try and overcome the issue

Within the current reforms a duty has been placed on CCGs to tackle HIs. In the past little prominence has been placed on the role of the health service for tackling HIs (Exworthy et al 2003a) but under

CCGs, individual clinicians as well as the health organisations have greater responsibility. Previous HI initiatives have included healthcare organisations, outlining their roles, often within larger initiatives (e.g. HAZs) however, the current guidance is vague, outlining a duty without any further direction. This duty is open to interpretation at a local level; therefore different initiatives could be implemented based on geography and population demographics.

Prior reports have been more descriptive about the role of healthcare in tackling HI, often implying that the role of the health service is minimal in tackling the wider determinants of health. In the Acheson Report (1998) out of thirty nine recommendations, only three referred to the role of the health service, comprising recommendations surrounding equity and improved access to services. This indicates that an imposed duty on CCGs (that lacks clarity) may be meaningless, as little prominence has been given to their role in prior initiatives. Further to this the importance of PH was acknowledged in the Acheson Report (1998) their assistance and skills were portrayed as pivotal in the formulation of population plans, this influence enables wider population information to be available for clinicians when providing and commissioning healthcare services.

This current piece of research, has demonstrated that issues of access and the role of PH in the creation of documents focusing on the local population health (e.g. JSNA) was still of importance to CCGs. However, local variation and working relationships were found to be influential on how these elements of HI initiatives were conceptualised, discussed and put into action. In site one, for example, access to both primary and secondary care for their deprived population was a key issue for the CCG. Research in this area reflects the findings of this project, with lower income groups more likely to access GP services whilst experiencing poorer equity levels for secondary care (Morris et al 2005).

Whilst there have been significant concerns expressed about the current upheaval surrounding PH (Tudor Jones, 2013, Local Government Information Unit (LGIU), 2012), this study suggests that the role of PH and their assistance in providing a population focus on health has not been lost. Under the current reforms, PH still holds an important role in information provision. However there is a changing dynamic and more expectations have been placed on the role CCGs can play in helping write and construct local population health documents (e.g. JSNA). At the current time, CCGs, PH and the LA have to work together on local health documents including the JSNA and the JHWS (Department of Health, 2013). The purpose of the JSNA has developed under the current reforms, it is no longer to be simply a descriptive document, instead it should analyse local health needs and address how action should be taken to overcome such issues (Tudor Jones, 2013). The co-authorship of these re-defines roles within and between these organisations; PH is no longer there to just formulate population plans, CCG representatives now have a role in thinking about the broader influences on health, enabling joint work practices to be developed together. These activities, if successful provide an opportunity for clinicians to engage with others and think about health in broader terms, this if carried out to its full potential will provide CCGs with knowledge that might help shape how they conceptualise and tackle HIs. This development toward co-authorship could be argued to have come from and have been

influenced by Marmot's (2010) Fair Society's and Healthy Lives paper, whereby HIs and the gradient in health is deemed to be everyone's responsibility.

11.2.2   What happened in PCTs?

When Labour came into power in 1997 this led to the introduction of more area based initiatives for tackling HIs. These included Health Action Zones (HAZs) (Sullivan et al., 2004, Judge and Bauld, 2006, Department of Health, 1998a) and Spearheads (Mathrani, Hippisley-Cox, 2009, Department of Health, 2005). Funding was supplied to areas that were regarded as deprived, to try and improve the health of the poorest with specific initiatives that were focused on the regarded problems in the area (see chapter 3). In site one, there was still evidence of these initiatives; programmes of work were discussed with reference to previous funding models. Now these initiatives have ended the responsibility of how to continue the work (if at all) remains with CCGs based on funding and priorities in their areas.

The initial policy evaluation of HAZs was implemented shortly after HAZs were introduced. The evaluation process consisted of four key areas; scoping and mapping (finding out what each area was doing to try and reach their targets); whole system change (partnership working and ways to provide national change); capacity to develop collaboration (evaluating the partnership aspect of HAZs); and the impact the zones had had on reducing HIs, (Bauld et al., 2005). HAZs struggled with whole system changes, trying to plan initiatives whilst managing the evaluation of them (Parry and Judge, 2005). Overall, Bauld et al. (2005) suggested that because there was a lack of baseline measures, there was no formal way of measuring the goal of reducing HIs. The impact on HIs was minimal; HAZs had limited resource and restricted time frames (Benzeval, 2003). However, HAZs had success in encouraging partnership working as well as increasing the profile of HIs in general. Benzeval (2003) suggests that to truly impact on HIs there needs to be a policy area concentrating on HIs with links being made to mainstream policy areas. In Marmot's (2010) most recent review of HIs, it suggests that to concentrate efforts on the poorest groups of society will only challenge a small area of the problem. Instead, it is suggested that action to tackle HIs is to be universal, concentrating on the whole of the gradient in health, to ensure that fairness is achieved for all. Action should relate to need and therefore Marmot suggests that proportionate universalism needs to be enacted, whereby the intensity of action relates to the different needs experienced by individuals across the gradient.

The 1997 White Paper (Secretary of State for Health, 1997) began to focus on the 'roots of ill health' and subsequent documents charged PCTs to work in partnership with the LA to try and tackle HIs; this was introduced to meet the wider policy objectives, by working together, the broader influences on health e.g. housing could be addressed together (Klein, 2010). Thus, all aspects of HIs were to be brought together across different organisations, to ensure that HIs were being tackled. However, as stated in chapter 3, partnership working is complex, different organisations follow different working practices which often leads to tensions and issues when partnership working is implemented (Evans

and Killoran, 2000, Lewis, 1999, Glendinning, 2002, Marks et al., 2011). Silo based working that is experienced across organisations, often to leads to the failure of partnerships success (Powell, 2007). Partnership working is relevant to this project and the structure of the NHS, LA and PH with the introduction of HWBs. CCGs and LAs have been charged with joint working to ensure that the population's health needs they serve are being taken into consideration. Chapter 9 referred to the relationship that was held between site one, site two and their respective LA's. It was clear that previous relationships were influential on the development of current partnerships. Where there are good, well established relationships based upon experience of working together, it is likely that CCGs will be able to continue working in this way. However, this project suggests that, where partnerships have not been well established in the past, old antagonisms are likely to affect current work. It remains to be seen whether the establishment of HWBs will provide a forum within which true partnership working becomes easier to achieve (Coleman et al., 2014).

PCTs were charged with overall targets to improve health, mainly focusing their attention on accessing and targeting local healthcare needs. As time went on, PCTs became more involved with the health improvement agenda, concentrating their attentions mainly on healthcare (Baggott, 2004). However, historically policy documents have placed little emphasis on the role of healthcare for HIs (Exworthy et al., 2003a). This has now changed with the current reforms placing a duty on CCGs to work towards tackling HIs. It could be argued that this duty is a response to the Marmot review (2010), whereby the responsibility to tackle the social gradient in health is placed on both local government and the NHS. Again, it is acknowledged that the NHS cannot overcome HIs alone, but more prominence has been placed on the role of the NHS in contributing towards the HIs agenda by reducing inequalities in health status (e.g. commission an equitable NHS, addressing the inequalities in healthcare; to engage with communities and other sectors so that they can work in partnership to provide a patient focused and integrated health service and to commission services that reduce negative health experiences that are caused by living in social disadvantage). Further to this, the recent paper Working for Health Equity: The role of Health Professionals (Allen et al, 2013) has provided a new focus on the role of healthcare for HIs within the new healthcare system. Although, many of the suggestions reiterate what has been written in the past, the document is giving a new role to healthcare to ensure that they are thinking about HIs, what causes them and how they can help influence patients and members of staff's social contexts to impact on HIs. The document concentrates on the individual role and the organisational roles within the NHS to ensure people challenge the issue of HIs at all levels. Healthcare may not be the only element of HIs but they need to ensure they are thinking about how they can impact on HIs in a variety of different ways. If the ideas contained within this document are taken forward it will impact CCGs and the way they focus and try to tackle HIs. Interestingly, Marmot is a co-author on this paper, again demonstrating his recent and ongoing influence on the role of healthcare and the HIs agenda. Overall, therefore, it seems that there has been a significant change away from a performance regime based upon the meeting of a relatively small number of 'must do' targets (Blackman et al., 2009) to one based upon a more general duty to improve equality whilst simultaneously improving a wide range of outcomes. It remains to be seen how this will play out in the longer term.

There is a clear difference between the HIs duty placed on PCTs and CCGs. It seems from the literature that PCTs had a clearer role in how they could approach the task of tackling HIs. Focus was placed on specific areas (e.g. health care access), whereas the recent duty placed on CCGs is much broader and ill defined. Thus, tackling HIs with little guidance could be interpreted as a more difficult task.

