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CEO foreword



I am delighted to introduce our Impact Assessment Report for 2016/17. Its purpose is to report against the framework of performance agreed with our Board, examine our impact through short case studies, and help us consider where the focus for our next improvement should be

Our performance framework includes major societal measures of health inequalities and the determinants of health. As the analysis shows on **pages** 7–8, many national trends remain in a downward direction, including inequality in life expectancy and child poverty. Notwithstanding some of the macro global forces behind this, our mission remains to have long-term, positive influence over these trends. I am therefore pleased that, as reported on **page** 9, we can demonstrate how NHS Health Scotland has been a major influence in much more policy now focusing on inequality.

I am also pleased to share the results of our enduring focus on the factors that prevent the health of disadvantaged people from improving. For example, on **page** 22 we describe our contribution to an increase in the number of vulnerable patients in the NHS able to get advice on fuel poverty. On **page** 29 we describe how the culmination of years of meticulous data collection, analysis and knowledge sharing on Monitoring and Evaluating Scotland's Alcohol Strategy has supported Scottish Government in taking bold steps to reduce harm to people from alcohol. On **page** 31 we describe how our evidence and then our facilitation has led to the creation of a national hub for Adverse Childhood Experiences, which will generate Scotland-wide, coordinated action to prevent and respond more effectively to the worst experiences of some of our children.

The report takes the reader systematically through our performance results, telling a story of steady progress across a broad range of

complex programmes of work. I am very satisfied that across our work programmes we maintained a full performance completion rate of 70%. This demonstrates well our ability to stay focused on priorities but also our ability to respond in-year to new demands and challenges. I also welcome the many positive indicators that we are sharing our knowledge in a variety of ways and that people continue to place high value on our products. I recognise the need to continue to improve how we work with partners and stakeholders so that they always get from us what they need when they need it. This is no more important than at the present time and I welcome that our priority for improvement for next year is to become even more effective in how we record and use stakeholder data. I am also delighted that we do this knowing that we are building on our success in achieving the EFQM Recognised for Excellence award this year, and from greatly improved customer platforms, including our new website.

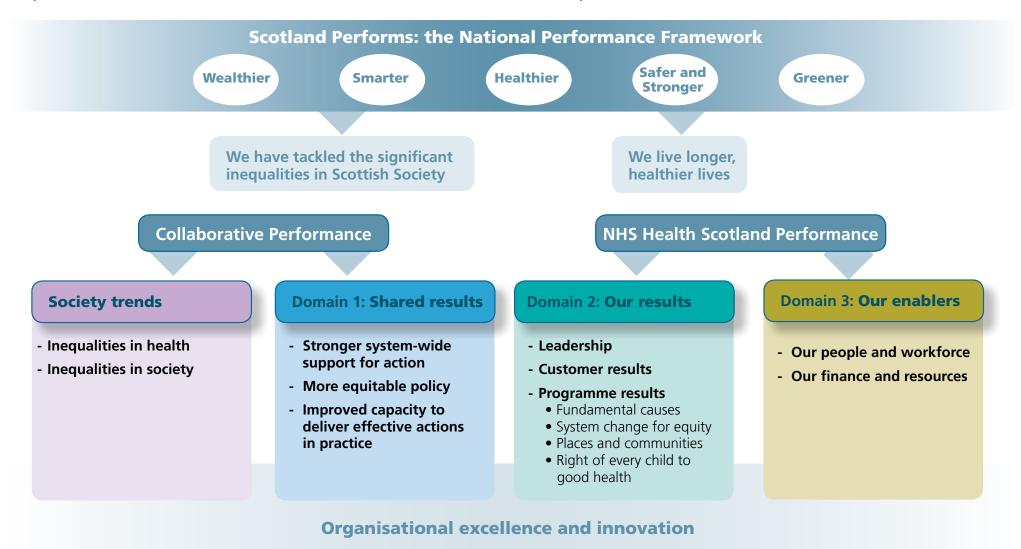
Our strong results on people and finance demonstrate staff who are committed to their work, and ongoing excellence in governance and partnership working.

We are now working in earnest towards the new national public health landscape. I believe this report demonstrates an organisation that is set on a steady path, in good health and clear about what we need to do next.

Gerry McLaughlin CEO NHS Health Scotland

Introduction

This is NHS Health Scotland's Impact Assessment report 2016/17. It focuses on the impact we have had as an organisation through implementing our 2016/17 Delivery Plan and highlights how we have contributed to the ambitions of our strategy, A Fairer Healthier Scotland 2012–17. We have structured this report around our **Performance Framework (shown below)**. The performance framework sets out measures to assess our performance and contribution at each level to evidence and demonstrate the impact of our work.



The framework covers results beyond our own control, which we achieve in conjunction with others (collaborative performance) and those within our own control (NHS Health Scotland's performance). Within these are the society trends we monitor, and three domains:

Society trends: indicators of current overall health improvement and health inequalities in Scotland and our contribution (see **pages** 7–9 of this document and Appendix A and B).

Shared results: indicators of our contribution to the corporate outcomes we set for our strategy A Fairer Healthier Scotland 2012–17. These outcomes depend on collaboration and shared efforts with our stakeholders (pages 10–17).

Our results: indicators of the four externally facing core programmes, through which we plan and deliver our work based on the evidence of what is needed to improve health fairly in Scotland (pages 18–36).

Our enablers: indicators of how we managed our organisational resources to meet these aims and how we delivered against our internal core programme, Organisational Excellence and Innovation (pages <u>37–42</u>).

Measuring our performance

Within each of the domains and sub-domains of the Performance Framework, we have used Key Performance Indicators (KPIs) and supplementary indicators to measure performance. We then accumulate KPIs within each domain and sub-domain and include narrative examples in order to assess overall impact.

- 1. Domains
- 2. Sub-domains
- 3. KPIs
- 4. Supplementary indicators

A rating criteria has been developed for KPIs and supplementary indicators to allow us to provide a red, amber, green (RAG) rating. These are included in the report alongside each indicator. In some cases, the overall RAG status is based on ratings of supplementary indicators.

Summary of performance ratings

The table below summarises our organisational impact through a series of key performance indicators (KPIs), with red, amber and green (RAG) ratings applied. The detail and additional narrative around each KPI follows within this document.

Domain	Sub-domain	No.	КРІ	RAG
Shared results	Improved and more equitable policy making	1	We have evidence that we have influenced policymakers to ensure that they consider the impacts on health inequalities and ensure policy is fairer.	Green
Shared results	Stronger support for action for prevention and better, fairer health	2	We have successfully developed stronger support for action among high interest and impact stakeholders.	Amber
Our results	Improved capacity to deliver effective actions in practice	3	NHS Health Scotland has enabled key partners to deliver knowledge about the reduction of health inequalities into practice.	Green
Our results	Leadership, organisational reputation and credibility	4	Key stakeholders with high interest and impact are positive about the work of NHS Health Scotland and provide positive feedback on our work, and as a result we are seen as leaders in the field of equitable health improvement.	Amber
Our results	Customer results	5	Our customers are satisfied with our products and services. ¹	Green
Our results	Core Programme Results	6	CP 1-4: We continue to deliver on what evidence tells us is needed to improve health equitably.	Amber
Our results	Core Programme Results	7	CP5: We continue to develop an excellent organisation.	Amber
Our enablers	People and workforce	8	Our workforce is appropriately skilled, engaged and motivated to deliver our corporate priorities and strategy, while a positive staff experience is promoted.	Green
Our enablers	Finance and resources	9	We spend our budget within the revenue resource limit. Corporate priorities are fully resourced (in terms of time and budget).	Green

^{1.} Net Promoter Score target >40%: The Net Promoter Score (NPS) contains a rating scale with ranges from -100 to +100. 0 is considered good, 40% is an excellent score. The NPS is a widely used measure of stakeholder satisfaction.

Context: society trends

There are two distinct aspects to society trends: the overall health inequalities outcomes, which we aim to reduce, and the key determinants of health inequalities, which are outside our direct sphere of influence.

The following page summarises current progress in relation to each of the Society trends KPIs.

Health inequality trends

No.	KPI	Progress commentary
10	Trend in the Slope Index of Inequality (SII) in mortality across Scottish Index of Multiple Deprivation (SIMD) deciles among those aged <75 years	The long-term decline in absolute mortality inequalities reversed in 2015, partly as a result in a rise of all-cause mortality rates (which were even greater for those over 75 years).
11	Trend in the Relative Index of Inequality (RII) in mortality across SIMD deciles among those aged <75 years	Relative inequalities (i.e. the number of times worse it is in the most deprived areas compared to the least deprived areas) in mortality have steadily increased since the start of the time series.
12/13	Trend in SII and RII in healthy life expectancy	Although life expectancy has continued to increase, it has increased most rapidly in the least deprived areas. Also, the length of time spent in ill health in the more deprived areas has remained substantially longer than in the least deprived.
14/15	Trend in SII and RII in Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)	Trends in inequalities have widened in terms of mental wellbeing.

Society trends

No.	KPI	Progress commentary
16	Trends in income Gini coefficient (i.e. distribution across the population)	Income inequalities increased substantially in the latest year of data available.
17	Trends in wealth Gini coefficient (i.e. distribution across the population)	Better data on wealth inequalities are now available. There was a small decline between 2006/8 and 2010/12, before a subsequent stabilisation.
18	Trends in the percentage of the population living in households below 60% of the UK median income (i.e. relative poverty threshold)	Poverty has increased substantially over the last few years.
19	Trends in the percentage of children living in households below 60% of the UK median income (i.e. relative child poverty threshold)	Child poverty has increased substantially over the last few years.
20	Trends in the proportion of the working-age population employed full-time or to their part-time preference	Underemployment rates have been relatively stable between 2013 and 2015.
21	Trends in the SII in S4 SCQF 6+ scores across SIMD quintiles	The absolute inequality in educational attainment has declined substantially.
22	Trends in the RII in S4 SCQF 6+ scores across SIMD quintiles	The relative inequality in educational attainment has declined substantially.

Analysis and context supporting society indicators can be found in Appendix A.

Commentary

Social, political and economic factors, some of which are global, influence health inequalities. The impact of economic changes in the UK overall since the 1980s are widely seen to have increased health inequalities both immediately and over time.

In the face of these larger driving forces, there is no doubt that NHS Health Scotland's leverage is limited. However, we have analysed our contribution where there is evidence that we have had an impact on general trends, for example, by following the ways in which our evidence has been disseminated and cited.

