NHS Health Scotland
Annual Report
2015/16

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NHS Health Scotland is a WHO Collaborating Centre for Health Promotion and Public Health Development.

Contents

Chair's statement

Welcome to NHS Health Scotland's 2015/16 Annual Report, the first since I took over as Chair on 1 December 2016. Our collective thanks go to my predecessor Margaret Burns OBE, whose eight years in post saw a transformation in Health Scotland's role and impact. She ensured a smooth handover when I joined and left the organisation in fine fettle. I am most grateful for that.

I joined Health Scotland from a non-NHS background and have had to learn a great deal very quickly about the organisation and what we do. Three things have struck me very clearly. One is the value of the robust evidence we provide and analysis we carry out to improve understanding of the causes and consequences of health inequalities. For example, our work on Monitoring and Evaluating Scotland's Alcohol Strategy has had a major influence on alcohol policy, including supporting the case for Minimum Unit Pricing. It is just one example of our great strength in Public Health Science.

Second, I have been impressed by how well we convert our knowledge into practical support for our many partners in tackling inequalities. One of my first duties was to help launch the Place Standard, a tool to help communities shape their environment to better support their health and wellbeing.

Our health and work service provides practical advice to a growing number of employers on creating a healthy working environment.

Our events are always thought provoking and well attended, highlights include our conferences on adverse childhood events and on the impact of welfare reform on health, both attended by Professor Sir Michael Marmot.

And third, the skills of our staff are outstanding. They apply deep, objective knowledge to a compelling sense of mission – a combination that gives me great confidence in our work and impact.

The year ahead is likely to see exciting changes in how population health and wellbeing are delivered in Scotland. We welcome these changes, we will do whatever we can to ensure their success, and we will continue our commitment to delivering a Fairer Healthier Scotland.

Chief Executive's introduction

2015/16, the penultimate year of our five-year strategy A Fairer Healthier Scotland saw us deliver a strong performance with an increased focus on describing our impact and the difference we make.

We made a significant leadership contribution to building stronger support for action to reduce health inequalities. In particular we have been able to track our impact on the public and policy discourse about health inequalities and the link between fairness and health.

But we have not simply been reiterating a description of the problem of health inequalities – we also demonstrated the value of investment in upstream measures and prevention through our Triple I report and in our Economics of Prevention briefing, our events and our learning exchanges.

Our work on the impact of place on health in communities was launched with the Place Standard and the Place Standard tool, both of which provide a strong platform for engaging local government and the third sector in place-based approaches to improving the public's health.

We have reviewed our progress in implementing A Fairer Healthier Scotland and undertaken a significant engagement with our key stakeholders.

As we begin planning for the next five years we have consulted on how we can best build on the progress we have made in establishing the case for concerted action to tackle the persistent health inequalities in Scotland.

This Annual Report illustrates examples of our work and as we move forward, provides a strong foundation to progress beyond establishing the case for change, but to deliver the concerted action to tackle inequalities and improve health.

