
NHS
Health
Scotland

# Impact Assessment Report

2017–18

# Contents

# Chief Executive's foreword

I am delighted to introduce our Impact Assessment Report for 2017/18. 2017/18 was an important year, in which much of our focus was on the future. Having engaged with our stakeholders throughout the previous year, we published our new five-year vision for a fairer, healthier Scotland. Building on the direction of travel set out in our first A Fairer Healthier Scotland strategy 2012–2017, this Strategic Framework for Action 2017–2022 describes the five strategic priorities that will form the basis of our work for the foreseeable future.

It was also a 12-month period that saw important work in relation to the Scottish Government's Health and Social Care Delivery Plan, which was published in December 2016. This included wide-ranging developments to ensure that Scotland's public health activities, and health and social care services are fit to meet the challenges of our changing society. It also included developments with direct implications for NHS Health Scotland, not least the decision to create a new national public health body and the direction of travel towards greater sharing of resources across NHS Boards.

Combined, this meant that 2017/18 was a year of consolidating our legacy by refreshing our vision within our Strategic Framework, together with engagement and involvement in new horizons. We agreed a work programme that continued to deliver impactful and influential work to reduce inequalities in health. We also created crucial new capacity to start to prepare for transition to the new public health body and other related changes.

Our aim was to ensure that our performance remained excellent and valued by our customers and stakeholders – despite the uncertainties that a changing context inevitably brings, and despite the trends in health inequalities that continue to demand our unstinting action. I believe this report demonstrates that we have met this aim.

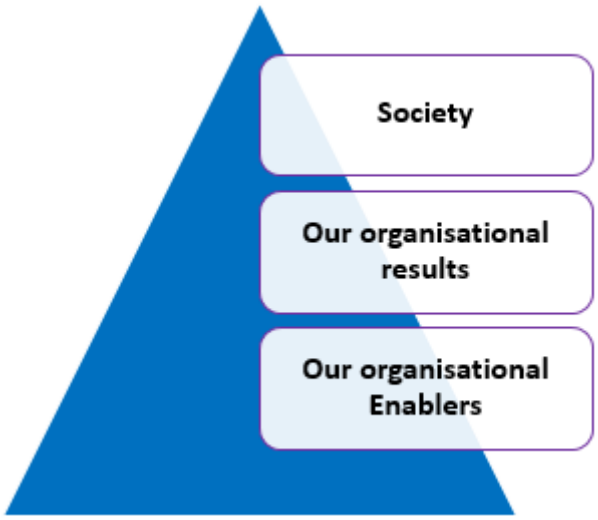
Gerry McLaughlin
Chief Executive, NHS Health Scotland

# 1. Our approach to measuring impact

Our vision is a Scotland in which all of our people and communities have a fairer share of the opportunities, resources and confidence to live longer, healthier lives. We measure our impact in relation to the short- and long-term outcomes which are steps on the way to achieving this vision. The long-term outcomes are set out in our Strategic Framework for Action 2017–2022 and the short-term outcomes are set out in our annual Delivery Plan.

## Our Performance Framework

We determine our impact using a Performance Framework, which comprises three domains:




1. **Society:** Trends in health inequalities[1] and the fundamental causes of health inequalities (inequalities in incomes, wealth and power).
2. **Our organisational results**: Our performance in relation to our work, including stakeholder engagement and satisfaction.
3. **Our organisational enablers**: Our performance in relation to managing our organisational resources, including our people.

[1] Health inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups.

Within each of the domains, we use Key Performance Indicators (KPIs) and supplementary indicators to measure performance. We provide a red, amber, green (RAG) rating for the KPIs, and supplementary indicators and narrative examples to demonstrate our overall impact. The RAG scale uses the colours of traffic lights to signal work status.

In summary, we aim to measure:

- whether or not we are set up for success
- whether or not we have achieved what we said we would in the reporting period
- the short- and longer-term impact of our actions and contribution.

# Summary of impact in 2017/18

We have seven KPIs. The first relates to the wider context in which we operate and measures societal trends in health and social inequalities in Scotland. The remaining six KPIs relate to either our direct work as an organisation or to outcomes to which we contribute. In 2017/18 we met or exceeded our targets in five of the six KPIs that are at least partially within our control.