11.2.3 The role of Public Health

As described in chapter 10 the role of PH in each CCG has been influenced by history and the current reforms. Each CCG has adopted a different model of working with their PHC and their local PH team. In site one, the CCG utilises the knowledge and expertise of PH through their PHC and her enactment of the 'service provider' role. PH is a service provided by the LA, whereby PH expertise is asked for when the CCG require it. In site two, the CCG has an embedded PH role; the PHC is the 'co-owner' of the agenda, with a voting role on the CCG governing body. PH is able to not only inform the CCG agenda but vote on what the CCG should do and how they should move forward as an organisation. In site three, the reform and development of the new organisation has helped shape the PHC's role as a 'critical friend', PH knowledge and expertise are used as an external lens to critique CCG plans and ensure that the organisation formed within the guidance that had been produced. Overall, the role of the PHC has been utilised differently across the three CCGs and this project has demonstrated that the role and value placed on CCG's PHCs has wider implications on CCG working practices and the HIs agenda.

The role and history of PH has been well documented within the literature (Baggott, 2004, Lewis, 1986, Jones and Pickstone, 2008). Essentially, since its inception as a discipline, PH has been subject to repeated policy changes and reorganisations. There has been little overall planning, and as a result, the role of PH has varied significantly in different contexts. The findings of this study fit clearly within this historical narrative. Thus, the role of PH both historically and in the current context has not been well planned or thought out, leading to variation across different areas. Lewis (1986) whilst examining the introduction of community medicine (a policy change and rename for PH) explored how PH had developed and become established overtime. This book explored the journey of PH illustrating how the changes that had occurred in PH were underpinned by several different factors, including government initiatives, tensions between clinicians and PH workers, a disconnect between front line PH workers and PH academics, and the key finding that PH had no clear philosophy underpinning its functions. Thus there has been a lack of direction for PH, leading to a reduction of responsibility, which has allowed other organisations to manage and steer the PH agenda. The aim of this section is to explore these key areas in more detail, examine how they have influenced the current PH agenda and how this has influenced the three roles of PH that were found in this piece of research.

In the 19th Century PH had a role to protect communities from the threat of infectious diseases; PH focused on local communities with duties surrounding housing conditions and food. By the 20th Century, medicine was developing further and there was a shift on the views of dirt and with germ theory being developed (Starr, 1982 p189). Scientific discoveries changed how PH was thought of; there was an increased enthusiasm for PH to focus on preventative medicine. As society has become more complex, so have the complexities of illness, chronic illness has increased and thus changed the role of PH and medicine (Adshead and Thorpe, 2009). The initial broad definition of PH began to narrow, when infectious diseases were reduced, a more specific PH focus was encouraged through politics. When the NHS was introduced in 1948 it was seen as a victory for PH, whereby a health service was to provide a more cohesive approach to health (Jones and Pickstone, 2008). However GPs began to take on the roles that PH physicians had previously carried out leading to tensions between the two healthcare professions. Lewis (1986) argues that the introduction of the NHS began to dismantle PH, and by its launch on July 5th 1948 PH had lost its previous power and philosophy, which was strong during the interwar years. Although there was a clear focus on preventative medicine there was no clear definition underpinning the way forward for PH. The lack of definition and philosophy made it difficult to draw clear distinguishable lines between PH and the clinicians. Thus, there was a lack of clarity surrounding the purpose of PH. Throughout time, there was a clear disjoint that was experienced between those teaching PH and those practising; academics acknowledged that PH had little conceptually to offer to the health service, causing tensions to arise within the profession of PH itself. From the 1970s onwards NHS re-organisations led to further confusion around the role of PH. Community Physicians were appointed to regional, area and district management teams whilst specialists in community medicine (PH) were appointed to the LA to advise on specific health matters such as environmental health (Lewis,1986). In the 1980s the position of PH had continued to deteriorate as health authorities were abolished and further confusion was experienced around the role of PH. The Hunter Report (1972) outlined the duties of PH; it was their role to promote integration between administrators and medical professionals to enhance planning in the health service. There was a recognition that PH would be able to bring a specialised skill set focusing on epidemiology to facilitate both planning and management of health. The publication of the Griffiths Management Report (1983) preceded the reconfiguration of the management structure in the NHS. PH Community Physicians lost their places on the management boards and became advisors to the system. These changes diluted the power of PH further within the NHS. The 1980s were a time for the 'new PH' where the prevention agenda was promoted by Thatcher. However, there was a lack of centralised funding, inhibiting local schemes. The publication of the Acheson Report (1988) reinvigorated PH, suggesting that community medicine be named PH and called for each health authority to have a Director of Public Health to lead the direction of PH focusing on the prevention and promotion of health. This report highlighted the responsibility of PH to prioritise, plan, evaluate, prevent and promote health. Verweij and Dawson (2007) claim that this view of PH focused on the utilisation of social activities to promote health. The Acheson report restored PH status and attempted to strengthen the leadership in PH; however changes to the LA structure meant that PH work could be varied across different areas.

During the 1980s and 1990s the Conservative Government's ideology was opposed to PH interventions because of the association of the interventions with the nanny state and collectivism, (Baggott, 2004). However, because of a number of PH crises the government accepted that they needed a more cohesive approach to PH. During the 1980s there were outbreaks of legionnaire's disease, food poisoning spates and there were raised concerns amongst the public about HIV/AIDS (Baggott, 2004). Additionally the Conservative Government was concerned that the public no longer trusted them on health matters and general healthcare issues. To encourage trust the government implemented a number of policies; screening programmes and a new form of remuneration for GPs to encourage them to emphasise health promotion all of which were popular with the public. Through the encouragement of GP schemes on health promotion they were able to make their policies more publically visible. Although these policies were more popular with the public they still had an element of individual responsibility which was a key component of Conservative Government ideology (Baggott, 2004).

Recommendations in The Health of our Nation (1998) publication produced under the Blair government resulted in the appointment of a Minister of PH to work amongst different policy departments. In the 1980s/90s the internal market was introduced into the NHS, the split between the purchaser and provider was seen to undermine PH and led to further fragmentation. The reconfiguration of organisations led to a disruption of working relationships, impacting on PH (Jones and Pickstone, 2008). Our Healthier Nation (Department of Health, 1999) set out the PH strategy for England, outlining the role of the social, environmental and economic factors impacting upon health. The introduction of the policy was a contract involving the government, local communities and individuals to improve health and was described as the 'Third Way' situated between the two extremes of the 'nanny state' and 'victim blaming' (Baggott, 2004). The relationship between PH and GPs were changing as GPs were beginning to concentrate on a much narrower aspect of health with GPs focusing less on the PH characteristics of health. The introduction of GP led commissioning; GP Fundholding (GPFH) received a mixed response of commentary with PH opposing the changes as they believed this type of commissioning would lead to GPs working in isolation irrespective of the population's need leading to further potential inequalities. GPFH was abolished but primary care commissioning continued with Practice Based Commissioning (PBC). Primary Care Groups (PCGs) were introduced with GP board membership to try and improve health in their community. In time PCGs became PCTs which held additional powers (e.g. providing community health services for their population).

This brief history of PH development outlines how PH has been shaped by political developments that have determined how PH work has been enacted at national, regional and area levels. Overall, PH and politics are strongly linked, with the political ideology of those in power shaping how PH has developed (Douglas, 2010). The lack of shared philosophy and conceptualisation of PH had led to it being manipulated and shaped into several different roles and iterations. The political journey of PH has had a turbulent ride, losing status and power and being moved from the LA to the NHS with confusion on the overall role. Historically PH responsibility has been passed between the LA and the NHS, each

time resulting in role confusion and the destabilisation of PH, leading to a professional disconnect between PH professionals and GPs. Hunter (2007) argues that the changing political journey for PH over time has reduced the professional focus for PH, instead it has had to adjust and try to understand its changing working environments.

The current structure that has been imposed on the NHS potentially causes a further disconnect between PH and primary care, with the move of PH back into the LA. This disconnect does not have to be viewed negatively; if the context of history is taken into consideration, the separation of the two professions allows for more distinct areas of responsibility to be defined, which may reduce the confusion surrounding the roles and duties of PH. In fact a number of PH teams are happy with the move of PH into LA, the transition is perceived as an opportunity to deliver local change (Tudor Jones, 2013). Hunter (2007) stated that there was a longstanding complaint that the influence of Local Government on PH had been ignored over the years and thus the influence had become marginalised. The PH Outcomes Framework 2013-2016 outlines how the integration of PH into the LA will allow PH duties to be carried out in a broader context, allowing service design and delivery to more easily include the wider influences on health e.g. poverty and housing, reflecting the findings that were published in the Marmot Review (2010). This could be argued to be a good thing in the context of this history, as it gives each profession, clinicians and PH a more distinct area of responsibility, it provides PH with a broader context to carry out their duties, in their own professional capacity.