A good example, which predates this business year but which we know continues to have impact, is the **Policy Review and associated evidence and reports** we produced as part of the Ministerial Task Force on Inequalities in 2013. Since then we have seen the lexicon of 'fundamental causes', along with a focus on the importance of tackling inequalities in income, power and wealth if health inequalities are to be reduced, becoming much more prominent. We have seen this within NHS Health Scotland's own materials and publications, but also within policy communities and among sections of the media and public.

Similarly, since its publication in 2015, we have seen ongoing citations of the 'Glasgow subway health inequalities map' (including the use by Government ministers and the Chief Medical Officer). Specific examples in 2016/17 include publishing, in collaboration with Glasgow Centre for Population Health, the most comprehensive report on the causes of excess mortality in Scotland and Glasgow, including a list of specific policy recommendations. The report was endorsed by a range of high-profile academics and received extensive media coverage and discussion in parliament. We also responded to multiple consultations covering wide-ranging topics including taxation, child and food poverty, as well as welfare and benefits – almost all of which have cited our responses extensively in their reports.

Our work has been reported extensively through the media. Examples include reporting on in-work poverty, how work affects people's health and income tax (see <u>Appendix A</u>).

Impact

The work within the fundamental causes programme, combined with a theory of change that detailed how this was designed to inform policy, confirms the following:

- 1. NHS Health Scotland has been one of the major influences in changing the public and policy narrative around health inequalities. Health inequalities are increasingly a subject of policy focus, and their causes are now widely understood to be rooted within socio-economic inequalities.
- 2. Policymakers and the public are now clearer about the effective policies and practices to reduce health inequalities as a result of our work.

So, we have yet to see sufficient implementation of policy action on the fundamental causes of health inequalities and, indeed, it is likely to be too early to expect such policy shifts to have occurred. However, the Scottish Government is increasingly making public priority actions to reduce poverty and inequality and the increasing devolution of powers to the Scottish Parliament will provide greater opportunity for divergence of policy from the rest of the UK in the coming years. While not our work alone, we are confident of the contributory and ongoing impact of several of the achievements described above.

Performance domain 1: shared results

Improved and more equitable policy making

To achieve this outcome, we would expect to see fairer policy being developed by Scottish Government public bodies. We would also expect to see our work effectively aligned with the policy landscape and well positioned to influence the development of policy.

1 Key Performance Indicator

We have evidence that we have influenced policymakers to ensure that they consider the impacts on health inequalities and ensure policy is fairer.



1.1 Supplementary Indicator

We can evidence that four identified Community Planning Partnerships (CPP) areas are using our products and services in the formation of their Local Outcomes Implementation Plans (LOIPs); and responded to four additional areas' in-year requests for support.



Red = <6 support packages provided Amber = 6-7 support packages provided Green = 8 support packages provided



Evidence

We made an offer of planned support to CPPs, aiming to influence the development of LOIPs to ensure a focus on health inequalities. We delivered a tailored programme of support for **Aberdeen** and **Highland** CPPs; we have been invited to input into the development of a knowledge hub for **Fife** CPP; and produced an analytical report for **South Lanarkshire** CPP (to enable them to make decisions about actions and resource allocation for those living in the most deprived areas).

We also responded to a number of areas' in-year requests for support. The knowledge, expertise and evidence we provided has contributed to the prioritisation of recommendations to address health inequalities within the Improvement Plan which followed **East Ayrshire** Council's Strategic Self-Assessment. It has also contributed to the reports of the **Dundee** Fairness Commission, the **Perth & Kinross** Fairness Commission, and the **Glasgow City** Health & Social Care Partnership, which in turn influenced the development of their local CPPs' LOIPs.

.2 Supplementary Indicator

NHS Health Scotland staff present at over 20 national level conferences/events which are relevant to our corporate priorities and core programmes.



Red = <17 **Amber** = 17-19 **Green** = ≥ 20



Evidence

In 2016/17 NHS Health Scotland staff presented at 24 national level conferences/events on the organisation's key messages.

1.3 Supplementary Indicator

We have responded to 95% of stakeholder consultations relating to our corporate priorities and core programmes.



Red = $\le 89\%$ **Amber** = 90–94% **Green** = $\ge 95\%$



Evidence

We achieved 100% rating against this indicator. In 2016/17 NHS Health Scotland responded and provided evidence to 42 consultations, across a range of policy areas. These included the Scottish Government's consultation on the Child Poverty Bill, the Review of the Scottish Social Housing Charter, and the Scottish Parliament Health and Sport Committee's Call for Evidence on Preventative Spend. As detailed in Appendix B, our evidence has been cited extensively in a number of consultation reports.



We engage with Scottish Government policy leads in at least 95% of our work that aims to influence policy.



Red = $\le 89\%$ **Amber** = 90-94% **Green** = $\ge 95\%$



Evidence

In 2016/17 NHS Health Scotland engaged with Scottish Government policy leads across a range of policy areas, including social security, diet and obesity and the Place Standard. We are able to measure our engagement at 95%.

Place Standard

Through wide-ranging engagement we promoted and generated interest in the Place Standard Tool internationally. The innovative approach of the Place Standard Tool received international recognition, and was shortlisted for the prestigious Royal Town Planning Institute Awards 2017. Arrangements are in place to work with the WHO Healthy Cities European Network, UNICEF, and the Dutch Centre of Expertise on Health Disparities in 2017/18.

World Health Organization (WHO)

We worked internationally as a WHO Child and Adolescent Collaborating Centre in Europe, and brokered discussions between the Scottish Government and the WHO. In December 2016 our staff were part of the UK delegation to the WHO conference on inter-sectoral and inter-agency action for health and wellbeing in Europe. This meeting adopted a draft declaration on working together for better health, to go to the WHO Regional Committee meeting in September 2017, and ultimately influence policy and practice throughout Europe.

1.5 Supplementary Indicator

We have influenced at least seven policy domains of the 2016/17 Programme for Government.



Red = <4 policy domains Amber = 4-6 policy domains Green = ≥ 7 policy domains



Evidence

The Scottish Government published its 2016/17 Programme for Government (PfG) in September 2016. Our work contributed to a range of the policy areas prioritised by the Scottish Government that we know have an impact on fairer health improvement. This includes the inequalities caused by poverty, the transformation of public services, and the nurturing of sustainable environments to live and work, as well as some of the new powers received under the Scotland Act (2016). Case study evidence is provided on the next page.

Child poverty

To help local authorities and NHS health boards identify steps to address the impact of child poverty, we shared approaches that have increased equality in health and education settings. We also supported the incorporation of financial inclusion referral pathways in local services, and informed the Scottish Government's decision-making on national roll-out of learning from NHS Greater Glasgow & Clyde's Healthier, Wealthier Children project.

Fuel poverty

We represented the NHS on the Fuel Poverty Strategic Working Group, with the Scottish Government accepting the group's recommendation to review the definition of fuel poverty. We supported development of fuel poverty actions across regional health boards, and provided e-learning to frontline health and social care practitioners (in collaboration with Shelter Scotland). This has resulted in an increase in vulnerable patients accessing support to tackle fuel poverty.

Primary Care transformation

We set up a Primary Care Evidence Collaborative with the Scottish School of Primary Care to support primary care transformation, developing a 10-year research and evaluation framework and engaging with key partners to develop specific proposals for addressing health inequalities through GPs.

Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS)

We updated analysis of alcohol price and sales data (May 2016) and received significant political, press and public attention. We continue to work closely with the Scottish Government to support the evaluation of Minimum Unit Pricing and the refresh of their alcohol strategy.

Place

We continue to work in collaboration with Scottish Government and Architecture & Design Scotland. In July 2016 we secured approval for the Place Standard Implementation Plan. In December 2016 we established a national governance and support infrastructure to coordinate roll-out of the Place Standard Tool across Scotland. Approximately 70% of Local Authorities are using the Place Standard Tool.

Good work

In November 2016 we published our inequality briefing 'Good work for all'. We engaged with the Scottish Government's Fair Work directorate, and submitted evidence to the Fair Work Convention. Due to the value of the evidence we provided, we have been engaged in scoping a role to support progress of the **Convention's Fair Work Framework**.

Health effect of welfare

Through our involvement in the Health Impact Delivery Group we engaged with the Scottish Government on use of their new social security powers. We collaborated with NHS Boards to implement practical actions to mitigate the health impacts of welfare reform, including supporting a review of NHS services' Welfare Reform Outcomes Focused Plan and development of a Financial Inclusion Referral Pathway Toolkit for early years services.

1.6

Supplementary Indicator

We have evidence that we have influenced stronger support for equitable policymaking in other UK countries.



Red = \leq 1 case study **Amber** = 2 case studies **Green** = 3 case studies

We also influenced support for fairer policymaking in a number of areas in other UK countries.



Evidence

In 2016/17 NHS Health Scotland engaged with Scottish Government policy leads across a range of policy areas, including social security, diet and obesity and the Place Standard. We are able to measure our engagement at 95%.

Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS)

In May 2016 we presented evidence on the Scottish approach to alcohol policy development, monitoring and evaluation to Members of Parliament at Westminster. Since then we have also provided alcohol sales data to officials from the Welsh Government, to help inform and evaluate their alcohol policy.

Health effect of welfare

On behalf of the Health Impact Delivery Group, we submitted a response to the UK Government's 'Improving Lives: the Work, Health and Disability' Green Paper consultation, opened in October 2016.

Good work

Our inequality briefing 'Good work for all' contained options for action for agencies operating at UK-level, including UK Government, DWP, Jobcentre Plus and Work Programme providers.

Stronger support for action for prevention and better, fairer health

To achieve this outcome, we would expect public leaders, politicians and third sector leaders to become further engaged with prevention and better, fairer health. Ultimately, this will enable the process of change and establish priorities across public services.

2 Key Performance Indicator



We have successfully developed stronger support for action among high interest and impact stakeholders.

2.1 Supplementary Indicator

Policy and decision makers would recommend our organisation.



Red = <0% **Amber** = 0-15% **Green** = $>15\%^2$



Evidence

In August 2016 we surveyed a sample of our stakeholders, our partners (the people we work closely with) and our customers (the people who use our products and services). The 2016/17 stakeholder survey sample was limited in its sample size, specifically for our partners, and did not allow us to come to a full conclusion regarding this indicator. Improvements plans for next year are in place. The result should be considered with this in mind. The survey was issued to 577 stakeholders, of which a total of 142 (20%) responded. Both partners and customers rated NHS Health Scotland positively. The average response rate for overall satisfaction was 7.7 out of 10. Our customers in particular gave us high satisfaction scores; however, we have room to become more influential with our partners.

² Net Promoter Score target >20%: The Net Promoter Score (NPS) contains a rating scale with ranges from -100 to +100. 0 is considered good, 40% is an excellent score. The NPS is a widely used measure of stakeholder satisfaction.