**1 Societal trends in health and social inequalities in Scotland show an improvement in absolute and relative health**

RED

**2 The Net Promoter Score (NPS)[2] for partners is greater than 0%**

GREEN

**3 The NPS for customers is greater than 40%**

AMBER

[2] The Net Promoter Score 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.

**4 Across all of the strategic priorities we have shared relevant products and resources to our identified high-impact/high-influence stakeholders**

GREEN

**5 Across all strategic priorities, our high-impact, high-influence stakeholders are satisfied with our products, services and resources**

GREEN

**6 All teams meet or exceed an [3]iMatter Employee Engagement Index (EEI)[4] of 74**

GREEN

**7 We spend our budget within the revenue resource limit.[5] Corporate priorities are fully resourced (in terms of time and budget)**

GREEN

[3] iMatter Survey is a staff-experience continuous improvement tool designed with staff in NHSScotland to help individuals, teams and Health Boards understand and improve staff experience.
[4] iMatter Employee Engagement Index (EEI) is generated from the responses to questions within the iMatter staff survey and provides an overall percentage of an organisation's level of positive staff experience.
[5] Revenue Resource Limit is the target that the Scottish Government sets for public bodies to spend.

# 2. Our context: societal trends

NHS Health Scotland's mission is to improve health and reduce health inequalities. These two elements go hand in hand because it is possible to improve overall population health while maintaining or even increasing the gap in health outcomes between different groups in society. This is what has happened in Scotland. The overall health of the population has been steadily improving since around 2003, but the health of the most affluent groups has improved at a faster rate than the least affluent groups. This means that inequality in mortality has been increasing steadily since 1981. The challenge therefore is to improve health overall, while ensuring that efforts are focused on those who currently experience the worst health outcomes so their health improves at a faster rate.

It will take time to reverse this steady increase in inequality and it is important to carefully monitor trends in health outcomes over time to see how Scotland's population health is improving. We will look at four key trends in health and inequality in this section: premature mortality, inequalities in healthy life expectancy, income inequality and relative poverty.[6] In doing this it is important to state that we do not mean to suggest that changes at this level can be attributed to our work alone. The contribution we make through the provision of evidence of what works to reduce health inequalities is just one part of a much wider picture of action being taken by organisations across all sectors in Scotland. Further, the trends we examine here are subject to the impact of wider UK, European and global developments and initiatives. This is why it is important to examine and monitor these trends to better understand the context in which we operate and guide our work to be as influential as possible.

In examining trends in health and social inequality, we look at both absolute and relative inequality.

- Absolute inequality is about differences in health outcomes between groups (e.g. 'there are 200 more deaths per 100,000 population per year in group A compared to group B'). Trends in absolute inequality can be used to show how the

[6] Using 'Long-term Monitoring of Health Inequalities'. Edinburgh: Scottish Government; 2017. **https://beta.gov.scot/publications/long-term-monitoring-health-inequalities/pages/7**

difference in health between those living in the least affluent areas compared to the most affluent areas has changed over time.

- Relative inequality is about ratios and the relationship between two groups (e.g. ‘there are twice as many deaths per 100,000 population per year in group A compared to group B’). Relative inequality measures can be used to show how many times worse health is among people living in less affluent areas compared to those living in more affluent areas and how this has changed over time.