New roles for CCGs mean that they will need PH expertise, but this research suggests that CCGs have not necessarily thought clearly about what this means for them. This study found three different ways that CCGs may interact with their local PH team (see chapter 10), and suggests that what has been called here the 'co-ownership' relationship is most likely to result in action to tackle HIs. In this model, PH has an embedded role within the CCG, allowing for greater collaboration and PH support to be disseminated into primary care. Although these roles were clearly distinguishable, it is important to note that each CCG had fallen into a particular way of enacting their relationship with PH, rather than addressing the issue consciously. A key message from this research is that, if CCGs actively consider how they wish to work with their local PH team, rather than accepting a default status quo, they have an opportunity to shape the ways in which HIs are tackled.

11.3 Implications of findings

11.3.1 Issues associated with broad definition of HIs

As discussed in the literature review (chapter 2), current definitions of HIs are broad and multifaceted. This study found that such broad definitions may have contributed to the difficulties experienced by CCGs members in conceptualising HIs. Broad and complex definitions make it difficult for CCG governing body members to conceive of what effective action might look like, especially those who have had no practical experience of work in this area. The use of the term of HIs was unhelpful to CCG

members in this study because of its lack of clarity. For the HIs agenda to be successfully tackled, it could be argued that a clearer definition is required, outlining specific areas where different public services can impact on the HIs agenda. The Marmot Review (2010, p15) when examining HIs in the context of today, defined the issue as *"a result from social inequalities. Action on health inequalities requires action across all the social determinants of health"*. It could be argued that the broad definition of HIs, concentrating on the social determinants of health has had very little impact on CCGs in this research and the work they are conducting. For example, it may have been more beneficial for CCGs to be encouraged to focus on a specific area of HIs such as equity of access. This would have provided CCGs with clear guidelines of what they should be working towards and how they could manage the HIs agenda as a healthcare organisation.

11.3.2   What is the meaning of duty?

The term duty also lacks clarity and definition. After the Future Forum (Field, 2011) suggested that HIs should be included in the current reform, giving CCGs a duty to tackle HIs, no further guidance was provided. Thus, a one off statement that CCGs had to tackle HIs was left for local CCGs to interpret and enact themselves. No formal structures or measures were linked to the duty. This does not complement existing ways of working that have been established in the English health service, whereby targets and performance management techniques are implemented to ensure that clinicians are doing the work that is required of them. Using Weick's concept of sensemaking and policy implementation models explored in this project (see chapters 2 and 4); it is clear that the duty imposed on CCGs has not enabled them to tackle HIs. Guidance itself needs to offer clarity about the HI's agenda, whilst being flexible enough for it to allow a diagnostic approach to be taken, to conceptualising HIs. Policy theories suggest that top level policy can override local level policy implementation, however clear guidance to CCGs would have been a 'cue' (Weick, 1995) to think about and interpret the HIs agenda based on previous experiences. Guidance would offer an opportunity for CCGs to think about HIs rather than providing a blueprint.

It can additionally be argued that the duty for CCGs to tackle HIs was a victim of timing. At the time the duty was published, CCGs were trying to establish themselves as new organisations, preparing themselves for the official process of authorisation which was a very time consuming process. In comparison to other areas of work (e.g. safeguarding), HIs could have been seen as less significant and therefore has been lost from the agenda. The findings from this project are contextual and are limited to the time frame that CCGs were establishing themselves within. However, this could be re-examined with future work, monitoring how CCGs plan to tackle HIs as fully functioning organisations.

11.3.3   The invisibility of Marmot

An interesting finding from this research is the invisibility of the Marmot Report (2010) within CCG meetings and interviews. Although it was mentioned on a few occasions during interviews, there was little prominence placed on the report when discussing HIs within meetings. The report has been discussed within the policy arena, taking into account the wider influences on health, as well as the role of health care in tackling HIs (chapter 3). The work of Marmot has been welcomed by Local Government and is visible in their approaches taken to tackle HIs (Dhesi, Forthcoming). The Marmot report's suggestions complement the work of Local Government, offering direction on how to tackle the wider influences on health (e.g. housing). Peate (2012) suggests that many services will be planned around the social determinants of health, based on the recognition of health being influenced by larger economic and social factors. The invisibility of Marmot in CCG work could possibly be explained by the timing of the project; CCGs were in their year of shadow, concentrating on authorisation and facing many competing demands. Additionally, the role of the NHS in the report is minimal and not a main focus, thus it may not be seen as a significant document. In the future it would be worthwhile carrying out a piece of policy research examining the influence of the Marmot Review (2010) on the HIs agenda across CCGs and their respective LAs.

11.3.4   What can CCGs do to tackle HIs?

The findings from this project have identified that the term HIs is convoluted; both organisational and individual interpretations are dependent upon the context within which individuals and organisations are working. Additionally, macro level policies that are constructed centrally, determine the practicalities and structures that allow policy to be implemented. Thus, how CCGs can tackle HIs is partly determined by centrally directed policies. For example, the current financial proposals (Pearce, 2013) that are being considered would enable financial resource to be provided based on population age rather than deprivation. Thus, CCGs providing services to deprived areas will not only be working with a challenging population, they will be doing so on restricted funds, and therefore tackling HIs will become more difficult on a stringent budget (Pearce, 2013, Bambra and Copeland, 2013). As argued, the duty and lack of definition that has been provided by the central policy makers has resulted in little guidance and structure for CCGs to try and challenge the issue. For the duty to have any significance it needs to be posed in a different manner. Firstly, the question 'what can CCGs do to tackle HIs?' needs to be asked. Policy makers need to examine what influence CCGs and the health service more widely could have on the issue of HIs. The literature (chapter 2) in this area states that the role of health services is minimal for tackling HIs. Marmot (2010) in his work Fair Society and Healthy Lives (the most recent work on HIs that has been acknowledged by the government) explains that it would be unrealistic to expect all inequalities to be removed, instead a more pragmatic approach needs to be adopted, by trying to reduce the social gradient of health (see chapter 3). Within the Marmot review there is little reference to what the health service can actually do to tackle HIs, instead it is acknowledged that HIs are part of the bigger picture, influenced by wider determinants (e.g. poverty

and housing). Marmot recognised that work carried out by the NHS will not be adequate enough to challenge HIs or reduce the gradient in health that is experienced by individuals. Of the six policy objectives that Marmot reflects on (see chapter 3) there is not one specific area that completely focuses on the work of the health service. Instead a prominence is placed on the PH prevention agenda and education across the life course. Healthcare was seen to have a role in both pre and post-natal interventions, to try and reduce any adverse effects that could occur both during and post pregnancy. There is little evidence in the literature that sheds light on the role of the health service for tackling HIs, with partnership working (Marks et al., 2011, Sullivan et al., 2004) and access to services seemingly to be the main way that health services can become involved with the HIs agenda. Although the literature indicates a minimal direct role for health services when trying to tackle HIs, this role needs to be clearly defined and articulated to health professionals and CCGs. Clear definitions and targets would allow CCGs to focus on specific elements of HIs that are relevant to them, enabling joint work to be carried out with local organisations and providing a framework for CCGs to operate within and focus on the HIs agenda.

11.4 What can CCGs do in the future?

11.4.1 Identify how they wish to work with Public Health

The important role of PH is a key finding from this project. The role that each PHC adopted in the three case study sites of a service provider (site one), co-owner (site two) or a critical friend (site three) has impacted on working relationships (both internal relationships and wider external relationships). The role of the PHC was also found to be influential on the HIs agenda as shown in site two, where co-ownership was being demonstrated. PH helped to shape the HIs agenda and had embedded PH support throughout the organisation. As discussed in chapter 10, the implications for the ways that CCGs choose to work with and establish their relationships with their PHC and the wider PH team can impact on the strategic direction of the organisation. Figure (22) summarises the findings from chapter 10 and the implications of the three roles identified in this project.

Public Health Role	Main Findings regarding the PH relationship	Recommendations
Site One: Service Provider	The relationship reflects the relationship structures in the NHS. There is no challenge to existing arrangements, the PHC is external to the decision making process.	CCGs will need to think about their external relationships and what they want from them. This process needs to be iterative to ensure that they are getting the support they require from PH. There is little opportunity to develop HIs agenda outside of the CCGs understandings knowledge of HIs.
Site Two: Co-owner	PH embedded in local decision making so unable to offer critique of agenda	Need to think about how the internal message will be carried forward when contracting work out to external organisations There is a risk that the CCG may become complacent with their work because PH is working closely with the CCG. They need to think of ways to ensure that the HIs agenda is challenged.
Site Three: Critical Friend	The CCG and PH work and operate separately. The CCG may struggle to grasp the HIs agenda because of the differences between the LA, the CCG and where PH is situated.	PH work may reflect LA ways of working because of the external role of PH. Therefore the CCG need to think about how they wish to utilise PH support and bridge the gap between the LA and CCG understandings of HIs.