2.2 Supplementary Indicator

85% of participants at our events indicate that they express a positive intention to apply the learning/ tools/resources from the event to their practice.



Red = <70% **Amber** = 70-79% **Green** = $\ge 80\%$



Evidence

Our events are a key opportunity to engage and influence our stakeholders. In 2016/17 we introduced a standardised evaluation form for use at seven of our events. Feedback shows that 89% of participants, from a range of sectors and organisations, expressed a positive intention to apply the learning/tools/resources from the event to their own practice.



We have engaged with 90% of our identified high-interest and high-impact stakeholders.



Red = <55% **Amber** = 55-79% **Green** = $\ge 80\%$



Evidence

Data from our strategic engagement Customer Relationship Management (CRM) tool shows that we engaged with 65% of our high-impact and high-interest stakeholders over the course of 2016/17.

When looking at this figure, it should be noted that there remain limitations around the collection of staff engagement data. We are therefore pleased to see this as a significant improvement on recorded contacts from the previous year and are also confident that not only will we see further improvements this year, but also that this figure is very likely to under-represent the contacts that our staff actually had with these stakeholders.

2.4

Supplementary Indicator

We engage with the Scottish Government policy leads in at least 95% of our work that aims to influence policy.



Red = $\le 89\%$ **Amber** = 90-94%**Green** = $\ge 95\%$



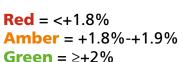
Evidence

In 2016/17 we monitored our engagement with Scottish Government policy leads across a range of policy areas, including social security, diet and obesity and the Place Standard. We are able to measure our engagement at 95%.



Supplementary Indicator

Media activity will increase by 2% on the current baseline.







Evidence

For 2016/17 we developed an overarching media indicator, allowing us to monitor our media activity. For both traditional and social media we have seen substantial increase against 2015/16 (traditional media: +3.3%; social media: +7.4%). There are a number of particular examples of where our work has been reported extensively throughout the media in 2016/17:

- Alcohol consumption, Minimum Unit Pricing, MESAS, Alcohol Mortality (traditional media)
- Place Standard work (social media)

Improved capacity to deliver effective actions in practice

If our corporate outcome is achieved, we would expect to have improved the capacity of public services to take action on health inequalities. Partners across sectors will be better able to access, understand and use our health inequalities knowledge in order to develop more effective local programmes that reduce health inequalities.

3 Key Performance Indicator

NHS Health Scotland has enabled key partners to deliver knowledge about the reduction of health inequalities into practice.



Supplementary Indicators

We have identified key local and national partners for each Core Programme.



- We engage with them and agree a tailored plan to improve their capacity to deliver Knowledge into Action, in order to reduce health inequalities in Scotland.
- 3.3 Identified partners' delivery plans include evidence-based actions to reduce inequalities.

Red = <3 case studies that meet indicators 3.1 to 3.3 Amber = 3 case studies that meet indicators 3.1 to 3.3 Green = 1 case study per Core Programme (4 in total) that meet indicators 3.1 to 3.3



Evidence

These three indicators are each met by the following examples, chosen from Core Programmes (CP) 1–4 respectively.

Case study

CP1: Fundamental Causes – Fuel poverty

Following our input into the Fuel Poverty Forum, we worked with a range of partners through participation in the Fuel Poverty Strategic Working Group (FPSWG). This included NHS Boards, Shelter Scotland and local agencies addressing deprivation and fuel poverty.

The recommendations of the FPSWG were mirrored in guidance which the Scottish Public Health Network (ScotPHN, part of NHS Health Scotland) provided to Directors of Public Health. Published in October 2016, this guidance informs knowledge and actions on fuel poverty and health, and we continued to facilitate the sharing of good practice and learning among key partners.

For example, we continue to support local health boards to plan and implement the actions – NHS Lanarkshire being the first to have produced a draft Fuel Poverty Action Plan.

Case study

CP2: Social and physical environments for health – Place Standard

Working in partnership with the Scottish Government and Architecture & Design Scotland, a significant number of local and national partners were identified and engaged in the design and delivery of the Place Standard. This included Ministers and other Scottish Government directorates; COSLA, the Improvement Service and all 32 Local Authority areas; CPP Boards, community councils and communities.

We worked with partners to negotiate and secure approval for the Place Standard Implementation Plan. This outlines how knowledge of what works can be applied collaboratively, to reduce the unfair and avoidable benefits gap in sustainable good places.

The Place Standard Tool was used in the development of CPPs' Locality Plans and Local Outcome Improvement Plans (LOIPs), as well as the Community Links Plus investment programme hosted by the Scottish Government and Sustrans Scotland.

Case study

CP3: System-change for health equity – East Ayrshire Council Strategic Self-assessment 2016

As part of our work to strengthen the potential of public sector services to address health inequalities we reviewed East Ayrshire Council's Strategic Self-assessment 2016.

We worked as part of a panel to make recommendations to strengthen the review. This included providing evidence to support explicit consideration of how they would contribute to the reduction of health inequalities among their population.

Our recommendations and the areas of improvement we identified were incorporated into the Council's Improvement Plan approved in June 2016.

Case study

CP4: The right of every child to good health – Child poverty

We engaged with a range of key partners, including the Child Poverty Action Group, the Scottish Government and a number of local authorities and NHS boards.

By highlighting approaches that have increased equality in health and education settings, we have helped partners to identify feasible steps that could be taken locally to reduce the impact of child poverty.

We supported the incorporation of financial inclusion referral pathways in local services, and are committed to supporting the national roll-out of learning from NHS Greater Glasgow & Clyde's Healthier, Wealthier Children project.

3.4

Supplementary Indicator

We will work with four CPP areas to ensure that their Local Outcomes Implementation Plans (LOIPs) include evidence-based actions to reduce inequalities.

Progress measure for 2016/17 cannot be rated. Agreed deadline for CPPs to produce LOIPs is October 2017.

For 2016/17 this indicator is included as a progress measure. The agreed deadline for CPPs to produce LOIPs is October 2017, which falls outwith our 2016/17 reporting period. Once all LOIPs have been completed, we will analyse them for evidence-based actions to reduce inequalities (including determining, articulating and prioritising outcomes to reduce health inequalities).



Supplementary Indicators

We will monitor our web analytics and user feedback to ensure we have designed journeys that enable users to put knowledge about health inequalities into practice.



New website launched in November 2016 – currently monitoring to establish baselines for the subset of supplementary indicators below.

a) Baseline measure: users visiting pages within 'Health Inequalities' / 'Fundamental Causes'/'Place', or 'Improve policy and practice' or 'Tools and resources' take one of the calls to action within content.

New website launched in November 2016 – currently monitoring to establish baseline. Our baseline for 2016/17 is 34%

b) Baseline measure: visitors follow links from popular content in 'Health' topics and 'Population groups' to the 'Health Inequalities'/'Fundamental Causes'/'Place', or 'Improve policy and practice' or 'Tools and resources' sections.

New website launched in November 2016 – currently monitoring to establish baseline. Our baseline for 2016/17 is 8%

c) Visitors click published email addresses on healthscotland.scot more often (>50%) compared to email addresses on healthscotland.com (previous website).



Red = <5% **Amber** = 5-30% **Green** = >30%



Evidence

Since moving to our new website, we have seen a 270% increase in email addresses being used on average, indicating website users find contacting us easier than before.

d) Visits to the 'Tools and resources' section as a proportion of all site visits increase by 10% compared with the previous NHS Health Scotland website as a baseline.



Red = <5% **Amber** = 5-8% **Green** = >8%



Evidence

Since moving to our new website, visits to the 'Tools and resources' section of the website (as a proportion of all visits) increased by 91%.

e) The proportion of users who visit content pages rather than directly access and download files without viewing content increases by 5% compared with previous NHS Health Scotland website as a baseline.



Red = no increase **Amber** = 1–4% increase **Green** = >4% increase



Evidence

Since moving to our new website, we have seen an 8% increase in users visiting content pages.

Over 70% of those people from our key target audiences who were surveyed told us they would prefer to access our products and services online. Our website has been developed to meet those users' needs. In November 2016 we launched **www.healthscotland.scot** which is designed to make it easier to do business with us.

The indicators shown above have been developed to help us monitor how well the website supports our ambition to enable our partners to put knowledge of what reduces health inequalities into practice. With the website only live for a short while, we use these measures to establish baseline figures of the website's performance so that in future we are able to keep improving.

Performance domain 2: our results

Leadership, organisational reputation and credibility

We aspire to ensure that our stakeholders have a positive view of our reputation and credibility, and are influenced by the knowledge we generate and disseminate. We have an overarching KPI for stakeholder engagement and supplementary indicators in two areas (ScotPHN and Community Planning Partnerships) as examples and for which we have the means to collect data.

4 Key Performance Indicator

Key stakeholders with high interest and impact are positive about the work of NHS Health Scotland and provide positive feedback on our work, and as a result we are seen as leaders in the field of equitable health improvement.

Supplementary Indicator

The Scottish Public Health Network (ScotPHN) has engaged its network at least four times in the implementation of the Public Health Review for Shared Service Portfolio – Public Health Programme.



Red = 0-1 engagements **Amber** = 2-3 engagements **Green** = >3 engagements

Evidence

ScotPHN engaged extensively with the wider public health community – including major data collection exercises, facilitation of a Professional Advisory Group and national stakeholder events – leading to the identification of six distinct workstreams to support implementation of the Public Health Review for Shared Services.



Supplementary Indicator

We can evidence that four identified CPP areas are using our products and services in the formation of their Local Outcomes Implementation Plans (LOIPs).



Red = <3 CPP areas **Amber** = 3 CPP areas **Green** = ≥ 4 CPP areas



Evidence

We supported CPPs and local authority areas to help them develop their LOIPs in relation to health inequalities. Aberdeen City, Fife, Highland and South Lanarkshire each received an offer of tailored support; generally our work focused on:

- Reviewing strategic documents in relation to how they would address health inequalities.
- Support and development for the CPP Board.
- Data analysis and use of evidence: we worked with key strategic partnership groups to develop consensus around a robust inequalities profile and informed discussion of local outcomes.
- Determining, articulating, prioritising outcomes: supporting local areas to refine and prioritise outcomes based on evidence.
- Partnership engagement with CPP members and wider stakeholders as part of the development of the strategic plan and to build commitment to its effective delivery.

While we achieved our target of working with each of the identified CPPs, it is fair to acknowledge that the depth of engagement and involvement by CPP staff was generally not as extensive as hoped and the impact of this programme of work is still to be fully realised. This remains a challenge for us and other national agencies and we will continue to explore different approaches to develop this programme in 2017/18.