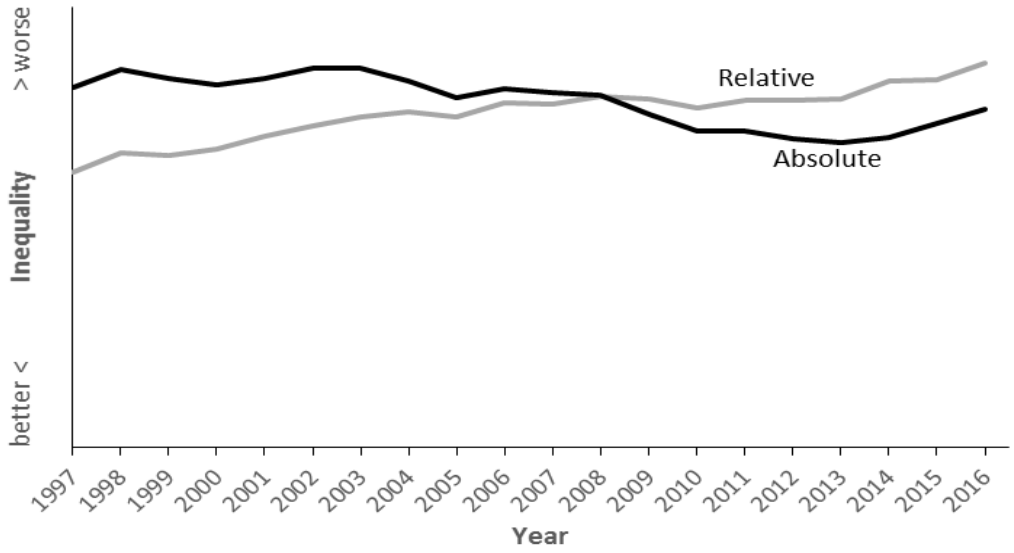
It is important to look at both absolute and relative inequalities for the reason described above. It is possible for absolute inequalities to improve, but relative inequalities to worsen.

# Premature mortality

Premature mortality is defined as death before the age of 75. We examine premature mortality because it is one of the most important indicators of the overall health of the population. Scotland has the highest rate of premature mortality in the UK.

**Figure 1** below shows the trends in inequalities for premature mortality. The data show that both absolute and relative inequalities in premature mortality are getting worse. Relative inequalities in premature mortality steadily increased between 1997 and 2008 before levelling off until 2013. They have subsequently increased again, due, in part, to an absolute rise in mortality in the populations living in the two least affluent tenths of areas. Absolute inequalities in premature mortality had declined between 1997 and 2013. This has also subsequently increased again due to a rise in mortality among those living in the least affluent areas.

**Figure 1:** Inequalities in premature mortality over time

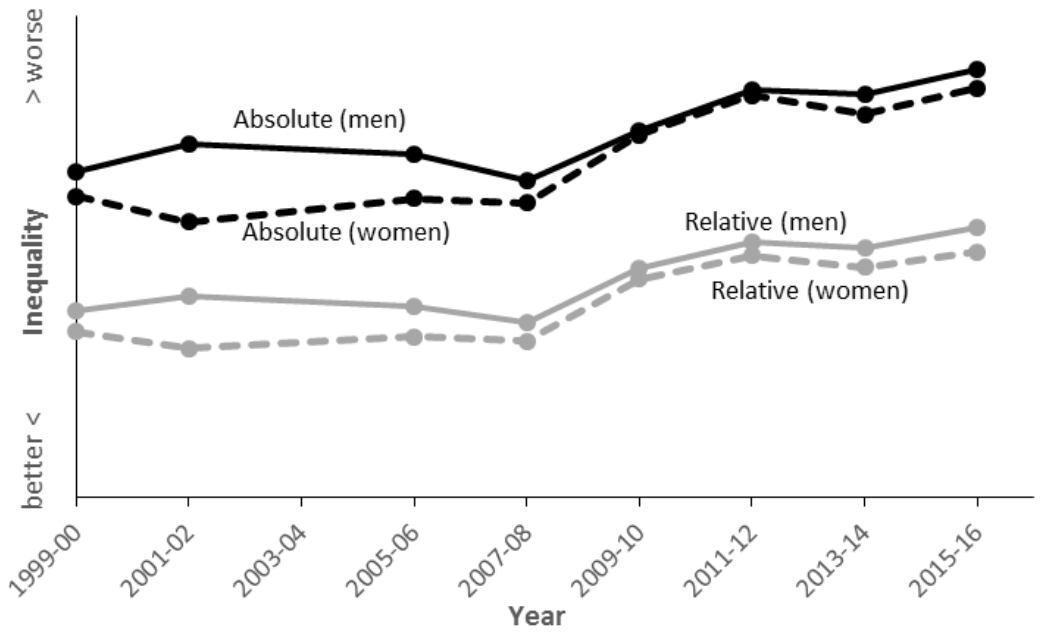



# Healthy life expectancy

Healthy life expectancy is a measure of how long people live while remaining in good health. It is an important measure of a population's health because we don't just want people to live longer, we want people to live longer in good health. Healthy life expectancy is lower in Scotland than most other European countries. **Figure 2** below shows the trends in inequalities for healthy life expectancy over time. Inequalities are generally higher for men than women and increased for all groups and on all measures from around 2007. Although healthy life expectancy has continued to increase across the whole population over time, it has increased more rapidly in the most affluent areas and the length of time spent in ill health in the least affluent areas has remained substantially longer than in the most affluent areas.[7]