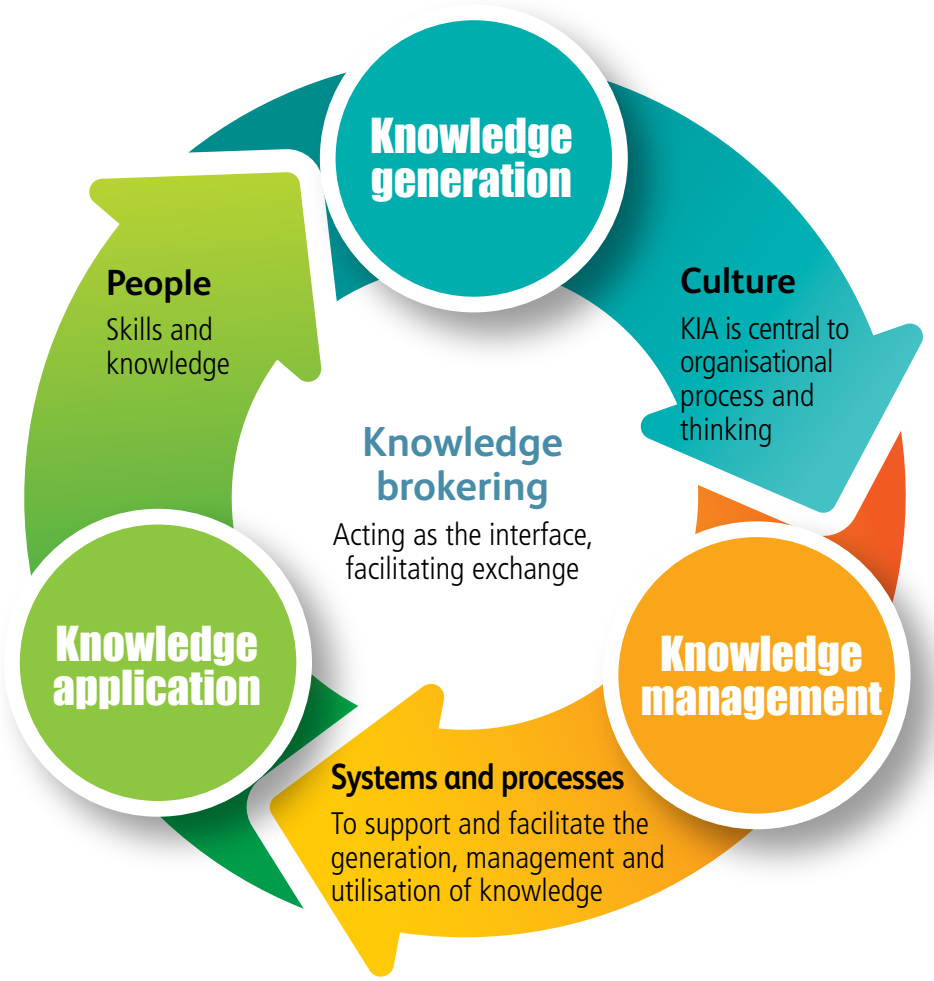
Who we are

NHS Health Scotland is a national Health Board working with public, private and third sector organisations to reduce health inequalities and improve health. Our primary role is to work with others to generate and share the knowledge of what works, and doesn't work, and to improve how that knowledge is turned into action. The Knowledge into Action (KIA) model we use is shown in the figure opposite.

Our strategy, *A Fairer Healthier Scotland*, sets out a vision for Scotland in which all people and communities have a fairer share of the opportunities, resources and confidence to live longer, healthier lives. Our work is designed to align and contribute to the Scottish Government's national outcomes, which are set out in the National Performance Framework. In particular its commitment to equality and fairness, and ultimately its purpose of creating an inclusive, economically vibrant Scotland.

We know that many organisations and individuals share our vision of a fairer, healthier Scotland and that many make a vital contribution to improving population health and wellbeing.

That's why we focus on working with the policy- and decision-makers responsible for the quality of the places people live, where they work, their income, social support and the access they have to the NHS and other public services. It's why our health information and marketing materials are designed to be accessible to all groups and communities.



KIA model: KIA is a complete cyclical process and involves knowledge generation, synthesis, dissemination, translation and application. It is important that all of these processes work together to effectively influence informing policy and practice.

Our performance – at a glance

Our contribution to Local Delivery Plan standards

Early access to antenatal care

100%

uptake from regional Health Boards for *Off to a Good Start*

Smoking cessation

33,838

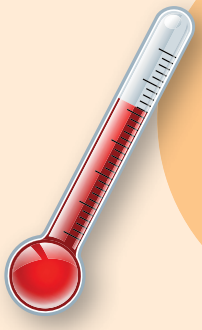
copies of *How to Stop Smoking and Stay Stopped* distributed

Alcohol brief interventions

5,493

Alcohol brief interventions primary care pack distributed

Our sickness absence rate



3.25%

which is below the target of 4%

People and performance

eKSF & PDP

Reached our

90%

target of completed eKSF and PDPs

Total print budget for year

Achieved

£49,456

in efficiency savings, a saving of 6.08%

We met the efficiency saving target of £1.050m

Progress against our Annual Review Action Plan

The graphic opposite describes the key themes highlighted in our 2014/15 Annual Review and our progress in implementing actions relating to these themes. The graphic highlights that we have achieved, or largely achieved, the actions detailed in our Annual Review Action Plan.

Further information on the actions detailed on the Annual Review Action Plan and our progress can be found in our self-assessment report available via NHS Health Scotland's website.

Demonstrating our impact

Our work is structured around five core programmes (four external and one internal).

1. fundamental causes
2. social and physical environments for health
3. system change for health equity
4. the right of every child to good health
5. organisational excellence and innovation.

The four external core programmes incorporate focused action in relation to the places that people work, where they live and the quality of public services they access. They are based on what the available evidence indicates would be most effective to fairly improve health in Scotland. The diagram below gives a summary of some of our work on the four external core programmes in 2015/16 and the section that follows provides further detail on each.