We have engaged with 90% of our identified high-interest, high-impact stakeholders in the development of our 2017–22 strategic framework.



Red = <55% **Amber** = 55-79% **Green** = $\ge 80\%$



Evidence

Throughout 2016/17 we developed our Strategic Framework for Action 2017–2022, the next iteration of A Fairer Healthier Scotland (2012–2017). To support this process we arranged a series of engagements with key stakeholders in order to gather their views on what would have the greatest impact in realising a fairer, healthier Scotland and what our role should be.

Of the stakeholders we identified for this purpose, we were able to engage with 70%.



We engage with Scottish Government policy leads in at least 95% of our work that is focused on policy formulation and implementation.



Red = $\le 89\%$ **Amber** = 90-94% **Green** = $\ge 95\%$



Evidence

In 2016/17, NHS Health Scotland engaged with Scottish Government policy leads across a range of policy areas, such as children and young people, housing, alcohol and mental health.

We are able to measure our engagement at 95%.



Supplementary Indicator

Policy and decision makers would recommend our organisation.

Red = <0% **Amber** = 0-15% **Green** = >15%³



This indicator is relevant for two KPI areas: evidence can be found on page 13, 2.1.

 $^{^3}$. Net Promoter Score target > 20%: The Net Promoter Score (NPS) contains a rating scale with ranges from -100 to +100. 0 is considered good, 40% is an excellent score. The NPS is a widely used measure of stakeholder satisfaction.

Customer results

We will only achieve our ambition of reducing health inequalities by building trusting, respectful and mutually valuable relationships with the people we work with and serve. The quality of our products and services is a crucial predictor of how likely they are to help people take the action required to reduce health inequalities and improve health.

5 Key Performance Indicator

Our customers are satisfied with our products and services.



Red = <30% **Amber** = 30-39% **Green** = $\ge40\%^4$



Evidence

Net Promoter Score is a direct measure of the strength of our relationships. The score tells us how others view us and indicates our likely influence as well as helping forecast future impact.

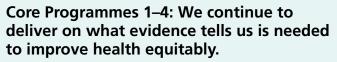
We surveyed a limited sample of our stakeholders, our partners (the people we work closely with) and our customers (the people who use our products and services). Both partners and customers rated NHS Health Scotland positively, in particular our customers, with a rating of 41% which, in Net Promoter Score definitions, is excellent. However, we have room to become more influential with our partners.

Core programmes

Through tracking performance of the delivery of our core programmes, we can identify over time how effective we are as an organisation in planning our work and delivering what we said we would deliver. From this process we can also learn the reasons for not delivering outputs and use this knowledge to improve planning processes year on year.

For 2016/17, corporate priorities were identified and aligned with the core programmes. The performance of the corporate priorities is demonstrated by the percentage of outputs delivered per core programme and with in-depth narrative examples of our impact.

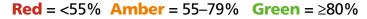
6 Key Performance Indicator





6.1 Supplementary Indicator

We have engaged with 90% of our identified high-interest and high-impact stakeholders.





This indicator is relevant for two KPI areas: evidence can be found on page 14, 2.3.

^{4.} Net Promoter Score target >40%: The Net Promoter Score (NPS) contains a rating scale with ranges from -100 to +100. 0 is considered good, 40% is an excellent score. The NPS is a widely used measure of stakeholder satisfaction.



Supplementary Indicator

100% of outputs / deliverables score >11, and 33% of outputs / deliverables score \geq 17 in the prioritisation process.



Red = <70% score >11 and <10% score ≥17 **Amber** = 70–89% score >11 and 10-29% score ≥17 **Green** = ≥90% score >11 and ≥30% score ≥17



Evidence

Our work is categorised into thematic programmes of work that we agree with the Scottish Government at the start of each business year and which we aim to deliver within one year.

As part of the corporate planning process for 2016/17 our business plan deliverables were prioritised to ensure alignment with the Scottish Government priorities and given a peer-reviewed score out of 20. The basic premise is that the more deliverables we have scoring higher on the prioritisation tool, the greater our focus is on work most likely to reduce inequalities. This approach aimed to ensure that resources were focused on work that would have the greatest impact.

At the end of 2016/17, of the 656 products and services (outputs) we planned to deliver, 459 (70%) were completed or reached their planned position.

Scoring against this indicator achieved 86% of outputs/deliverables score >11, and 29% of outputs score ≥17.

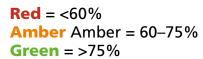
Core Programme 1: Fundamental causes

The focus of the fundamental causes programme is on reducing health inequalities caused by social and economic drivers, which result in unequal distribution of power, money and other resources.



Supplementary Indicator

85% of outputs under CP1 are delivered on time and in scope.









Evidence

In 2016/17 we measured a rating of 66%, compared to 74% in 2015/16.

Fuel Poverty Strategic Working Group

- People who live in the coldest homes are three times more likely to die from cold-related illnesses.
- Households in the lower income bands have the highest rates of fuel poverty.

The Scottish Government's Fuel Poverty Statement (2002) stated: 'The Scottish Government aims to ensure that by November 2016, so far as is reasonably practicable, people are not living in fuel poverty in Scotland.' In 2015 it was apparent that this target would be missed.

The Fuel Poverty Strategic Working Group was tasked by the Scottish Government with developing a vision for the eradication of fuel poverty in Scotland. Their **report** was published in October 2016.

The Scottish Fuel Poverty Forum (SFPF) supports the work of the Fuel Poverty Strategic Working Group. The SFPF has two NHS representatives: ScotPHN, representing Directors of Public Health (DsPH) Group, and NHS Health Scotland.

We contribute to the work of the SFPF in the following ways:

- Supported funding of the Strategic Working Group.
- Participated in the short life review of fuel poverty.
- Facilitated input from poverty agencies to help explore collaborative approaches that would better reach the fuel poor.
- Actively sought information on local approaches to collaborative work, good practice, challenges from a wide range of stakeholders including local organisations and partnerships working directly with local people to help tackle fuel poverty.
- ScotPHN produced **papers** for DsPH Group to raise the profile of fuel poverty across public health and highlight relevant recommendations for the NHS from the Strategic Working Group.
- Attended meeting with Cabinet Secretary to provide overview of key recommendations.

Impact

We helped develop understanding and awareness of fuel poverty from a health inequalities perspective and as a public health issue.

We increased the extent to which the NHS is contributing to tackling fuel poverty.

We supported development of fuel poverty actions across a number of NHS territorial boards resulting in an increase in vulnerable patients accessing support to tackle fuel poverty.

We engaged nine different NHS Boards in a Shelter Scotland project. Shelter provided a fuel poverty eLearning course for individuals working on the frontline in health or social care, highlighting the links between health and fuel poverty to help frontline health and social care practitioners spot signs of fuel poverty and identify how to refer patients for help. Report published by Shelter December 2016.



Next steps

- Continue development of partnerships and dissemination of learning and good practice.
- Integrate our work on fuel poverty with our work on Housing and Health, Place Standard, Health and Social Care and Public Service Reform.
- Support NHS Boards to develop local tests of change to determine new approaches, including routine intervention at key points.

A Healthcare Retail Standard for Scotland

Food Standards Scotland's research highlights the growth in the out-of-home food and drink market in Scotland – a growth which is expected to continue.

In Supporting Healthier Choices: a voluntary framework for action (2012) the Scottish Government and Food Standards Scotland invited businesses and the food industry to work with them to improve Scotland's dietary goals. The policy highlights the crucial role of caterers and retailers in this.

Standards for caterers within the NHS have consistently been developed and raised. Following a new Health Promoting Health Service Chief Medical Officer's letter, caterers are now expected to meet the healthyliving award plus (HLA plus) by 2017.

To ensure retailers would be working to similar standards as caterers, the development of retail standards aimed to be comparable to the HLA plus in reducing fat, sugar and salt in the Scottish diet.

Being highly experienced in the development and implementation of catering criteria within and outwith the NHS, the healthyliving award team was asked by the Scottish Government to support the new retail standard.

We:

- supported the development of the standards and comparability in line with HLA plus and dietary goals
- produced guidance to support implementation within the retail setting
- contributed experience, expertise and learning to the implementation of the standards and assessment process
- commissioned and supported the evaluation process.

Impact

Service level agreements now set out the requirements for a retailer and/or caterer looking to operate within the NHS.

A set of standards has been developed, piloted and fully implemented across the NHS/Healthcare settings. This new standard is comparable with the existing catering criteria and provides an even playing field in which to operate for businesses.

The Minister recently launched the first new Royal Voluntary Service store to achieve the standard in the Western General Hospital in Edinburgh, noting the partnership achievement and the contribution of the healthyliving award.

NHS England and regional Trusts are looking closely at the developments in Scotland and have been in contact to learn more about development and implementation of standards. It is likely that a similar approach will be adopted.

The evaluation will report in 2017/18.



Next steps

Going forward, we will provide an advisory role to the Implementation Group. We will also work with colleagues in NHSScotland, Scottish Grocers Federation and the Scottish Government to create joined-up messaging to inform visitors and staff of the healthy eating standards, drawing on our marketing and publishing experience to allow regional NHS Boards to tailor marketing and informational material to reflect local sites.

Core Programme 2: Social and physical environments for health

Our work on social and physical environments focuses on where we live. Our home, neighbourhood, workplace, social meeting places and green space have a huge influence on how we live, the quality of lives and our long-term health and wellbeing.



Supplementary Indicator

85% of outputs under CP2 are delivered on time and in scope.

Red = <60% **Amber** = 60-75% **Green** = >75%







Evidence

In 2016/17 we measured a rating of 71%, compared to 72% in 2015/16.

Place Standard launch and implementation plan

The crucial relationship between physical and social places, health and inequalities is well documented and fully illustrated in our health inequalities **theory of causation**.

The Place Standard Assessment Tool (PST), launched in December 2015, provides a practical evidence-based mechanism for communities, organisations and businesses to identify and respond to the strengths and development needs of the places in which they live, support, learn and/or invest.

To ensure the Place Standard's effective and consistent application across Scotland, the design, delivery and governance of a national implementation plan was identified as a requirement by NHS Health Scotland in partnership with the Scotlish Government and Architecture & Design Scotland.

With our partners, we:

- developed the Place Standard Implementation Plan in July 2016 and secured final approval by the Scottish Government's Chief Architect and members of the Place Standard Board
- established a national governance and support infrastructure to aid implementation
- created a network of local Place Standard leads for each local authority (28 out of 32 by March 2017)
- promoted and generated UK and European (WHO and UNICEF) interest in using the tool in 2017/18.