[7] Healthy life expectancy: deprivation deciles. Edinburgh: ScotPHO; 2015. URL: **www.scotpho.org.uk/population-dynamics/healthy-life-expectancy/data/deprivation-deciles** (accessed on 29 December 2015).

**Figure 2:** Trends in healthy life expectancy inequalities over time



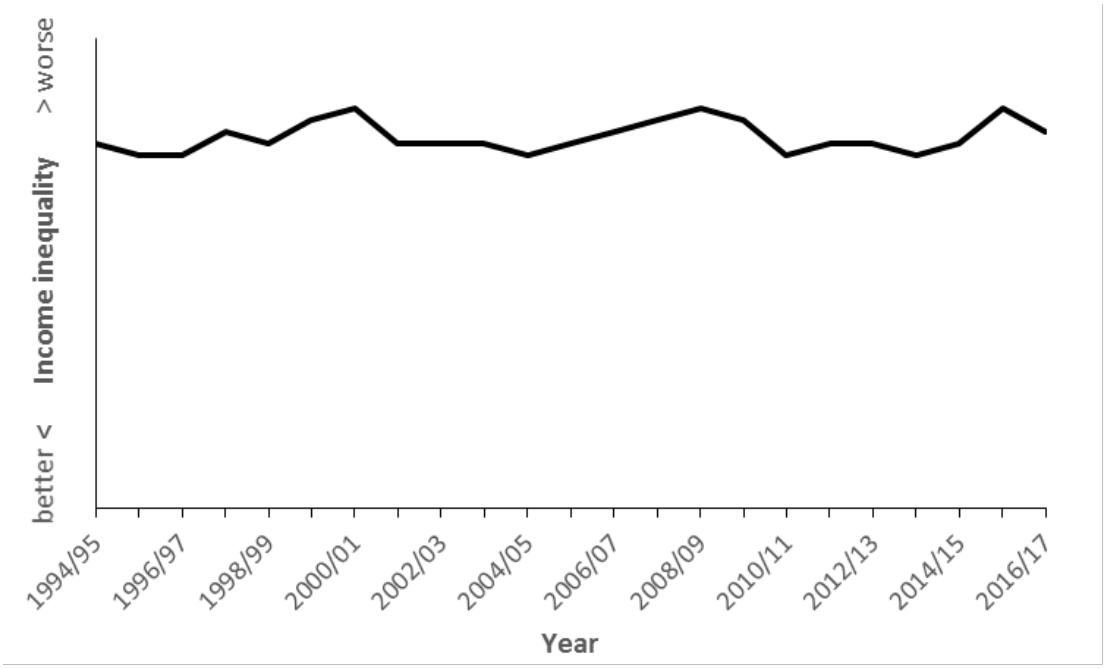

# Income inequality

Socio-economic inequalities are one of the most important factors in determining the overall health of a population and the extent of health inequalities. Lower levels of income inequality are associated with improved societal outcomes across a range of areas, including health and wellbeing. Reducing income inequality across a population is therefore an important component of any strategy to reduce health inequalities.

**Figure 3** below shows the trends in income inequality from 1994/5 to 2015/6.[8] Income inequality in the UK worsened during the 1980s and 1990s as a result of increases in incomes in the richest households and decreases in incomes in the poorest households. Income inequality then stabilised at around that level, though the value has been very varied over the last 12 years. Scotland is slightly more equal than the UK overall.

[8] Data are from the households below average income data set held by the UK Government department responsible for welfare and pension policy, the Department for Work and Pensions, and published in: Poverty and income inequality in Scotland: 2014-17. Edinburgh: Scottish Government, 2018.