Examples of impact 2015/16

Core programme 1: Making work better for health and wellbeing: We drove the adoption of **Good Work** principles in the fair work recommendations, and we will deliver on these recommendations in 2016/17.

Core programme 2: Improving neighbourhoods and communities: We successfully delivered and launched the **Place Standard**, and we will lead on its implementation in 2016/17.

Core programme 2: Reducing the health impact and inequalities associated with crime: We helped shape a **Community Justice** improvement framework for community planning partners.

Core programme 3: Improving physical health of people with illness: We targeted key partners to build awareness and make plans to improve the **physical health of people with mental illness**.

Core programme 4: Reducing the rate of teenage pregnancy: We worked with the Scottish Government policy team to develop Scotland's first strategy focused on **pregnancy and parenthood in young people**.

Core programme 4: Improving awareness of **child poverty, health and wellbeing**: We helped introduce an e-learning module for a range of people working with children.

Core programme 1: Fundamental causes

Good work

Good work was one of our identified corporate priorities for 2015/16, as being in work has the potential to improve health. However, jobs that don't protect against poverty, offer limited freedom/discretion and increase the risks to mental or physical health can be as bad for health as unemployment. The Marmot review (2010) argued that to reduce health inequalities 'jobs need to be sustainable and offer a minimum level of quality … getting people off benefits and into low-paid, insecure and health-damaging work is not a desirable option'. Paid employment is not a guaranteed route out of poverty. Around 30% of those moving into employment remain in poverty.

Our two key ambitions were to:

1. align the 'fair'/'good' work agenda with health inequalities
2. get health inequalities recognised as a key consideration of a good work concept.

Actions were identified at both the national and local level. Nationally, we contributed evidence to the Fair Work Convention, such as Good Work data and research of what works, as well as the health inequalities briefing *Good Work for All*, which was well received by partners. Locally, we focused on working with the social care sector, as our early research highlighted that the caring and personal service occupation group has low unemployment but also suffers from a lack of hours, instability, a high accident rate and low control.

Impact

As a result of our work, the Fair Work Convention has reflected on our evidence in the *Fair Work Framework*, which was published in March 2016. We have built capacity into our 2016/17 plans to carry out work to be agreed with the new Fair Work Directorate within Scottish Government. This provides us with an opportunity to influence wider causes of health inequalities through a new governmental department.

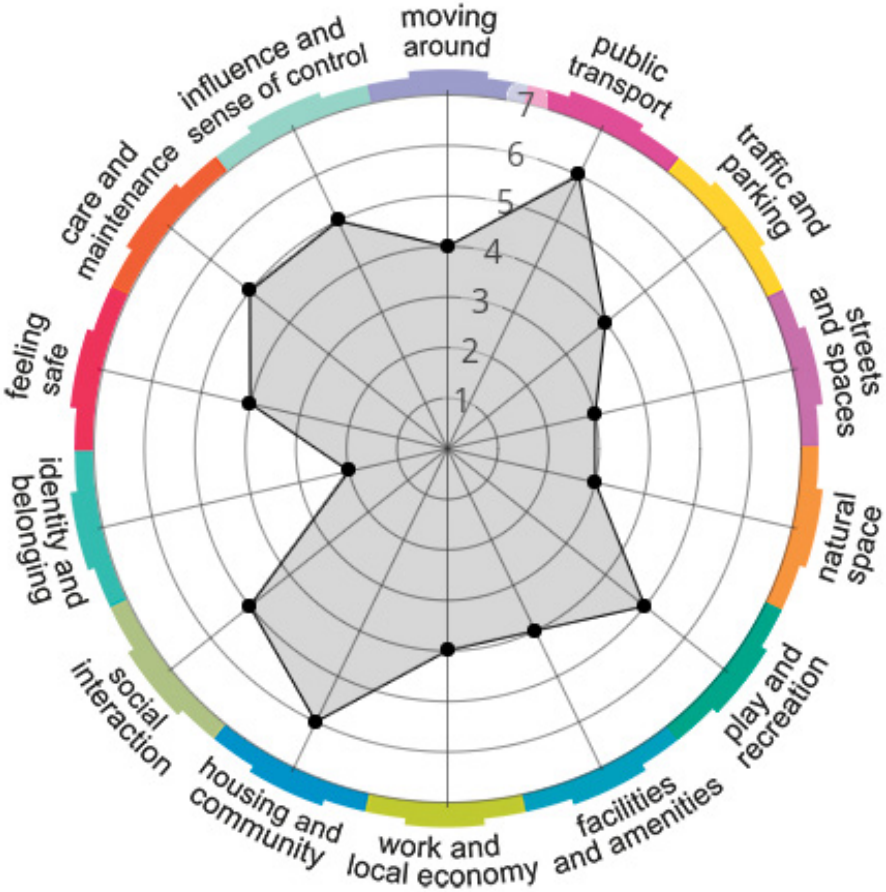
Locally, we have made a contribution to developing good work practice. One example is the in-work progression pilot, led by Glasgow City Council with City Deal funding.