Impact

Recorded to date 75 applications across Scotland (up to 1000 participants in one application).

Embedded with Local Authorities, with approximately 70% using the PST and PS Leads appointed in 28 out of the 32 Local Authority areas.

PST used in the development of Local Outcome Improvement Plans and Locality Plans. PST used in the multi-million pound Community Links Plus (cycling infrastructure) investment programme.

Universities and colleges embedding the PST into learning and outcomes. UK and international recognition and future applications through collaborations with WHO Healthy Cities European Network, UNICEF and Dutch Centre for Health Inequalities.

The PST's impact on communities and organisations is outlined in a series of case studies summarised at www.ads.org.uk/placestandard_introduction. In addition to this the NHS Health Scotland Place Standard Evaluation (due for publication in May 2017) further illustrates through five new case studies the positive impacts of the PST.

7

Next steps

This year, 2017/18, we move into year two of a three-year implementation plan in which we will increase investment into the coordination, delivery and governance functions of the PST. All will continue to focus on achieving the plan's key outcomes.

The PST has been shortlisted for the prestigious Royal Town Planning Institute Awards 2017.

Homelessness and Health

Following an innovative partnership engagement approach to the drafting of the ScotPHN Report 'Restoring the Public Health Response to Homelessness' in May 2015, a series of opportunities opened up for stronger collaborative working between public health and the homelessness sector.

The considerable impact of the report – and more importantly the active follow through of new opportunities for public health to partner with the homelessness and housing sector – was recognised at national level. A Consultant in Public Health Medicine from Fife was seconded part-time to NHS Health Scotland for 2016/17 to continue to drive the agenda in a highly visible 'champion' role, leading to:

- extensive networking and active dissemination of the ScotPHN report
- financial support to allow a focus on building local and national activity across many areas and agencies
- supporting reform of the national Health and Homelessness Group
- publishing and dissemination of briefings on homelessness and housing
- input to strategic level conversations and national housing/homelessness events and committees.

Impact

Using a proactive engagement approach with key individuals across the system to build strong relationships and collaborative working at national, regional and local levels.

A vibrant and constructive relationship between the public health community and the housing/homelessness sector which was previously almost non-existent.

National health and homelessness data sharing, including: all-Scotland historical data linkage (by National Records of Scotland), planned addition of homelessness data from 2017, availability of homelessness evidence on ScotPHO.

Collaborative work programme with Shelter and excellent developing relationship with Chartered Institute of Housing (CIH).

Public health presence on key national groups.

An active national Health and Homelessness Group and formation of a Scottish branch of the Faculty for Homeless and Inclusion Health.

7

Next steps

The relationships, openings and positions on strategic groups are now all in place for public health at national and Board level to actively contribute to the housing agenda and to address the deep exclusion experienced by homeless people. Housing and homelessness are now part of core business for NHS Health Scotland and a workplan is in place for the national Health and Homelessness Group.

Core Programme 3: System-wide change for health equity

Core programme 3 defines our contribution to facilitating System Change for Fairness and Equity, with particular emphasis on public services.



Supplementary Indicator

85% of outputs under CP3 are delivered on time and in scope.

Red = <60% **Amber** = 60-75% **Green** = >75%







Evidence

In 2016/17 we measured a rating of 68%, compared to 77% in 2015/16.

Obesity

The prevalence of obesity in Scotland remains stubbornly high, at around 1 in 4 adults and 1 in 6 children. The prevalence of adult obesity has been relatively stable since 2008. There is evidence of socio-economic inequalities in obesity rates, with higher prevalence in those living in the most deprived areas, particularly for women and children.

Obesity is associated with reduced social wellbeing and quality of life. It contributes to a number of physical and mental illnesses and is associated with premature death.

In response to a request from the Scottish Government obesity policy team, we prepared an internal briefing paper for the Scottish Government, 'Making Progress on Obesity', setting out available evidence on effective interventions.

This paper provides **key evidence** about effective weight management interventions and sets this in the context of the wider obesity epidemic in Scotland.

Impact

The Programme for Government set out to develop a new Diet and Obesity Strategy.

We submitted written and oral evidence to the Scottish Parliament's Health and Sports Committee to inform their inquiry into obesity. Our evidence was cited in the committee's letter of response to the Minister of Public Health and Sport, who invited the Committee to provide comments on areas they felt should be covered in a new obesity strategy.



Next steps

We will continue to support the development of the Scottish Government's Diet and Obesity Strategy in providing evidence and evaluation expertise. This will include an evidence summary paper on restricting promotions of food and drinks high in fat, salt and sugar.

Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS)

Alcohol consumption remains one of the key health risk factors in Scotland. We were tasked by the Scottish Government to lead the Monitoring and Evaluating of Scotland's Alcohol Strategy (MESAS). This included a commitment to publish an annual update of analysis of alcohol sales and price data. The publication of the sales data is a unique NHS Health Scotland contribution and provides the gold standard measure of population levels of alcohol consumption in Scotland. The work is used by a range of stakeholders, including Scottish Government, third sector organisations and academic partners, for the purposes of informing policy and research, and raising awareness of the alcohol problem in Scotland.

We obtained, analysed, and interpreted the latest data, and communicated the findings in an accessible, engaging briefing with infographics. The style of the briefing incorporated comments received by stakeholders in 2015/16.

Impact

The briefing, and associated press release, were picked up by a number of national press and broadcast media outlets, including the Herald, Daily Record, BBC News and the Express. NHS Health Scotland's Mark Robinson appeared on BBC News Live and BBC Radio Scotland to discuss findings. The work was also referred to during First Minister's Questions and was discussed during the court case on Minimum Unit Pricing. The work therefore makes an invaluable contribution to ensuring that decision makers, opinion formers and the general public are informed with the most up-to-date intelligence on alcohol consumption in Scotland to help drive the reduction in alcohol-related harm.



Next steps

In June 2017, we will publish updated analysis of alcohol sales and price data. After consulting with key stakeholders, data on other alcohol-related indicators will also be incorporated, with the aim being to produce a compendium that will become a key reference document for those looking for the latest alcohol statistics in Scotland.

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

All of our core programmes include projects that impact on children, young people and families. Our specific core programme on the right of every child to good health allows us to articulate our vision for action on achieving the best start in life. It creates the framework for the actions that we believe will have the strongest impact on reducing health inequalities from people's earliest years throughout their life course.



Supplementary Indicator

85% of outputs under CP4 are delivered on time and in scope.

Red = <60% **Amber** = 60-75% **Green** = >75%







Evidence

In 2016/17 we measured a rating of 53%, compared to 70% in 2015/16.

These results are in the context that this programme has undergone a significant review based on our own analysis and feedback from stakeholders. Because of this, our delivery plans changed through the year.

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) can impact our health in a number of ways, including affecting child brain development, health harming behaviours, poor mental health and affecting the context in which we live (e.g. education, income, social isolation). We know that people living in areas of deprivation are more at risk of ACEs. It is estimated that in Scotland approximately half of us have experienced at least one ACE and at least 9% of our population, most likely more, will have experienced four or more ACEs.

Scotland's Public Health Network (ScotPHN) published **Polishing the Diamonds: Addressing Adverse Childhood Experiences in Scotland** (May 2016) which provides an overview of ACEs, their impact on our population and suggested actions for preventing and responding to childhood adversity in Scotland.

We are leading national work to advocate for action to prevent childhood adversity and to develop more informed responses.

A multi-agency Adverse Childhood Experiences Hub has been established with representation from the NHS (including Health Scotland), Scottish Government, local government, the third sector and academics. This group is championing a Scotland-wide movement to raise understanding and inform action in preventing and responding to ACEs. Through our contribution in 2015/16, we implemented the following:

- ACEs Hub hosted a national conference, 'Polishing our Gems: A call for action on Childhood Adversity', looking at how our understanding of childhood adversity can be built into public sector services.
- We collaborated with key policy and practice stakeholders, in particular to:
 - develop guidance to inform decisions on use of Pupil Equity Funding
 - share knowledge and understanding with key stakeholders by presenting at a number of events and conferences.

Impact

We fostered relationships and collaborations with key stakeholders:

- Linking ACE work with NHS Education Scotland to develop a competency-based framework for trauma informed services.
- Working with local NHS Boards to influence their strategic planning on child health and health inequalities.
- Influencing the development of a new Child and Adolescent Health and Wellbeing Strategy for Scotland, ensuring childhood adversity is recognised within the context of inequality.

To date, the work of the ACEs Hub has focused on raising awareness of ACEs and associated health implications of experiencing childhood adversity. We have established a solid foundation for joint action and partnership working going forward – our planned contribution to local and national policy development will seek to improve health and reduce health inequalities for children at risk of, or affected by, ACEs.

Child Poverty eLearning module

Current levels of child poverty are significant: 1 in 4 children in Scotland live in poverty (this increases to 1 in 3 where the child has a disability) and 70% of children who are living in poverty are in households where at least one person is working. Poverty adversely impacts on children's social, emotional and cognitive outcomes and increases levels of stress for families.

It is recognised that health professionals working with children and families need to have an understanding and knowledge of the impact of poverty.

The focus of our eLearning resource is on undergraduate and continuing professional development programmes in midwifery and health visiting. It also has application to a wider range of staff and students working with children and families. We brought together key partners from academic, local authority, NHS and third sectors to develop the resource.

We led on the development of the module, establishing a planning group, producing content, applying the quality assurance process and evaluation. We also contributed to the active dissemination with key stakeholders (higher education institutes, further education colleges), professional organisations and the showcasing of the module e.g. 'Facing Up to Child Poverty in Schools' in November 2016. We held events in February 2017 which included 'The Gathering 2017' and the 'Financial Inclusion Referral Pathways' event.

Impact

We launched the eLearning module on Child Poverty, Health and Wellbeing in September 2016. It is available free of charge from the NHS Health Scotland Virtual Learning Environment (VLE).

We engaged with a range of higher education institutes, course leaders, including health visiting and midwifery, to promote the incorporation of the module into undergraduate programmes. Between October 2016 and February 2017, 234 learners completed the module. Feedback from those who have completed the evaluation shows that 82% feel their awareness of the issues has been raised; 78% would challenge negative stereotypes; and 82% would share the learning.

This module will form part of the package of support that will be on offer from NHS Health Scotland to support the implementation of the Fairer Scotland Action Plan and, in particular, the Child Poverty (Scotland) Bill.



Next steps

We are developing a series of case studies to complement the module that will focus on the practical actions that learners can take within their role to impact on child poverty.