These findings suggest an opportunity for CCGs to re-evaluate their working relationships, consider the dynamics they currently work within and how they want to utilise PH within their organisation. It would be far too simplistic to argue that these roles would be easy to establish; this project has demonstrated like others (Coleman et al., 2010) that history is influential in the establishment of relationships. Indeed, the concept of sensemaking emphasises how powerful unconscious assumptions based upon previous experiences can be. However, sensemaking also tells us that 'noticing cues' can be a trigger to initiating change (Weick, 1995). It could be argued, for example, that one of the reasons that each of the CCGs studied arrived at a different role and relationship with their PH team was because, at a time of great change and turmoil, this relationship was subject to little conscious sensemaking, rather developing automatically based upon historically-based assumptions ('schemata'). This research, if actively disseminated, has the potential to draw the attention of CCGs to this important relationship, providing a 'cue' to more active sensemaking by drawing the attention of CCGs to its central role in the drive to reduce inequalities. The different types of PH role offer different opportunities for tackling the HIs agenda and could help shape the strategic direction of the CCG over time; properly disseminated, this research could provide evidence to support CCGs in making a conscious choice rather than continuing with the role which has developed by default. I intend to work with my supervisors to consider how I might use their existing networks to support this dissemination. Further to this the Department of Health published a document outlining that PH had a responsibility to offer advice to CCGs. PH is to *"identify vulnerable populations, marginalised groups, and local HIs and advising on commissioning to meet the local health needs"* (p2) (Department of Health, 2011e). Thus, PH support is deemed as important for the HIs agenda in CCGs.

In an introduction to the Public Health Outcomes Framework 2013-2016 key objectives that PH will have to concentrate on within the designated timeframe were set out. The document clearly states that the role of PH is to:

"focus attention on reducing inequalities between people, communities and areas in our society" (Department of Health, 2012b)(p3)

In this document the vision of PH is outlined and underpinned by two objectives and four domains, consisting of indicators to monitor the progress of PH (see Figure 23 below). However, on closer examination of the framework it seems clear that HIs are simply added on to each of the objectives. There is not a separate objective for PH to focus on tackling HIs. This approach of including HIs within a larger agenda reflects the duty that has been imposed on CCGs to tackle HIs. The incorporation of HIs into all of the PH objectives could be interpreted as HIs being an important consideration in every outcome from PH. However, as discussed in section 11.3.1 of this chapter a broad approach to tackling HIs can become meaningless and without a clear strategy for tackling HIs, the task becomes a tick box exercise rather than a planned initiative to overcome the outlined problem. In practice this means that HIs are being acknowledged in wider initiatives but the duty to tackle HIs lacks both strategic direction and a practical objectives to fulfil. Thus, there is a danger that PH will assess

existing policies on how they tackle HIs rather than construct new policies to tackle the issue head on. Therefore, HIs work for both CCGs and PH could lack meaning and direction.

Vision: *"To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest".*

Outcome 1: Increased healthy life expectancy

Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities

Domain 1: Improving the wider determinants of health
Objective: Improvements against wider factors that affect health and wellbeing, and health inequalities

Domain 2: Health improvement

Objective: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Domain 3: Health protection
Objective: The population's health is protected from major incidents and other threats, while reducing health inequalities

Domain 4: Healthcare public health and preventing premature mortality
Objective: Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

11.4.2 Development of future relationships

Section 9.3 reflected on the relationships that CCGs held with their LA and how they were formulated based on history. Although, this has shaped how existing relationships have been developed it provides an opportunity of reflection for CCGs. CCGs are able to think about the relationship they hold with their LA, the problems they have faced during previous iterations of commissioning (PCTs, PBC etc) and how they wish to establish future relationships with other organisations. It could be argued that many relationships that have been influenced by history have little opportunity for change to be made. The findings from this project, suggest that a 'good' relationship with the LA was formulated by a practical relationship on the ground, whereby the CCG and LA were aware of how they wished to work together and in what context; this understanding of a 'good' relationship could be taken forward and introduced when trying to establish new working relationships. Under the current reforms, Health and Wellbeing Boards (HWBs) were also introduced and were in development at the time of data collection.

HWBs did not exist previously and the operation of the HWB was a new way of working for LAs and CCGs (see chapter 3). The relationship between CCGs and HWBs is more complicated than that with the LA. Governing body members of each CCG sit on the HWB (representing the CCG); they can actively take part in the HWB meetings and have a vote on the decisions being made by the HWB. The relationship is strategic in nature; the CCG has to take into account the JSNA when setting out their plans and be part of the development of the JHWS, a document the local HWB is responsible for, it sets the overall strategic direction for the health and wellbeing of the population locally. The JSNA is now to be co-produced by CCGs and the LA (Department of Health, 2013), focusing on the health and wellbeing of their local population. The HWB is able to challenge the CCG if the JSNA and has not been taken into consideration. Thus, the relationship has two main elements, CCG members are active HWB members working alongside the LA and the HWB has the power to challenge the CCG if strategic plans fail to reflect the needs of the local population. Although the relationship with the HWB is partly a strategic one, as CCGs develop they will need to think about how to ensure that the relationship is also practical. If the CCG and the HWBs are able to move beyond strategic thinking, making practical decisions they will be able to work jointly and co-operatively on the local shared agenda. Ensuring that practical elements of their strategic ideas are enacted, in turn providing an opportunity to tackle the local HIs agenda jointly. In the longer term, following the authorisation process and when initial formalities have ended, relationships will be based on what has been expected of them and their local contexts. Thus, the HIs agenda may become lost in the wider policy arena. If relationship dynamics are challenged when relationships are in early establishment, it will allow greater opportunity for relationship development and could have a significant impact on the HIs agenda.

11.5 Summary

In summary, the 'duty' placed on CCGs to tackle HIs has no meaning for CCGs. CCGs struggle to conceptualise HIs clearly which leads to a lack of clear progress being made on the HIs agenda. This research has highlighted that there are some underlying conditions (e.g. the CCG relationship with PH and the LA; and the influence of history) which partly explain the approaches taken (or not taken) to tackle HIs. The key finding from this research is that the relationship that CCGs hold with PH can have a significant impact on how CCGs conceptualise and tackle HIs in the future. CCGs within the current reforms have an opportunity to think about their relationship with PH, how they wish to utilise PH expertise helping shape how HIs are tackled, ensuring that they encapsulate both the health service and PH within the process. This project suggests that CCGs also have an opportunity to develop new working relationships with their local HWB to try and strategically and practically help tackle the HIs agenda. However, partnerships were found to be influenced by previous ways of working across organisations, therefore it is difficult to suggest how new relationships will be formed within areas that are influenced by local history and practices.

11.6 Strengths and Weaknesses of the study

11.6.1 Defending Qualitative Research

There have been many criticisms of qualitative research and those that are specific to this project briefly discussed later in this section. However, other qualitative researchers have identified that the traditional criteria for evaluating research projects is not necessarily applicable to qualitative research. Lincoln and Guba (1985) referred to the trustworthiness of research explaining that trustworthiness was the way to evaluate qualitative research to ensure that a 'trust value' can be identified focusing on its applicability, its consistency and its neutrality. Lincoln and Guba state that credibility, transferability, dependability and conformability are good measures of qualitative research. These measures are explained and described with reference to this project in figure (24) below.

	Meaning	In the context of this study
Credibility	To ensure that the subject is accurately identified and described.	The case study approach allowed the complexities of qualitative research to be incorporated into the project, methods of observation and interviews allowed key individuals to offer their opinions and thoughts to the project, whilst observations allowed individual behaviour and wider organisational plans to be monitored in real time. Therefore a number of different contexts were taken into consideration.
Transferability	Invite the reader of research to make connections between elements of the study and contexts relevant to them.	As stated above the results are contextual and therefore comparisons and analysis has only been conducted on the sites that have taken part in the study and therefore no wider generalisations are planned.
Dependability	Changes are made to the study to reflect changes in the phenomenon and context studied.	This study was adopted and changed to reflect the changing policy context, the title changed three times and the project was adapted to take into consideration different CCG formations and timings.
Conformability	Objectivity-control for bias of the research when analysing the findings.	Data analysis was iterative and findings were discussed with the wider research team to ensure that my interpretations were challenged ensuring that they reflected the data.

11.6.2 Generalisability

This is a small study, the findings from three case studies are difficult to legitimately generalise beyond the setting that the data has been collected in. For example, in site two the history of primary care commissioning and the population they served specifically influenced how they conceptualised HIs and planned to tackle them. Although, not necessarily generalisable, the in-depth, longitudinal approach has added depth to the findings. Additionally, meanings and values of both individuals and

organisations have been explored and examined to try and consider the original research statement 'exploring how CCGs are tackling HIs'. Further studies could helpfully follow up from these research findings and conclusions.