Through our input to the steering group, we have informed and directed the design of a two-year pilot to test a sustainable model of employee progression which will improve the skills and earning potential of low-paid employees in the care sector. Significant progress has been made – the pilot was launched in March 2016 and an evaluation will establish if the delivery model is successful within the sector. If so, it can potentially be rolled out to other sectors such as retail and hospitality.

Core programme 2: Social and physical environments for health

The Place Standard

The term 'place' refers to the combined social, economic, physical, cultural and historical characteristics of a location. It is the part of people's life circumstances that relates to where they live and spend their time. Place encompasses both the physical environment (the buildings, streets, public areas and natural spaces that make up neighbourhoods) and the social environment (the relationships, social contact and support networks that exist in a community).



These characteristics of place, and the interactions between them, have an important influence on our health and wellbeing throughout our lifetime. Some aspects of a place will nurture and promote good health, while others can be detrimental. The distribution of these characteristics is not equal. Those living in areas of greater deprivation are more likely to be exposed to harmful environmental factors, such as poor air quality, and less likely to have access to beneficial ones, such as green space.

The Place Standard was launched in December 2015 and has been successfully delivered in partnership with Scottish Government and Architecture & Design Scotland. The Place Standard:

- delivers a framework for the assessment and improvement of new and existing places
- supports consistency in the delivery of high-quality, sustainable places that promote wellbeing, low-carbon behaviour and positive environmental impacts
- provides a framework for structured conversations, supporting public and private sectors and communities to work together to deliver high-quality places
- maximises the contribution of place to reducing health inequalities across Scotland.

Impact

We have had substantial influence over the Place Standard's content and there is a focus on action that helps to tackle health inequalities embedded throughout. In particular, themes on 'work and local economy' and 'influence and sense of control' relate directly to the fundamental causes of power, income and wealth.

Stakeholder engagement has been extensive, reaching all key stakeholders identified. Pilots took place during 2015 that explored the potential of the tool alongside local partners, including Community Planning Partnerships in Glasgow City and Shetland.

Implementation of the Place Standard is key to its overall long-term success. An implementation plan has been agreed by all project partners involved (NHS Health Scotland, Scottish Government, and Architecture & Design Scotland) and was signed off by the Place Standard Project Board in June 2016. We led on the drafting of the implementation plan and are now taking forward a wide range of actions to deliver it.

We are also leading an evaluation of the Place Standard. As it has only recently been launched this is expected to be based on the use of the tool by customers and stakeholders during 2016/17. Overall, implementing and embedding the Place Standard is likely to take place over several years.

Community justice

There were approximately 7,600 people in prison in Scotland in 2014, which is around 141 per 100,000. This is the second highest in Western Europe. It's important to consider the societal inequalities that are risk factors for offending. The correlation between income inequality and imprisonment is strong, and Scotland's prison population predominantly reflects our most socially deprived communities.

However, experience of poverty alone does not lead to a prison sentence; rather, the interrelationship between poverty and other socially restrictive factors enhances the risk. Having poor mental health, using harmful substances, having gender and identity issues, being a young person and/or having been a previous victim of violent crime can increase the likelihood of a negative impact through contact with justice services.

Around 50% of all prisoners have a history of debt, with one-third never having had a bank account. A total of 47% of all prisoners have no formal qualifications, compared with 15% of the general population, and more than 20% of the prison population need support with reading, writing and basic arithmetic. In total, 41% of men, 30% of women and 52% of young men in the prison system were permanently excluded from school, and although less than 1% of all children are in care, looked-after children account for more than 25% of all people in prison.

Impact

We established a new workstream in anticipation of the Community Justice Act 2016 and the proposed transition arrangements for Community Planning.

The Community Justice work aims to encourage earlier intervention and action to mitigate the health impact and reduce the inequalities associated with crime, offending, being a victim and its impact on community health. A new health improvement framework and use of improvement approaches with local partners are underway.