Early Learning and Childcare

A key Scottish Government priority is the provision of high quality, flexible early learning and childcare (ELC) that is affordable and accessible for all. Since August 2014 free entitlement to ELC has increased to 600 hours per year for all 3 and 4-year-olds and eligible 2-year-olds. This will be increased to 1140 hours by 2020, equating to around 30 hours per week during school term time. At the heart of this is ensuring that developmental outcomes for all children are improved, in particular those who will benefit the most, ultimately reducing health and educational inequality.

We have made a substantial contribution to the policy development underpinning the expansion of ELC and plans for evaluation of its success. We have provided:

- contribution to national groups, the ELC Strategic Forum, chaired by the Minister for Childcare and Early Years and the Strategic Evidence group
- input to policy development sessions and provision of specialist evidence, health economics and evaluation advice
- a Rapid Systematic Evidence Review for the Scottish Government on the potential impact of the expansion of ELC on parents' outcomes in collaboration with the Scottish Collaboration for Public Health Research & Policy
- an evaluation assessment of the ELC expansion for the Strategic Evidence group.

Impact

Our evidence and evaluation work has influenced the Scottish Government's monitoring and evaluation programme for the ELC expansion in the coming years.

We aimed to ensure that the expansion of ELC plays a key role in addressing developmental, educational and social inequalities among our youngest children. This is reflected in the Scottish Government's A Blueprint for 2020: The expansion of Early Learning and Childcare in Scotland, published in March 2017.

As a result of our work, our evaluation expertise has been sought by other key stakeholders:

- We are providing Children in Scotland, Glasgow City Council and the Glasgow Centre for Population Health support to evaluate a three-year project to establish improved, affordable and sustainable childcare in three Glasgow neighbourhoods: Calton/Bridgeton; Parkhead/ Dalmarnock; and Tollcross/West Shettleston.
- We are members of the steering group for the Audit Scotland Early Learning and Childcare Audit.
- We facilitated outcomes planning for the Care Inspectorate which enabled them to think through a new structure for carrying out inspections which would be needed in order to support the roll-out of ELC.



Next steps

Our contribution to this flagship policy area is likely to continue for several years. We will continue to work with the Scottish Government to influence the policy implementation and on the monitoring and evaluation framework for the ELC expansion. In the immediate future we are providing support around quality in ELC, impact on children's outcomes and value for money.

Core Programme 5: Developing an excellent organisation

So that we can effectively support delivery of our work, we continuously challenge ourselves to be an excellent organisation. This includes making the most effective use of our financial and other resources, having a fully engaged and skilled workforce, and ensuring processes are in place that support the greatest use of the knowledge generated by the organisation.

7 Key Performance Indicator

CP5: We continue to develop an excellent organisation.



7.1 Supplementary Indicator

85% of outputs under CP5 are delivered on time and in scope.

Red = <60% **Amber** = 60-75% **Green** = >75%





O

Evidence

In 2016/17 we measured a rating of 78%, compared to 64% in 2015/16.

At the end of year 2016/17, 78% of the products and services (outputs) we planned to deliver under Core Programme 5 were completed or reached their planned position.

CP5 is about the core work that supports the organisation to be efficient, effective and to deliver all of our strategic objectives well. To avoid duplication, each of the CP5 workstreams (Improved staff experience; Improved planning and use of resources; Improved stakeholder experience; and National leadership development) are measured against the KPIs and supplementary indicators present within other sub-domains.

Improved staff experience:

7.2

Supplementary Indicator

All teams meet or exceed an Employee Index Score of 69%.

Red = <60% **Amber** = 60-66% **Green** = ≥67%



2015/16 Green

Evidence can be found on page <u>37, 8.1</u>.

Improved planning and use of resources:

7.3

Supplementary Indicators

Resource alignment: 80% of the available resources within NHS Health Scotland have been allocated to signed-off projects within the Business Plan by Q2 of each business year.

2016/17 Green 2015/16 Green

Red = overspent (or forecast to be overspent at year end)

Amber = overspent during financial year, or underspent during financial year Green = on target and forecast to be on target 7.4 Budget expenditure: the resource revenue will be managed to the following percentages in terms of budget committed and spent:



2015/16 Green

- a) 31 January 95% committed (costs incurred + outstanding committed spend to 31 March)
- b) 28 February 90% spent (costs incurred)
- c) 31 March 95% spent (costs incurred)
- d) Closure of accounts 99% spent (costs incurred)

Red = overspent (or forecast to be overspent at year end) **Amber** = overspent during financial year, or underspent during financial year

Green = on target and forecast to be on target

Corporate priority leads state that corporate priorities were adequately resourced in terms of staff time.



2015/16 Amber

Red = overspent (or forecast to be overspent at year end)

Amber = overspent during financial year, or underspent during financial year

Green = on target and forecast to be on target

Corporate priority leads state that corporate priorities were adequately resourced in terms of budget.



2015/16 Green

Red = overspent (or forecast to be overspent at year end)

Amber = overspent during financial year, or underspent during financial year

Green = on target and forecast to be on target Evidence for supplementary indicators 7.3 to 7.6 can be found on pages 41 and 42.

Improved stakeholder experience, better knowledge:

7.7

Supplementary Indicators

90% of all corporate priorities are delivered on time.

Red = <55%

Amber = 55–75%

Green = >75%



2015/16 Amber

Evidence can be found on page <u>37</u>, <u>8.2</u>.

7.8

Policy and decision makers would recommend our organisation.

Red = <55%

Amber = 55–75%

Green = >75%

Evidence can be found on page 13, 2.1.



National leadership development:

7.9

Supplementary Indicator

The Scottish Public Health Network (ScotPHN) has engaged its network at least four times in the implementation of the Public Health Review for Shared Services Portfolio – Public Health Programme.



Red = 0-1 engagements

Amber = 2–3 engagements

Green = >3 engagements

Evidence can be found on page 18, 4.1.

7

7.10 Supplementary Indicator

We can evidence that four identified CPP areas are using our products and services in the formation of their Local Outcomes Implementation Plans (LOIPs).



Red = <3 CPP areas

Amber = 3 CPP areas

Green = \geq 4 CPP areas

Evidence can be found on page 18, 4.2.

These results indicate that while overall resource management was satisfactory, we are not yet doing enough to prioritise resources on specific delivery areas – particularly staff time.

Performance domain 3: Our enablers

Our people and workforce

The delivery of our work depends to a great extent on the productivity of our staff. We consider staff experience to be a useful proxy indicator of productivity. We measure this via the Employee Index Score from the iMatter survey, the national tool being used across all NHSScotland Health Boards to measure staff experience at an organisational, team and individual level. 2016/17 is the first year for which we have gathered a complete organisational score via iMatter.

8 Key Performance Indicator

Our workforce is appropriately skilled, engaged and motivated to deliver our corporate priorities and strategy, while a positive staff experience is promoted.



8.1 Supplementary Indicators

All teams meet or exceed an Employee Index Score of 69%.

Red = <60% **Amber** = 60-66% **Green** = >67%



2015/16 Green



Evidence

In 2016/17 we achieved a rating of 78% which mirrors our rating in 2015/16 which was a part score.



90% of all corporate priorities are delivered on time.

Red = <55% **Amber** = 55–75%

Green = >75%







Evidence

In 2016/17 66% of our corporate priorities were delivered on time (compared to 70% in 2015/16).

We also monitor indicators in line with the five themes of the NHSScotland Staff Governance Standard.

Well informed:

8.3 Supplementary Indicators

Percentage of staff who respond positively to iMatter question on getting the information needed to do job well.



2015/16 Green

Red = <60% **Amber** = 60-69% **Green** = $\ge 70\%$

Appropriately trained and developed:

8.4 Supplementary Indicator

Percentage of staff with completed Personal Development Plan (PDP).

Red = <80% **Amber** = 80-89% **Green** = ≥90%







Evidence

In 2016/17 we achieved 95%, compared to 88% in 2015/16.



Supplementary Indicator

Percentage of staff with active PDP entries on e-KSF, other than mandatory training, within the last 12 months.





Red = <80% Amber = 80-89% Green = >90%



Evidence

In 2016/17 we achieved 98%, compared to 76% in 2015/16.



Supplementary Indicator

Quality of PDP conversations: specifically that performance, development and career aspirations were discussed.





Red = <59% **Amber** = 60-69% **Green** = >70%



Evidence

In 2016/17 we achieved 62.5%, compared to 56% in 2015/16.



Supplementary Indicator

Percentage of staff denied training that was agreed in their PDP.

Red = >16% **Amber** = 7.6-15%

Green = <7.5%







Evidence

In 2016/17 we achieved 5%. There were no data for this supplementary indicator in 2015/16.



Supplementary Indicator

Percentage of staff who responded positively to iMatter question on being given the time and resources to support learning growth.





Red = <33% **Amber** = 34-66% **Green** = >67%



Evidence

In 2016/17 we achieved 66%. There were no data for this supplementary indicator in 2015/16.

Treated fairly and consistently:

8.9

Supplementary Indicator

Staff turnover rate.

Red = <4% or $\ge 16\%$

Amber = 4–5% or 11–15%

Green = 5-10%

2016/17 Green 2015/16 Amber



Evidence

In 2016/17 our turnover rate was 5.6%, compared to 12.18% in 2015/16.



Supplementary Indicator

Number of formal grievances.

Red = ≥11% **Amber** = 6-10% **Green** = <6% 2016/17 Green 2015/16 Green



Evidence

In 2016/17 our formal grievance rate was 0, compared to 1 in 2015/16.



Supplementary Indicator

Percentage of staff who responded positively to iMatter question on being treated fairly and consistently.

Red = <55% Amber = 55-74% Green = >75%



2015/16 Green



Evidence

In 2016/17 we achieved a rate of 84%, compared to a part score of 77% in 2015/16.

Involved in decisions:



Supplementary Indicator

Percentage of staff who responded positively to iMatter questions on involvement in decisions about staff governance standard.



2015/16 Amber

Red = <60% **Amber** = 60-69% **Green** = ≥70%



Evidence

In 2016/17 we achieved a rate of 77%, compared to a part score of 60% in 2015/16.

Healthy and safe working environment:

8.13

.13 Supplementary Indicator

Rate of accidents at work.

Red = ≥25 **Amber** = 15–25 **Green** = <15



2015/16 Green



Evidence

In 2016/17 our rate of accidents at work was 6, compared to 7 in 2015/16.

8.14

Supplementary Indicator

Staff absence rate.

Red = ≥8.1% **Amber** = 4.1–8% **Green** = ≤4%



2015/16 Green



Evidence

In 2016/17 our rate was 3.8%, compared to 3.25% in 2015/16.



Supplementary Indicator

Completion rate for mandatory Health & Safety training.