11.6.3   Limitations of the sample

It could be argued that the sample could be seen as a limitation of this study. The cases themselves were purposively sampled (see section 5.4), ensuring that influences on the HIs agenda such as population were taken into consideration at the outset of the study, allowing comparisons to made across the cases. However, it has to acknowledged that all three of the sites were based in the North of England and therefore wider factors such as the differences between the North and the South of England (a factor well researched in the HIs arena (Doran et al., 2004, Whitehead, 2011) and wider geographical factors could not be taken into consideration. Although this may be seen as a limitation of the research, in the context of a PhD project it has to be acknowledged that a large scale project using sites across the UK would have been beyond the means of a lone researcher. This limitation of the sample was inevitable, I reside in the North of England and to ensure that I could spend a good quality of time in each site they needed to be located within a geographical area that I could not only travel to but also commit to for the period of a year. For future work, this could be resolved by working in a larger research team where sites are shared and therefore geographical boundaries can be opened up to cover a larger footprint.

11.6.4   Limitations of analysis

The analysis process and the findings from this project can be argued to be contextual. The project was formulated and conducted at a time of change and upheaval in the NHS, CCGs were forming themselves based on Government guidelines and trying to prepare themselves for the official authorisation process. The findings from this project are specifically related to this time of transition and therefore are defined by the context that they were explored within. This is normally seen as a limitation of research; however in the context of policy research it has be acknowledged that it is a common problem that is part of the process. The policy process is dynamic and ever changing and therefore all data from specific time frames is contextual. For example Health Action Zones (HAZs) were introduced by the Labour Government to try and reduce HIs in specific areas of the UK. This policy lacked evaluation and time to be implemented on the ground. However, wider policy implementation still went ahead and research was conducted on this specific area, with comparisons and lessons learnt still being used today to explain current situations or occurrences' (Bauld et al., 2005). Thus, findings may be contextual but they provide information on a specific time in policy development, enabling key findings to be identified and carried forward to be compared in a different context and challenged in the future.

11.7 Reflexivity

When carrying out qualitative research over a longitudinal period it is important to ask the questions who am I? And how am I perceived? within the research setting. What impact did my presence have on the three sites where I was conducting research? In sites one and two, I found there to be little influence over the agenda and meetings. I found a place in meetings whereby CCG members were happy with my presence, conducting their meetings as normal. However, in site three my presence as a researcher was notable. It was interesting to see how CCG governing body members interacted with me both during and outside of CCG meetings. All CCG governing body members were aware of my project title and therefore knew what areas of their meetings would be of interest to me. Over time, as CCG members became more comfortable with my presence they would specifically refer to me in meetings when they thought they referring to elements of the HIs agenda. Therefore, my presence influenced how the HIs agenda was addressed in meetings. In practice, this would not have occurred if I was not there carrying out a study examining HIs.

Further to this, site three initially had outstanding criteria for HIs during their authorisation process. To try and overcome the outstanding criteria they submitted this project as evidence that they were thinking about the HIs agenda. Therefore, my non-participatory role was used to help evidence CCGs plans. It was clear that in both observations and interviews that I was viewed as the 'expert' in the area and therefore when asking how people understood the term HIs they often said you will know more about this than I will, thus my presence and investment in the project impacted on the dynamics of site three's meetings, their authorisation process and how they spoke about HIs in general.

When using a concept to underpin a research project, in this case sensemaking (Weick, 1995) it is important to reflect on the usefulness and purpose of the framework. Sensemaking was chosen to help examine the findings from this project for a number of reasons. In the literature there are few frameworks that regard history as an important factor that is able to influence current findings. However, the influence of history is well documented within the literature as being influential on the development of NHS organisations (Pope et al., 2006, Coleman et al., 2010). Therefore, to understand how new organisations were being constructed and where the HIs agenda sat within the formation of these organisations, history needed to be explored as an influential factor. At the time of fieldwork CCG governing body members were trying to make sense of the changing policy agenda and where they sat within this. Weick's concept explores how individuals and organisations make sense of changes as they are occurring, retrospectively comparing situations as they occur to those that have happened previously, thus new experiences are defined and shaped by what has been previously experienced. This concept fitted the project and the data that was obtained, allowing historical influences to be explored, examining their effect on relationships, organisation formation and the developing HIs agenda. The framework proved really useful and helped examine the key findings from the project, their development and their wider implications. The key issue regarding this framework is that sensemaking is largely subconscious, both individuals and organisations react to situations without any

formal rational process being implemented; therefore reactions to situations are often instinctive. This was visible in the findings from this research, CCGs were all experiencing the same policy changes; however, policy was interpreted and made 'sense' of differently based on their own experiences and knowledge.

11.8 Suggestions for future work

In an ideal world where timing and funding was not limited the whole study would be replicated to examine if the HIs agenda had developed in each site beyond the authorisation process and if so, how. This would help explore and examine the contextual element of this project, were the findings generated in this research an output of the timings of the research? Are past factors that have influenced HIs (i.e. HAZ models, Spearhead areas) still influential on the HIs agenda? Or does formal monitoring and CCG development still dominate the CCG agenda with HIs being an area of little concern? This would involve a replication of this study using the same three CCGs, examining the HIs agenda post authorisation. The use of interviews and observations would allow comparisons to be made across the different pieces of research, examining the impact of the changing contexts of CCGs on the HIs agenda.

Another area of future work is the role of PH; this is a key finding from this research. A future project could re-examine and explore the role of PH (and the PHC within this) further. The roles identified in this project of service provider, co-owner and critical friend (see chapter 10), although formulated in a piece of cross sectional research could have a longitudinal impact on the wider relationships that CCGs develop with other organisations and the HIs agenda. Therefore, this finding needs exploring further, in a variety of different CCGs to examine whether these roles are used in other CCGs and to concentrate on the long term impact that these roles can have for CCGs and the future of primary care commissioning.

11.9 Final Word

This has been a truly exciting and interesting three year project, which has enabled me to develop my research skills and understand the complexities of policy and primary care commissioning research. The findings from the project, although discussed with the wider research team are my interpretations of the data and knowledge of the CCGs that I developed over the eleven months of fieldwork. If others read my notes and attended the meetings I am sure they would interpret the findings differently, they are based on my understandings of the field, experiences of working with three different sites and the analytical approach that I adopted. Finally, I would again like to thank the three sites that welcomed me into their meetings and working lives at a time of upheaval and uncertainty; without the three sites this project would not have been developed and the final thesis would not have been possible.

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Appendices

Appendix One: Board Paper Spreadsheet

Site 1: Health Inequality Board Papers				
Report	**Date**	**Purpose of the paper**	**Implications for Access and inclusion**	**How does the proposal contribute to reducing health inequalities?**
Finance & Performance Committee	February 8th 2012	To summarise the year to date and forecast variances against budget and QIPP plans for the XXX CCG. To alert the CCG about providers' deficiencies in delivery of Operating Framework and contractual requirements.	No direct impact on access and inclusion	No direct impact on health inequalities
Chief Officer	February 8th 2012	To recommend changes to the XXX CCG board to enable it to lead an authorised CCG for XXX	Board representation of patient groups via establishment of a patient and public advisory group	No direct impact on health inequalities
	April 11th 2012	To update the board on the development of the constitution and associated documentation, including the inter practice agreement	No implications for access and inclusion	No direct impact on health inequalities
	May 9th 2012	To update the board on the development of the constitution and associated documentation, including the inter practice agreement	No implications for access and inclusion	No direct impact on health inequalities
DOPH	February 8th 2012	To update the CCG boards on the outcome of the VCS review following due consideration of all Equality Impact Assessments and service user consultation programme	Equality Impact Assessments underataken and reviewed for any impact on protected groups	Equality Impact Assessments undertaken and reviewed for any impact on protected groups

197

Communications and Engagement	February 8th 2012	To update the board on comms & enagagement activity to date and to outline plans for the first quarter of 2012	Potential positive impact on access and inclusion	Some of the work outlined will be of particular relevance to supporting self care and mangaing long term conditions
Chief Officer-Referral Gateway	February 8th 2012	To update Board on referral gateway activity	Significant as Gateway assists Organisation in getting patients to the right place as close to their home as possible	The Gateway allows the full range of services to be available to the population
	March 14th 2012	To update Board on referral gateway activity	Significant as Gateway assists Organisation in getting patients to the right place as close to their home as possible	The Gateway allows the full range of services to be available to the population
Planned Care	February 8th 2012	To update the board on the key work streams for planned care during the previous month.	Initiatives identified are intended to improve access to services and achieve consistent access to care pathways	The projects highlighted are intended to improve access to clinical effective pathways for the whole population.
	April 11th 2012	To update the board on the key work streams for planned care during the previous month.	Initiatives identified are intended to improve access to services and achieve consistent access to care pathways	The projects highlighted are intended to improve access to clinical effective pathways for the whole population.
CVD Programme Manager	February 8th 2012	To update the Board on key work areas associated with Long Term Conditions in XXX	Access to primary prevention and long term conditions management across communities will be improved (including promoting access to self care services)	The management of LTCs includes identifying patient at risk as well as those with a condition. Practices will be contacting patients that don't traditionally access services routinely, where diseases are prevalent.