The Community Justice work aims to provide guidance on effective and, where available, evidence-informed actions that the variety of partners involved in community planning structures can take.

Three key pillars are proposed to take this forward nationally and locally:

1. opportunities for earlier intervention
2. mitigating the impact of offending and sentencing
3. opportunities to sustain change and build resilience.

Core programme 3: System change for equity

Physical health of those with mental illness

Morbidity and mortality rates of those experiencing mental illness are higher than those of the general population. Furthermore, there are inequalities in relation to the access to and experience of health and social services that people with mental illness receive. We are focused on reducing inequalities related to mental illness within marginalised groups.

We were contracted by Scottish Government to collaborate on delivering Commitment 28 of the Mental Health Strategy. It is increasingly emphasised that mental health services are integral to health-promoting health service activity.

Together we are testing the relevance of the secondary care Physical Activity Pathway in mental health services.

To generate impact in this area, a number of key activities were undertaken to build the case for change.

1. **Providing strategic influence** – We encouraged the mobilisation of stakeholders to work with us by working with and through the health-promoting health service and mental health national network.
2. **Encouraging other programmes to focus on mental health/internal working** – This includes both internal engagement (ensuring they have the knowledge to include a focus on mental health outcomes within their programmes) and external delivery of work (such as smoking and mental health and prisons).

Impact

The impact of this work has been threefold:

1. NHS Ayrshire and Arran's forensic mental health service in Ailsa Hospital has implemented the Physical Activity Pathway.
2. NHS Greater Glasgow and Clyde included assessing and addressing physical health needs within their mental health services.
3. NHS Forth Valley implemented an assessment of physical health needs in their forensic mental health service.

Core programme 4: The right of every child to good health

Child poverty, health and wellbeing eLearning module

Over one in five children in Scotland are living in poverty and the Institute for Fiscal Studies forecasts an increase of more than 50% in the proportion of children living in poverty in the UK by 2020/21. Health professionals have an important role to play in mitigating the effects of child poverty. One example is through the development of referral pathways between the NHS and the advice sector around financial inclusion – health professionals can ask pregnant women and families with young children about money worries and, with their consent, refer them to a local advice service. As a result, there have been significant financial gains to pregnant women and families.

As part of an assessment of the learning and workforce needs of health visitors, midwives and school nurses on how they approach financial inclusion in the early years, we identified a gap in knowledge and awareness of child poverty and its impact on health and wellbeing.

In consultation with a number of partners, we agreed that an eLearning module on 'child poverty, health and wellbeing' would be the most effective approach to address the identified needs (partners included NHS Education for Scotland, several course leaders on undergraduate programmes for health visiting, midwifery and school nursing as well as Child Poverty Action Group Scotland).

While the initial audience for the module is health visitors, midwives and school nurses, we decided to widen the module's application to other key groups of staff and students in undergraduate and continuing professional development programmes, such as early years workers, housing officers, teachers and welfare rights officers. A steering group has been set up to shape the content and tone of the module as well as how to embed the module in practice.

Impact

Through partnership working and stakeholder engagement, we are developing a product that is identified as useful, practical and timely. Critically, it enjoys strong buy-in and there is a commitment to incorporate the module into undergraduate, postgraduate and continuing professional development programmes.

Pregnancy and Parenthood in Young People strategy

The Pregnancy and Parenthood in Young People (PPYP) strategy came from a recommendation from the Health and Sport Committee's Inquiry into Teenage Pregnancy. Although the rate of teenage pregnancy has been decreasing in Scotland since 2007, there is still a strong inequalities gap.

Young people living in Scottish Index of Multiple Deprivation (SIMD) 1 are 4.8 times more likely to have a teenage pregnancy and 12 times more likely to deliver their baby than young people living in SIMD 5. The aim of the PPYP strategy was therefore to pull the issue of teenage pregnancy out of health and into the wider social environment in order to help narrow the inequalities gap.

Impact

We successfully led the development of the first Scottish Strategy for PPYP with cross-ministerial support. Our accompanying outcomes framework provided strong evidence for the strategy's actions.

We led the public consultation, engaging with young people throughout the process, and gained high stakeholder engagement by running multi-sector consultation events. We produced a policy mapping, and managed and contributed to a national steering group with representation from across all sectors. We led on the Equality Impact Assessment and Child Rights and Wellbeing Impact Assessment to ensure the strategy enhanced the equality and rights of young people.

As a result of our work, the PPYP strategy was published in March 2016. The embedded inequalities focus covers a wide political landscape, bringing the issue of pregnancy in young people into the wider social environment to narrow the inequalities gap.