Red = <60% **Amber** = 60-95% **Green** = >95%



2015/16 Amber



Evidence

In 2016/17 our rate was 90% for DSE training, compared to 84% in 2015/16.



Supplementary Indicator

Occupational Health referral rate.

Measured against statistically significant deviation:



2015/16 N/A



Evidence

Red = significant Green = insignificant

In 2016/17 our rate was 8 referrals. There were no data for this supplementary indicator in 2015/16.



Supplementary Indicator

Percentage of staff who responded positively to iMatter questions on health and wellbeing.



2015/16 N/A

Red = <60% **Amber** = 60-80% **Green** = >80%



Evidence

In 2016/17 we achieved 83.5%. There were no data for this supplementary indicator in 2015/16.

Our finance and resources

Successful delivery of the A Fairer Healthier Scotland (2012–2017) strategy depends on effective allocation of the organisation's finances and resources to deliver our core programmes and priorities.

This report provides a high-level overview. Further information on 2016/17 finances is provided elsewhere.

9 Key Performance Indicator

We spend our budget within the revenue resource limit. Corporate priorities are fully resourced (in terms of time and budget).



We have continued the trend of improved efficiencies with all statutory targets having been met. In addition to the overarching KPI data we have a number of supplementary indicators which build a greater picture of our performance in relation to finance and resources.

9.1 Supplementary Indicator

Resource alignment: 80% of the available resources within NHS Health Scotland have been allocated to signed-off projects within the Business Plan by Q2 of each business year.



2015/16 Green

Red = overspent (or forecast to be overspent) at year end **Amber** = overspent during financial year, or underspent during financial year

Green = on target and forecast to be on target

O

Evidence

In 2016/17 our rate was 96.2%, compared to 83.7% in 2015/16.

9.2

Supplementary Indicator

Budget expenditure: the resource revenue will be managed to the following percentages in terms of budget committed and spent:





- a) 31 January 95% committed (costs incurred + outstanding committed spend to 31 March) (97.9% 2016/17, 96% 2015/16)
- b) 28 February 90% spent (costs incurred) (87.8% 2016/17, 98% 2015/16)
- c) 31 March 95% spent (costs incurred) (99% 2016/17, 99% 2015/16)
- d) Closure of accounts 99% spent (costs incurred) (99% 2016/17, 99% 2015/16)

Red = overspent (or forecast to be overspent) at year end Amber = overspent during financial year, or underspent during financial year Green = on target and forecast to be on target



Supplementary Indicator

Corporate priorities are fully resourced: Corporate priority leads state that corporate priorities were adequately resourced in terms of staff time.







Red = <60% **Amber** = 60-80% **Green** = $\ge 80\%$

Evidence

In 2016/17 our rate was 67%, compared to 65% in 2015/16.



Supplementary Indicator

Corporate priorities are fully resourced: Corporate priority leads state that corporate priorities were adequately resourced in terms of budget.



2015/16 Green

Red = <60% **Amber** = 60-80% **Green** = ≥80%



Evidence

In 2016/17 our rate was 94%, compared to 100% in 2015/16.

Each corporate priority was led by a senior member of staff. 67% of our corporate priority leads felt that they were fully resourced in terms of staff time and staff allocation. This mirrors our performance on this indicator in 2015/16. Staff capacity has been identified as the main reason we are unable to deliver on planned/unplanned outputs and these figures also potentially indicate that we have some way to go to fully focusing resources on identified priority areas.

We plan to use our Corporate Planning Tool to establish a fuller understanding of how we spend our time, in order to improve how we plan staff capacity in the future.

Glossary

'A Fairer Healthier Scotland' (AFHS)

NHS Health Scotland's five-year strategic statement for the period 2012–2017, which set out our mission and vision.

Absolute inequalities

A practical value measurement that measures the difference between the lowest and the highest socio-economic groups.

Community Planning Partnership (CPP)

A group of public agencies that work together within the community to plan and deliver better services which make a real difference to people's lives.

Core Programme (CP)

NHS Health Scotland's work is grouped under five core programmes (2012–2017).

Corporate Planning Tool (CPT)

An online system that supports business planning by helping us to plan, record and report on our work and organisational resources.

Corporate Risk Register

Lists the strategic risk the organisation faces, who is the responsible director and what action is being taken to mitigate the risk. This document is revised on a continual basis.

Department for Work and Pensions (DWP)

The largest government department in the United Kingdom, responsible for welfare and pension policy.

Employee Index Score

This is generated from the responses to 28 questions within the iMatter staff survey and provides an overall percentage of an organisation's level of positive staff experience.

Fair Work Convention

The independent body established to develop a clear blueprint for fair work practices in Scotland.

Fuel Poverty Strategic Working Group

The Scottish Government initiative set up to develop a vision for the eradication of fuel poverty in Scotland.

Gini coefficient

Method used to measure the distribution of income in a given country.

Health Impact Delivery Group (HIDG)

Group established by the Scottish Government that comprises representatives from health, local government and third sector. The group is looking to produce advice on actions NHS Boards can take in the short and long term to reduce impact of the welfare reform on the NHS.

Health inequalities

The unfair and avoidable differences in people's health across social groups and between different population groups.

Homelessness Prevention and Strategy Group (HPSG)

Steering group set up 'to assess, inform, influence and further embed homelessness prevention activity in Scotland'.

iMatter

A staff-experience continuous improvement tool designed with staff in NHSScotland to help individuals, teams and Health Boards understand and improve staff experience.

Key Performance Indicators (KPIs)

Measurements of performance against our performance framework.

Knowledge Into Action (KIA)

Turning knowledge or evidence into policy and practice.

Monitoring & Evaluating Scotland's Alcohol Strategy (MESAS)

Programme established to evaluate Scotland's alcohol strategy.

Morbidity

Frequency in which a disease or unhealthy condition appears in a particular area.

Mortality rates

The number of deaths in a given area or period, or from a particular cause.

Net promoter score (NPS)

A measurement tool used to gauge satisfaction with a service provided.

Programme for Government

Sets out the actions the Scottish Government will take in the forthcoming year and beyond.

Red, amber and green (RAG)

Scale that uses the colours of traffic lights to signal work status.

Relative Index of Inequality (RII)

Measure of the extent to which a chronic illness/early death varies dependent on socio-economic factors.

Relative inequalities

An analytical measurement that looks at the ratio between the lowest and the highest socio-economic groups.

Revenue resource limit

The target that the Scottish Government sets for public bodies to spend.

Scottish Index of Multiple Deprivation (SIMD)

The Scottish Government's official tool for identifying those places in Scotland suffering from deprivation. It incorporates several different aspects of deprivation, combining them into a single index.

Slope Index of Inequality (SII)

Measurement that is a regression line (slope) showing the relationship between a class or group's health status and its rank in socio-economic terms.

Socio-economic inequalities

A person's social and economic position in relation to others, based on income, education and occupation.

Strategic Engagement Customer Relationship Management (CRM)

An online system to help us to manage, record and report on our interactions with strategic stakeholders. It is a tool that lets us understand who the organisation is strategically engaging with, in which areas and on what.

Supplementary indicators

Additional measurements of our performance.

Warwick-Edinburgh Mental Well-being Scale (WEMWBS)

A tool that can be used for assessing a population's mental health.

World Health Organization (WHO)

A specialised agency of the United Nations concerned with international public health. It works with national governments and other partners to ensure the highest attainable level of health for all people.

Health inequalities trends

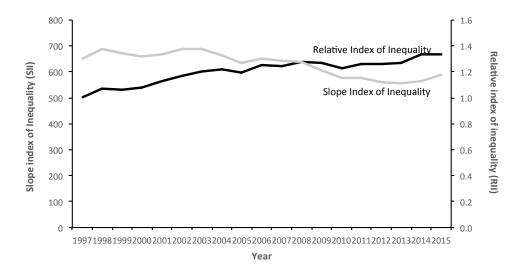
'Social inequalities (or inequities) in health refer to health disparities, within and between countries, that are judged to be unfair, unjust, avoidable, and unnecessary (meaning: are neither inevitable nor unremediable) and that systematically burden populations rendered vulnerable by underlying social structures and political, economic, and legal institutions.'

We selected three indicators to cover premature mortality, morbidity (or ill-health, measured in terms of healthy life expectancy) and wellbeing and report these in both relative and absolute terms.²³ The positive measures of health (healthy life expectancy and wellbeing) are derived from survey data, but no new such data are available since last year.

Figure 1 shows the trends in absolute and relative inequalities for premature mortality. Relative inequalities (as measured by the RII) steadily increased between 1997 and 2008 before levelling off until 2013. They increased further in 2014 and 2015, due in part to an absolute rise in mortality in the tenth of the population living in the most deprived areas. Absolute inequalities in premature mortality had declined between 1997 and 2013 but this has also subsequently increased, again due to a rise in mortality among those living in the most deprived areas.

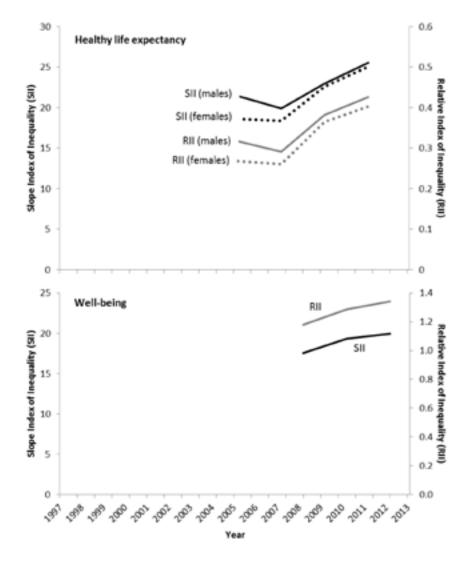
Figure 2 shows the trends in inequalities for mental wellbeing and healthy life expectancy for the longest time period available (to 2013 and 2012 respectively). These inequalities have increased in relative and absolute terms from around 2007/8 onwards on both of these measures. Although life expectancy has continued to increase across the whole population over time, it has increased more rapidly in the least deprived areas and the length of time spent in ill-health in the more deprived areas has remained substantially longer than in the least deprived areas.⁴

Figure 1 – Trend in premature mortality (<75 years, Scotland, 1997–2015)



- 1 Krieger N. A Glossary for Social Epidemiology: part II. J Epidemiol Community Health 2001;55:693-700.
- 2 Premature mortality is defined as European Age-Standardised mortality Rates (EASRs) for those aged <75 years; healthy life expectancy is a combination of self-reported health and life expectancy; and wellbeing is measured as the proportion of the population scoring below average on the Warwick-Edinburgh Mental Health and Wellbeing Scale (WEMWBS). All inequalities are calculated using the income and employment domains of the Scottish Index of Multiple Deprivation (SIMD) to rank datazones (small areas with a mean population of c.700 people).
- 3 Only healthy life expectancy is routinely reported separately for men and women.
- 4 Healthy life expectancy: deprivation deciles. Edinburgh, ScotPHO, 2015 [accessed at www.scotpho.org.uk/population-dynamics/healthy-life-expectancy/data/deprivation-deciles on 29 December 2015].