			Access to primary prevention and long term conditions management across communities will be improved (including promoting access to self care services)	The management of LTCs includes identifying patient at risk as well as those with a condition. Practices will be contacting patients that don't traditionally access services routinely, where diseases are prevalent.
	March 14th 2012	To update the Board on key work areas associated with Long Term Conditions in XXX	Access to primary prevention and long term conditions management across communities will be improved (including promoting access to self care services)	The management of LTCs includes identifying patient at risk as well as those with a condition. Practices will be contacting patients that don't traditionally access services routinely, where diseases are prevalent.
	April 11th 2012	To update the Board on key work areas associated with Long Term Conditions in XXX	Access to primary prevention and long term conditions management across communities will be improved (including promoting access to self care services)	The management of LTCs includes identifying patient at risk as well as those with a condition. Practices will be contacting patients that don't traditionally access services routinely, where diseases are prevalent.
Chief Officer-OD Plan	March 14th 2012	To agree the Organisational Development Plan for the CCG	The Organisational Development Plan reinforces this as part of the CCG's Commissioning Strategy and its values	The Organisational Development Plan reinforces this as part of the CCG's Commissioning Strategy and its values
Finance Directorate Month	March 14th 2012	To summarise the year to date variances for the XXX CCG and highlight the key areas where the forecast outturn is not expected to be in line 2011/12 budget	No direct impact on access and inclusion.	No direct impact on health inequalities.
	April 11th 2012	To summarise the year to date variances for the XXX CCG and highlight the key areas where the forecast outturn is not expected to be in line 2011/12 budget	No direct impact on access and inclusion.	No direct impact on health inequalities.
	May 9th 2012	To summarise the year to date variances for the XXX CCG and highlight the key areas where the forecast outturn is not expected to be in line 2011/12 budget	No direct impact on access and inclusion.	No direct impact on health inequalities.

Governance Sub-Group	March 14th 2012	To outline a proposed process for identifying and dealing with practice variation	Tackling variation will support key practices to improve the care they provide to patients, which will reduce current barriers to equitable access to quality care.	The report deals with variations in the way patients are managed and therefore contributes towards reducing health inequalities.
Locality Director of Finance	April 11th 2012	To update the CCG on the development of financial plans for NHS XXX and the further action required to agree budgets at CCG and practice level		
Finance Directorate	April 11th 2012	To outline a range of options for the CCG with respect to the practice level budget setting process for 2012/13 and to support the F&P Committee in making a recommendation to the Board for approval in March 2012.	No direct impact on access and inclusion.	No direct impact on health inequalities.
NE Sector Commissioning Board	May 9th 2012		N/A	N/A
Senior Commissioning Managers	May 9th 2012	To update the Board on key work areas associated with Urgent and Integrated Care in XXX	Access to primary prevention and long term conditions management across communities will be improved (including promoting access to self care services)	The management of LTCs includes identifying patient at risk as well as those with a condition. Practices will be contacting patients that don't traditionally access services routinely, where diseases are prevalent.

Appendix Two: Information Sheet

MANCHESTER
1824

The University
of Manchester

RESEARCH PROJECT INFORMATION SHEET

Exploring how Clinical Commissioning Groups are tackling health inequalities

Introduction

You and your colleagues are invited to take part in a PhD research study investigating Clinical Commissioning Groups and health inequalities being conducted by a single researcher from the University of Manchester. Before you decide whether you wish to take part in the research project it is important that you read through the following information so that you are aware of what the research involves and what is expected of you if you do decide to take part. Please feel free to contact the researcher if you wish to receive any more information or if you have any queries.

The Overall Study

The purpose of the study is to focus on the newly forming Clinical Commissioning Groups to see how they are tackling health inequalities in their area.

The main research questions that are being addressed by the study are:

- What are newly established Clinical Commissioning Groups doing to tackle health inequality?
- What are the implicit programme theories underlying the decision making processes carried out by Clinical Commissioning Groups when addressing health inequalities?
- What are the contextual factors influencing the approaches taken by Clinical Commissioning Groups to tackle health inequalities?

Research Design

Three case studies will be carried out running parallel alongside each other for a period of approximately 12-18 months from autumn 2011. Each case study will be based upon a Clinical Commissioning Group (CCG). The data collection methods will be qualitative, consisting mainly of observations e.g. meetings of CCGs, meetings between CCGs and other groups etc as well as interviews (with key individuals from the CCG and other associated organisations) and analyses of any available documentation. Observations of meetings will be recorded in the form of written notes by the researcher and typed up after the event. Interviews will be audio-recorded with consent and transcribed. If people do not offer consent hand written notes will be taken throughout the interview. I

will also seek to collect documents that are related to health inequalities along with documents that are related to the meetings that have been observed.

Confidentiality, safety and ethics

Information that is gained from observations, interviews and documents will be combined and used for the PhD thesis as well as conference presentations and potentially academic journal papers. The final study report will be available for all organisations that took part in the research. All findings will be reported anonymously, without any individual's names or names of the organisations being included. All information will be stored securely and coded ensuring that confidentiality and anonymity is kept at all times. Ethical approval will gained from the University of Manchester Ethics Committee, as well as research governance from the appropriate sites before the study will take place.

Contact for further information

If you have any queries about the study or would like more information, please contact:

- Lynsey Warwick-Giles lynsey.warwick@postgrad.manchester.ac.uk
- Dr Kath Checkland Katherine.checkland@manchester.ac.uk (lead supervisor)
- Dr Anna Coleman anna.coleman@manchester.ac.uk (co-supervisor)

Contact address:

Health Policy, Politics & Organisation Research Group

School of Community-based Medicine

Fifth Floor, Williamson Building

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Oxford Road, M13 9PL

Tel: 0161 275 7601

Appendix Three: Consent Form

Health Policy, Politics & Organisation Research Group (HiPPO)

5th Floor Williamson Building, Oxford Road

University of Manchester

Manchester M13 9PL

Tel: +44(0)161 275 7601

Fax: +44(0)161 275 7600

Title of the project: An exploration of how Clinical Commissioning Groups are tackling health inequalities

Name of principal researcher: Lynsey Warwick-Giles

Please <u>tick</u> the box if you agree with the

1.   I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions

2.   I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my or my organisation's involvement in the project being affected in any way

3.   I understand that I will be asked if I want to give consent to the interview being taped and transcribed. I do not have to say yes to be interviewed.

4.   I agree to the use of anonymised quotations from interviews being reported in research reports, journal articles, and presentations.

5.   I agree to take part in the above study

_____   _____   _____

Name of Participant   Date   Signature

_____   _____   _____

Researcher   Date

Please complete both copies of the consent form (keeping one for your own records)

Appendix Four: Interview Topic Guide

'An exploration of how Clinical Commissioning Groups are tackling health inequalities'

Person Profile

- Who are they, what is their job title? (Background / experience)

- How did they become involved with CCGs?

- What does their job role (with the CCG) entail? How many hours a week do you work for the CCG?

- How is the role developing within the CCG? / What do you think your role is within the CCG?

CCG Development and Commissioning

- What is the structure of the CCG? (Board, committees, localities etc)

- What made them go for this particular structure? (PHs involvement and role)

- How are Board/ Governing Body members being paid for their work?

- How is the development of localities going? What are they based on? What powers do localities have? (Delegated budgets)

- Is there anything in place that is focusing on GP and Practice engagement? If so what…

- Does this structure fit with any historical configurations eg GPFHs, PCG/Ts, PBC

- Apart from yourself who sits on the CCG Board/Governing Body? (GPs, officers, PMs, nurses etc)

- What are the CCGs current commissioning priorities for their local population? Where does the provision lie in house or CSS?

- Where do health inequalities fall into commissioning priorities? (If at all)

Health Inequalities

- What is your understanding of health inequalities? What is their justification for this?

- What is their role in relation to health inequalities? (new role or previously existing role. Formal/informal, no role)

- What is being done to tackle health inequalities? (ask for specific examples, is this something new or existing to respond to policy?)

- Why was this route chosen to tackle health inequalities? How was it decided upon? (Duty, commitment, belief etc)

- Do they monitor and measure health inequality initiatives and if so how? If so who provides the oversight and in what way? (NHSCB)

- XXX: There is a section on the board papers relating to health inequalities and access. What is the purpose of it and do you find it useful?

- Are there any specific issues locally that you can point to which have helped / hindered with a) getting HIs onto agendas   b) tackling HIs

- How will success in tackling health inequalities be measured? (long and short-term measures/ use of proxy indicators?)