The World Health Organization's collaborative, cross-national study on health behaviour in school-aged children selected the PPYP strategy as a success story which was showcased at a European conference in June 2016.

Financial performance

	(1) Limit as set by SGHSCD £000	(2) Actual outturn £000	(3) Variance over(-)/under (1)-(2) £000
Core revenue resource limit	19,656	19,430	226
Non-core revenue resource limit (depreciation)	269	269	–
Core capital resource limit	100	53	47
Cash requirement	20,000	20,073	73

Our 2015/16 core revenue resource limit announced by the Scottish Government was £19.656m. This total comprised three elements: baseline recurring (£18.037m), earmarked recurring (£0.266m) and non-recurring (£1.353m).

The Board ended the 2015/16 financial year with a revenue surplus of £226,000, which is 1% of its revenue budget and within tolerance (+/-£50,000) of its planned year-end forecast surplus of £0.2m, which can be carried forward to 2016/17 under an arrangement with the Scottish Government.

Reports on the financial position were presented to the Audit Committee and the Board throughout the year and financial performance was monitored closely. Financial performance for the year is summarised under item 2 (actual outturn) in the table above and disclosed in detail further in this section.

In relation to financial performance management, appropriate Board officers had a personal objective which required that, for the budgets for which they are responsible, 95% were fully committed by 31 January 2016, 90% spent by 28 February, 95% spent by 31 March and 99% spent by the closure of accounts.

Although our actual spend was lower than target at 28 February, taking into account our planned year-end outturn and budgeted costs in March, our actual spend on this basis was 90%. We traditionally have a higher spend than average in March, which was again the case this year. Overall, with this one exception, these targets have been met and improved on as shown in the following table.

Carrying forward the surplus revenue for 2015/16 into the financial year 2016/17 will enable the Board to progress actions

Target	Performance
95% commitment by 31 January 2016	96%
90% spent by 28 February	88% (see above)
95% spent by 31 March	99%
99% spent by closure of accounts	99%

taken during the year to make workforce changes as agreed in partnership and to progress other actions planned to increase efficiency.

During the year the Audit Committee played a key role in monitoring performance in delivering the 2015/16 delivery plan and reviewed actions taken by the Corporate Management Team, particularly in relation to improving budget profiling and reducing year-end pressures. We provided regular update reports the Board at its meetings.

Efficiency savings

For financial year 2015/16, the Board met its efficiency savings target of £1.050m and savings were reported to the Scottish Government via the monthly financial performance reporting process.

The Board's efficiency savings target for 2016/17 is £0.972m and plans are in place to meet this target.

Estates strategy

The third phase of the Board's estates strategy commenced in 2015/16 with a review of the floor usage requirement at Meridian Court and certain changes in our office layout at both offices. We will all move to one floor at Meridian Court and undertake certain layout changes at both offices, with this project commencing in 2015/16 working to completion in 2016/17.

Financial assistance was provided by the Scottish Government in 2015/16, being the third and final year of the estates strategy.

Annual Accounts

A full copy of the annual Accounts 2015/16, including:

- Performance Report
- Accountability Report (which includes the Remuneration Report)
- Independent Auditor's Report (unqualified audit opinion)

can be found on our website:

www.healthscotland.com/documents/28335.aspx

Board members

The Board is responsible for the governance of the organisation and for ensuring that NHS Health Scotland delivers Scottish ministers' policies and priorities. In common with other Boards, NHS Health Scotland's Board delegates responsibilities to a number of governance committees, they are: Audit, Health Governance, Remuneration and Staff Governance.

The year 2015/16 marked a period of transition for the Board with a number of non-executive members coming to the end of their terms, including the Chair, Margaret Burns, OBE. David Crichton was appointed as Chair from 1 December 2015 and he and the Board have welcomed a number of newly appointed board members over the year. More information on the Board and its governance committees is available on our website: **www.healthscotland.scot/our-organisation/our-board-and-executive-team/nhs-health-scotland-board**

Margaret Burns – Chair until 30 November 2015

David Crichton – Chair from 1 December 2015

Joan Fraser – Board member until 31 January 2016

Maggie Mellon – Board member until 31 January 2016

Anne Maree Wallace – Board member until 30 June 2016

Russell Pettigrew

Ali Jarvis

Michael Craig

Paul Stollard

Gerald McLaughlin

Cath Denholm

Andrew Fraser

Paul McColgan – Appointed from 1 February 2016

Jane-Claire Judson – Appointed from 1 February 2016

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