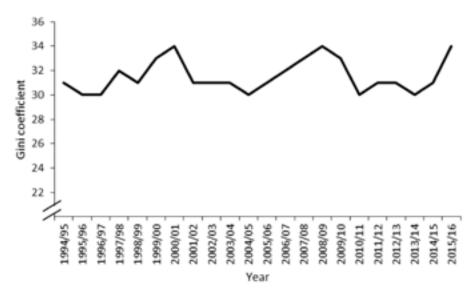
Figure 2 – Trends in inequalities in healthy life expectancy and wellbeing (Scotland, 1997–2013)



Trends in fundamental causes

Figure 3 shows the trends in income inequality from 1994/5 to 2015/6 using the Gini coefficient (where a value of zero represents complete equality and 100⁵ represents complete inequality (where one individual receives all of the income)). The most unequal countries in the world (e.g. Mexico) have Gini coefficients in the 40s, and the most equal have coefficients in the mid-20s. The Gini coefficient in the UK increased from the mid-20s to the high-30s during the 1980s and 1990s before stabilising at that level. Scotland has a slightly lower Gini coefficient than the UK overall and the value has been very varied between 30 and 34 over the last 10 years. Income inequality in Scotland increased in the last two years and now sits at the highest level since 2008/9.

Figure 3 – Trend in income inequality in Scotland (as measured by the Gini coefficient, y-axis truncated)⁶



5 The Gini coefficients here are given on a scale of 0–100 rather than the traditional 0–1 scale for ease of interpretation.

⁶ Data are from the Households below Average Income dataset held by the Department for Work and Pensions and published in: Poverty and income inequality in Scotland: 2013/14. Edinburgh, Scottish Government, 2015.

Relative poverty in Scotland declined steadily from around 2000 to around 2011 for the total population, pensioners and children, but not for working-age adults. There has subsequently been an increase in poverty from 2011 for all groups (Figure 4).

Data on wealth inequality trends in Scotland are now available as a Gini coefficient (with a higher number indicating greater inequality). This suggests that wealth inequality in Scotland decreased from 2006/8 to 2012/14 (Figure 5).

Figure 4 – Trends in the percentage of the population in relative poverty (below 60% of median income in the same year, after housing costs)

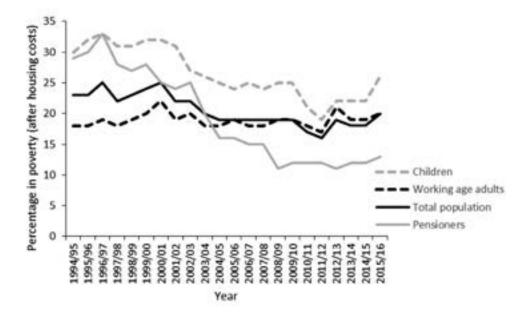
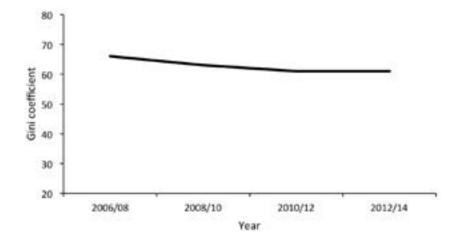


Figure 5 – Trend in the Gini coefficient of total household wealth (Scotland, y-axis truncated)⁷



⁷ Wealth and Assets Survey. London, Office for National Statistics, 2015.

Fundamental causes of health inequalities: contribution analysis evidence

List of media citations recorded on report of the causes of excess mortality in Scotland and Glasgow:

- Sunday Herald: 'Revealed: "Glasgow effect" mortality rate blamed on Westminster social engineering'. www.heraldscotland. com/news/14493634.Revealed Glasgow effect mortality rate blamed on Westminster social engineering
- Blog by Wee Ginger Dug: 'Showing the Union a real Glasgow effect'. https://weegingerdug.wordpress.com/2016/05/15/showing-the-union-a-real-glasgow-effect/
- Evening Times: 'UK government policies blamed for Glasgow effect on health'. www.eveningtimes.co.uk/news/14494207.UK government policies blamed for Glasgow effect on health/
- Commonspace online blog: 'Scotland Office policies blamed for Glasgow Effect in forthcoming report'. www.commonspace.scot/ articles/8404/scotland-office-policies-blamed-glasgow-effectforthcoming-report
- David Walsh interviewed on BBC Two Scotland's 'Scotland 2016' programme. www.bbc.co.uk/iplayer/episode/b07cb36k/scotland-2016-17052016
- Bruce Whyte interviewed in Gaelic on excess mortality for BBC Alba's An La news bulletin. <u>www.bbc.co.uk/programmes/b07b9j11</u>
- Bruce Whyte interviewed in Gaelic on excess mortality for BBC Radio Nan Gaidheal morning radio show.
- STV News: 'Labour let down Glasgow's poor. Nicola Sturgeon must not do the same'.http://stv.tv/news/politics/1354974-labourabandoned-glasgows-poor-nicola-sturgeon-must-not-do-the-same/

- The Conversation: 'Sick Scotland: SNP plans to deal with health inequality are lukewarm at best'. https://theconversation.com/sick-scotland-snp-plans-to-deal-with-health-inequality-are-lukewarm-at-best-59294
- The Guardian: 'We are one step closer to roving squads of child-catchers' www.theguardian.com/commentisfree/2016/ may/28/one-step-closer-to-squads-of-child-snatchers
- The Guardian: 'Is city living bad for your health?'
 www.theguardian.com/healthcare-network/2016/jun/08/city-living-bad-for-health
- The Guardian: 'The Glasgow effect: "We die young here but you get on with it"'. www.theguardian.com/cities/2016/jun/10/glasgow-effect-die-young-high-risk-premature-death
- David Walsh interviewed on BBC Radio Scotland's Stephen Jardine programme. <u>www.bbc.co.uk/programmes/b07cz706</u>
- Commonspace blog: 'The Glasgow Effect: Activism as a public health issue'. www.commonspace.scot/articles/8599/glasgow-effect-activism-public-health-issue
- Sunday Post: 'Sick man of Europe gets sicker: Scots life expectancy lower than former communist states'. www.sundaypost.com/news/scottish-news/scotland-set-sick-maneurope-life-expectancy-worse-former-communist-states/
- Glasgow Live: 'Kevin McKenna's diary: A big, fat Glasgow wedding in Canada'. www.glasgowlive.co.uk/news/glasgow-news/kevin-mckennas-diary-big-fat-11584211
- The Geographer (Royal Scottish Geographical Society magazine): 'Explaining "excess" mortality in Scotland and Glasgow' (interview with David Walsh and Gerry McCartney) – Summer 2016 edition.
- Commonspace blog: 'Take a tour of Glasgow's industrial past with the Our Land festival'. www.commonspace.scot/articles/9120/clementine-sandison-take-tour-glasgows-industrial-past-our-land-festival

- The Guardian: 'Naomi Eisenstadt: "By comparison England is so grim!", www.theguardian.com/society/2016/sep/06/naomieisenstadt-poverty-adviser-to-nicola-sturgeon
- Clare Bambra's new book, Health divides: where you live can kill you, discusses the GCPH excess mortality work, including listing some of the report's policy recommendations. https://policypress.co.uk/health-divides
- Excess mortality report commended in parliament by Alison
 Thewliss MP for Glasgow Central: 'I commend to the House the
 recent report by the esteemed Glasgow Centre for Population
 Health, "History, politics and vulnerability: explaining excess
 mortality in Scotland and Glasgow", which seeks to explain why
 Glaswegians continue to die younger than they should. The policy
 of this Government and of previous Governments has a lot to
 answer for, and we must not make the same policy mistakes now.'
- BBC Scotland's Inequalities Week: 'Dying in poverty: How being poor can cut short your life'. www.bbc.co.uk/news/uk-scotland-38003373
- Excess mortality report mentioned on BBC Radio Scotland's Newsdrive programme. www.bbc.co.uk/programmes/b081nntt
- The Herald: 'Blaming London for Glasgow's decline only tells half the story'. www.heraldscotland.com/opinion/14513010.Blaming London for Glasgow 39 s decline only tells half the story/

List of consultations responses which cited our input in their reports:

- Scottish Labour Party's 'Commission on Health Inequalities' consultation
- Hunger & Food Poverty Inquiry call for evidence
- Setting the Persistent Child Poverty Target
- Inquiry into the devolution of further fiscal powers
- The Scottish Government's scrutiny of the draft budget 2015–16
- Women and Welfare Call for Evidence

- Call for evidence on the future of local taxation
- Consultation on the Regulations and Statutory Guidance under the Welfare Funds (Scotland) Act 2015
- Budget July 2015: Have Your Say
- Land Reform (Scotland) Bill Call for Evidence
- Call for Evidence on the Scottish Rate of Income Tax
- Call for Evidence on Devolved Social Security Powers for Scotland
- Welfare to Work Inquiry
- Benefit Delivery Inquiry
- Call for Evidence: Feeding Britain
- Call for evidence: APPG on Health in All Policies inquiry into the impact of the Welfare Reform and Work Bill 2015–16 on child poverty, child health and inequalities

Examples of media reporting of our work:

- STV and the Daily Record covered Martin Taulbut's evidence to the Holyrood Economy Committee on how the work affects people's health. It also featured on the BBC's Democracy Live web channel.
- Martin Taulbut's work on health and employment was referred to in a Scotsman article on in-work poverty.
- Our input to the Work, Wages and Wellbeing inquiry was also featured in the Herald: 'Work may be bad for your health, NHS Health Scotland tells MSPs' and in the Evening Times: 'Low pay bad for your health'.
- We published What comes first, the healthy economy or the healthy society? in Holyrood magazine the first print media appearance by NHS Health Scotland Chair David Crichton.
- Two Press Association stories were picked up in relation to our oral evidence to Parliament on the SRIT in national and local papers. Nationally, the stories were picked up in the Scotsman: 'Scots income tax raise would fight health inequality' and the Herald: 'Income tax in Scotland should be increased to help tackle health inequalities'.

This resource may also be made available on request in the following formats:















nhs.healthscotland-alternativeformats@nhs.net

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