<u>Wider relationships</u>

- What relationship do they / the CCG have with Health and Wellbeing Boards (HWB)?
- What role do they or others play on HWB's?
- What is your their of involvement with HWBs? (individual or organisational involvement)
- How does the CCG fit in with the HWB and the Health and Wellbeing Strategy?
- Do they have any relationships with any other specific individuals/ organisations relating to health inequalities? (Directly/indirectly e.g. public health, JSNA. Are these relationships new or have they previously worked together? How do the relationships work?
- Who would you say are your main partners in trying to tackle health inequalities locally? (LA, PH, HWB, other CCGs, etc)
- How does the CCG use information from the JSNA?

<u>Concluding Q's</u>

Anything you expected me to ask which I haven't or anything you'd like to add?

Interview Site One ID1

I Just to start are you ok to introduce yourself and say what your job title is?

R Yeah, I'm XXX XXX. I'm a general practitioner in XXX and I am the vice chair of XXX CCG.

I and how did you become involved with the CCG?

R ok I was asked to become involved by some of the existing members..almost two years ago now. I was hesitant of getting involved, I'd been involved in the previous carnation which was the PCT, I was peck chair for a number of years. So I had experience of that sort of work. When XXX and XXX were putting the shadow board together they asked me if I would be interested and I went forward. Little bit ambivalently I have to say and I am still here two years later. But I'm at the moment considering you know whether to stay involved to be honest so that's my current state.

I is it just the experience of the changes and the things like that?

R you mean the reason why I'm ambivalent?

I yeah.

R a lot of it is to do with the fact that we are going through another reorganisation you know. Another set of reorganisations and another set of establishments another body and I see that as a rather wasteful use of resources and time to be honest with you. And doing all of that hacks me off to be honest. It's not interesting and it's not productive, it just has to be done. It's been done three of four times so you know then thing that you are talking about today which is addressing health inequalities I think we have hardly touched upon it as we are trying to form ourselves as an organisation.

I so what does your job your role entail within the CCG? You have mentioned that you are vice chair.

R yeah that's the kind of the official bit that I will be deputising for the chair when he's not around. Turning up for meetings which are to do with organisation development really but I think my real role is my clinical role. Which is about chronic disease management and long term conditions. So looking at diabetes and looking at neighbourhood teams which is to do with long term conditions trying to keep people out of hospital who have multiple morbidities. Trying to draw people in from the mental health side, people from district nursing, perhaps health visiting, social work to sort of look at these groups of people who consume a lot of resources, who have poor health outcomes. Then the other traditional sort of chronic diseases you've got diabetes, COPD and that kind of thing looking at developing services for that group of patients as well.

I you've mentioned that your time currently as a board has been sorting out things, but how do you think your role will develop within the CCG?

R it may not develop as I have not decided whether to continue with it. I think the end of this year the beginning of next, probably April 2013 when we are authorised that would be an appropriate junction to decide whether to carry on with it on not…yeah.

I so what is the current structure of the CCG at the moment? I know you've got your board and patches. What else in terms of the structure of the CCG have you got.
R yeah good question, it's all written down and I am not even sure I could recall it from the top of my head. So we have an executive group which I am part of. I mean we have only reconstituted it since August which we are now still in aren't we so we have only just put together the new structure. As you say we have the board, the patch chairs and we have the area divided up into three geographical patches and we have an executive group and a group below that. Then we will have things like an audit committee which is being set up and we already have a finance commissioning group. We have a prescribing subgroup so we have a number of sub groups that feed into the board.

I ok. So is there any particular reason why you went for the particular structure that you have gone for? Is it based on past organisations?

R it is probably based on a template that has been provided by the Department of Health saying this is what a typical CCG would look like. The theory is that it is a group made up of its constituent practices then that is where the patch structure comes from. So each practice is part of a patch and each patch feeds into the board.

I and how is the development of the patches going?

R well the patches are reasonably well developed because they go back a couple of years. They've got well established meetings which are pretty much mandatory. So the practices have to attend those and get paid for attending. So those happen monthly bar August as we have a lull. But we have a fairly established patch structure which practices will be in the habit of going to.

I and what are they based on?

R well they are a mixture they are divided into business, CCG business and clinical topics.

I right ok.

R ok so you might have a typical patch meeting that updates people on the arrangements of the board informing them that we have got some new members or we are having to do X, Y and Z this month. So they will be part of that. So the patch chair is a GP and a member of the board and the other person who is in parallel with that is one of the management staff not from the board but the CCG. So they will have a mixture of business and a mixture of clinical. So for instance looking at atrial fibrillation and looking at the way of improving care for people with atrial fibrillation because what we know is that a good number of them aren't treated up to current standard they haven't had echoes. So it's about raising standards in clinical care which I guess it's the bit that clinicians will mainly come along for.

I do the patches hold any power within the CCG?

R Well the GPs are voted on by their peers so in that sense yes. But as patches not really no.

I right ok. You have obviously mentioned the patches but is there anything that the CCGs are specifically doing looking at GP and practice engagement?

R it's got plans but I'm not sure whether they have carried it out yet. I mean we have a referral gateway as you are probably aware. So all the referrals that GPs generate go through a process where it's really reviewed by their peers. A big part of that is to use resources effectively so some referrals will be redirected to a more appropriate service so for instance the CATS service that is historically underused, you may redirect a referral that may have ended up in the local trust to CATS. Or you may use a tier two or you may actually refer the referral back to the GP and say have you thought of this or that. So there is some of that going on and that will inform clinical governance. So there may be a particular issue with a particular practice or a particular service like dermatology say as we had to reconfigure that recently. I forgot what the question was now, remind me.

I practice engagement.

R yeah I mean that there are some topics that are stand alone outside of the patches that we are trying to engage practices with like diabetes. We have a new professor in diabetes at the local trust who has been coming out and delivering an educational package over a series of meetings. So that's another engagement. I mean what we are gonna look at, two big areas I suppose we are gonna look at in the future is neighbourhood teams which will involve the whole of the XXX patch.

I does that include the local authority?

R that will include the local authority yeah. So we will need engagement for that which has started in a small way. The other one is to look at poorly performing practices which is the other side to it I suppose. So we are looking at poorly performing practices who on a number of indices who are not

performing as good as their peers. So maybe going in and doing some work in those practices. That's in its early stages yeah.

I and apart from yourself who sits on the CCG board?

R do you want me to name them?

I roles?

R It is down on some piece of paper somewhere it is not in my head. We have a chief officer, GP chair, etc etc.

I have you got a new chair recently that has been appointed?

R well we have a lay chair now. We've got XXX I forget his surname… who is our new lay chair. We have just appointed our two new lay members. I know XXX from PCT days and for part of his time he was chair of our PCT. I have forgotten the name of the other lady as she has only been to one meeting. So we've appointed the two new lay members and I think we have appointed the nurse. Although there was some difficulties with that. We certainly have not appointed the consultant because of the lack of clarity of where they can come from. As you probably know we are not supposed to appoint someone who has any kind of relationship with the CCG. We commission with loads of trusts so that's more difficult for us.

I narrower niche to find someone.

R yeah we will have to go further a field and then if you go further a field you know a then you have problems of can they get to your meetings if they are based in you know XXX or somewhere and what relevance might they offer if they aren't familiar with the local set up. So that's another one, I think that was kind of an afterthought to stick a nurse and consultant on the board.

I yeah I think that came from the listening exercise.

R in my view anyway yeah.

I what are the current commissioning priorities for the CCG for their local population?

R right ok, I suppose in a nutshell we've got an area of poor health outcomes so we've got very deprived area with high rates of typical things, cardiovascular disease, high rates of cancers particularly lung cancer. High incidents of drug and alcohol misuse and the problems that are related to that. Mental health problems including suicide and violent death in our sort of young men. Infectious

diseases including HIV which is a problem locally. Blood born viruses including hepatitis C and all those kinds of things that you associate with deprivation.

I so you've mentioned deprivation. Where do you think health inequalities fall in terms of commissioning for the population?

R well we'll say that we are concerned about that but I can't honestly say how we've tried to tackle it. I mean our agenda is that our population in XXX is uniformly deprived. XXX does not have any pockets of affluence so you can't say that we would like make everyone as healthy as people living in X because there is not and X. We might say we want to bring our population up to nearer the England average or nearer the XXX average. But that is not a fantastic comparison because the XXX itself is a deprived area. So we would say thinks like that we want to improve the health of our population because we look after a deprived, disadvantaged group. But, I'd be hard pushed to prove to you that we've actually set out to demonstrate how we are going to do that. I think it's very difficult as the rest of the health of people who are healthier than our population is probably moving up slowly in the same direction so we in a sense don't get any nearer to it.

I what is your understanding of health inequalities?

R simply that certain sections of society have poorer health outcomes than others.

I and what is your role in relation to health inequalities?

R I don't have a specific role, no.

I you've mentioned that you don't think there is anything you can specifically say, are there any schemes that have been mentioned by the CCG in terms of tackling health inequalities.

R they don't come to mind immediately no. I mean anything we do should be to improve the health of our local population but how that relates specifically to reducing health inequalities I'm not sure. I find that difficult to answer. I mean if we were to improve the outcomes for our population in terms of cardiovascular mortality then that would give our population a boost up the league table so to speak. But that will probably be happening in other areas so it is difficult to pin down is not it.

I I have noticed from my observations of board meetings that there have been discussions around access to primary care. Is that from a health inequalities point of view or is more political, well I know that overview and scrutiny have been involved. What angle is that being looked at from?

R several angles I mean the sharpest angle is that the local councillors in XXX have got an issue with closing the walk in centre in XXX. They wanted to see that access to GPs was good before that walk in

centre was closed because their perception would be anecdotally and to some extent they may have a case that people in the area were telling them that it was hard to access GPs. So the walk in centre if you like was an add on an easier way for people to access primary care. So they said to us if you want to close the walk in centre you are going to have to prove to us that access is adequate. Now that's difficult to do because if you, if your evidence is that people say that it is hard to get an appointment with a GP then I think that it is difficult to change. There will always be someone who says they couldn't get an appointment with their GP. We did a survey which showed mixed results and that is a couple of months out of date now and we are hoping to repeat that. But I mean a lot of our surgeries have signed up to LES's and DES's around access so in theory they should be doing that anyway because it is part of their contract. For a while now the government has pushed access to GPs etc we know that a lot of our population will use the A&E department sometimes for primary care. We know that sometimes people pitch up in hospital with things that maybe should be coming to primary care. We know that sometimes some people are diagnosed with quite serious conditions like lung cancer or heart disease by turning up to hospital. So there may be an issue there about access but it is not straight forward. It is not as straight forward as saying you know that I couldn't get an appointment with a GP it is about people's behaviour, lifestyle behaviour whether they actually go to see a doctor early on or whether they delay things and wait and wait. So I don't think there is a direct correlation necessarily to access to GPs and health inequalities because that is far too simplistic a view. It is due to lots of other things like lifestyle, poverty, smoking, rates of alcohol consumption, access not access but use of screening programmes and all that kind of stuff.

I you mentioned turning up and using A&E where primary care could be used. Is anything being done in sense to deal with that?

R well GPs are encouraged to reflect on that and reflect on their data and hopefully try and look at their practices and make access easier for their patients.

I it's not straight forward though is it? You cannot stop someone turning up to A&E.

R yeah well there has always been various initiatives around people getting to practices usually. And I think one of the ones we have signed up to at the moment is sort of an instant access LES for the ambulance service and for A&E to actually have a practice number to ring and say look your patients called an ambulance or has pitched up to A&E it sounds like it is more appropriate for you to see them. Can they come down and see you this afternoon? So we have signed up to that although it does not seem to be used quite often so I don't actually know how useful that has been. Sorry remind me what the question was again. I have gone off on a tangent.

I no, no you are fine. We were looking at specific things to tackle health inequalities and I was asking about access only because I have observed the discussions in meetings.

R yeah.

I in terms of the board meetings I have noticed on the front of the board papers there is a section saying how does this paper relate to health inequalities.

R that's right.

I and access. Do you think they are well used or do they have a purpose?

R no it's just a tick box. It does not dictate which papers come. It is just on the front there to as an aid memoir and I suppose the theory is if it does not tick any of those boxes why is it coming to the board. You know…it could be a paper about the audit committee which does not tick any of those boxes on the front but they still come to the board because they have to.

I is there anything that you can think of locally that helped or hindered getting health inequalities onto the agenda?

R yeah I mean it's probably not the right question in a way. It's on the agenda, everyone is aware of it. I mean you would have to be blind and deaf to work in XXX and not see that you are working with a population that has poor health. I think the problem is you know that you are running to a stand still just to serve it you know. On a busy wet Tuesday you are seeing people come through the door as a GP and probably the same if you are a doctor in the accident and emergency department.

I yes.

R I mean the board is the place where it should be reflected upon and we should be coming up with ideas of how we can deal with that. But I mean we are looking at a shrinking resource so I'm not optimistic that it is going to change. I mean in the next few years if you look at it and analyse it, it would probably get a bit worse rather than better.

I ok. In what way do you think it will get worse? Just due do shrinking staff members?

R I'm not, I'm not convinced that the reorganisation is actually gonna give us a better health outcome. I think if you, it's very hard we talk about QIPP don't we? Improving quality on less resource. What were we doing with the money before you know if we are gonna have less of it I think you have to be very clever and very smart to improve outcomes on a dwindling resource as well as cutting management. So I think that any hard analysis of the next few years when you have a reorganisation which is unproven and a dwindling resource, you'll be doing well to stand still I think.

I yes, that's fine.

R I'm not being pessimistic I'm just being realistic.

I no that's fine. What relationship does the CCG have with the health and wellbeing board?

R I don't know I mean I have not been involved with that area so much.

I that's fine.

R I'm sure that XXX or XXX would answer that question better than me.

I more in their area. Are you aware if the CCG fits in with the health and wellbeing strategy or has that not been brought to board or anything yet?

R I wouldn't know a health and wellbeing strategy is to be honest.

I that's ok. Are you aware how is the information from the JSNA used by the CCG?

R I don't know.

I that's fine. Who would you say are your main partners in terms of the CCG in terms of tackling health inequalities?

R yeah I think local authority probably. Local authority and our local hospitals.

I are the relationships in place with the organisations at the moment in terms of health inequalities? I know you obviously have relationships with the organisations.

R yeah I mean the two I mentioned I mean the relationships with the local authority are probably as good as they have ever been because we are tasked to bring in neighbourhood teams and look at long term conditions. So the relationships are pretty good on the back of that. That's not to say say the task is easy but the relationship is good. And the relationships with the local trust are probably as good as they have ever been, because we meet them on a regular basis with the commissioning agenda. So again those relationships are good that again that does not equate to you know better commissioning or better care. But certainly the relationships are good because the changes are focusing people's minds.

I Yes. Ok and that is everything thank you.

Appendix Six: Emerging Codes for Analysis

Code	Meaning/application
Performance	References to performance
QIPP	Any reference to QIPP plans or processes
Governance	References to governance
Quality	
Locality/Patch	Any reference to localities and patches
Patient Engagement/Community Engagement	Any reference to engagement
Health and Wellbeing Strategy	Any reference to the Health and Wellbeing Strategy
Service Re-design	Reference to service re-design
Authorisation	Anything relating to getting authorised and the authorisation process. Including specific job roles and formalities
Finance	Any reference to finances including the cost of services
Risk	Any reference to risk for the CCG
Reorganisation	
Clinical Support Services	Any reference to clinical support services
JSNA	Any reference to the existing or new JSNA
Contracts	Any reference to contracts
OD Plan	Organisational Development Plan
Integration	Any reference to service integration
Health Inequalities-Access to services	Access to wider services not primary care e.g. bereavement services
Health Inequalities-Access to Primary Care	Access to Primary Care – Doctors appointments. Doctors surgeries
Health Inequalities- Wider Determinants of Health	Any reference or discussion using the terminology WDOH.
Health Inequalities-Decision Making	Reference to health inequalities being mentioned relating to decision making processes
Health Inequalities-Partnerships	Reference to working with other groups/organisations with regards to health inequalities
Health Inequalities-Barriers to health	Reference to barriers of health e.g. public transport
Health Inequalities-Education	Reference to education in terms of understanding health and knowledge of health
Health Inequalities-Behaviour Change	Reference to changing behaviours with regards to health inequalities
Health Inequalities-Medicine Usage/Prescribing	Reference to medicine use/knowledge with regards to health inequalities i.e. certain groups more likely to ask for specific medication.
Health Inequalities-Improvement/Prevention	Reference to improving health and preventing illness to reduce health inequalities
Health Inequalities-Variation	Any reference to variation linked with health inequalities e.g. practice variation
Health Inequalities-Other	Anything relating to health inequalities that are not included in the above sections
External Relationships with Public Health	Anything relating to the CCGs external relationships with these groups
External Relationships with Local Authority	
External Relationships with Health and Wellbeing Board	
External Relationships with Providers	
External Relationships with other CCGs	
Roles- Formal Roles	Formal Roles related to Health Inequalities
Roles-Informal Roles	Informal Roles relating to Health Inequalities (people do things when they don't have to).
Staffing Structures	Any reference made to the staffing changes of the CCG
Equity	When the CCGs make reference to equity
Role as a researcher	When I am clearly brought/referenced in the meeting

Health inequalities-Equality Impact Assessment	Site 3-when the EIA are referenced with relation to HIs
Health inequalities-Gaps in Service	When a gap in service is highlight as an inequality
Joint Commissioning	
Transition	Reference to the shadow year and period of transition
Membership Organisation	Working on being a member organisation
Practice Engagement	
Joint Commissioning	
Sustainability	

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