**Figure 3:** Trend in income inequalities in Scotland over time



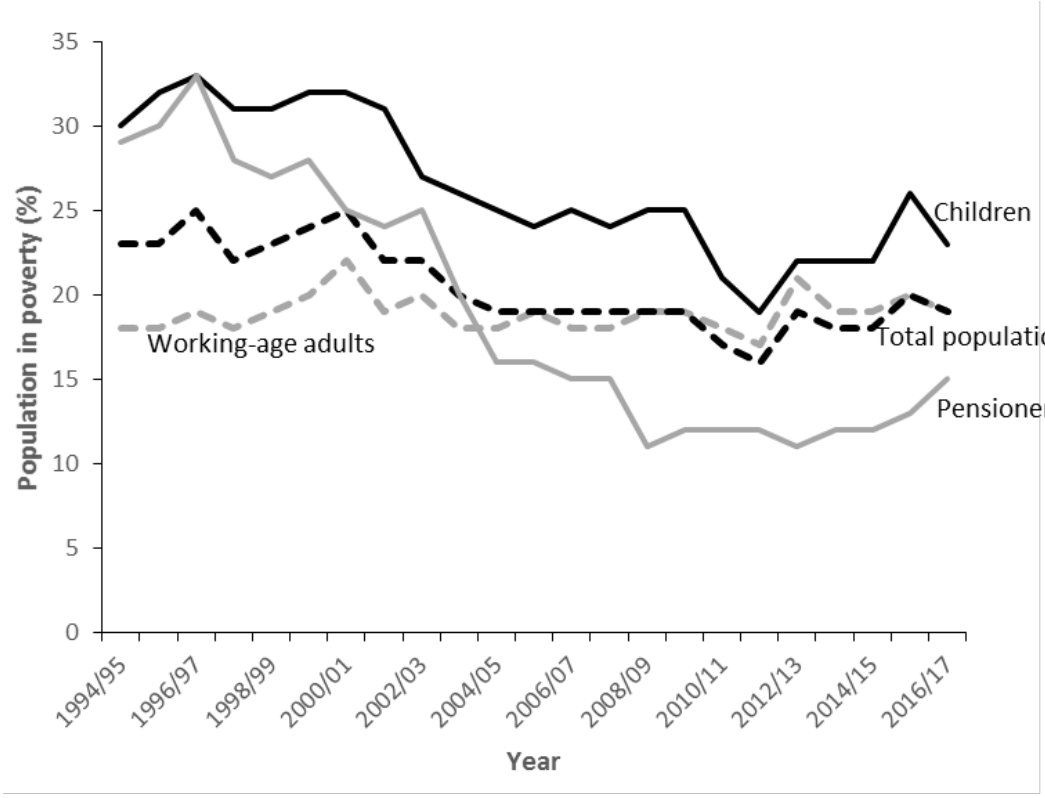

# Poverty

Living in poverty is known to be damaging for health and one of the main causes of poor health and health inequalities. In general terms, poverty is when the income available to an individual or household does not meet their needs. It influences health directly through the goods and services that people buy, which can support, or damage, their health. Poverty also influences a wide variety of factors that have an indirect impact on health, including social status and control over unforeseen events.

Relative poverty is defined as having less than 60% of median household income after housing costs. The median is the income level where half of the households in the population have more income, and half have less. Relative poverty is therefore a measure of inequality – it shows the extent to which the income of the least well off households in the country are keeping pace with middle income households.

As can be seen in **Figure 4** below, poverty in Scotland declined steadily from around 2000 to around 2011 for the total population, pensioners and children. It did not decrease for working-age adults. From 2011 onwards there has been an increase in poverty for all groups.

**Figure 4:** Poverty trends from 1994/5 to 2016/17




In summary, NHS Health Scotland aims to reduce health inequalities and improve the overall health of people living in Scotland. Inequalities in mortality are very high in Scotland compared to the rest of Europe and have continued to increase on many measures in recent years. It is likely that these increases are related to the context of austerity, high poverty levels and changes to the social security system that have reduced the real value of benefits as well as increasing their conditionality (the things people have to do to qualify for benefits). However, a number of the recent socio-economic policies enacted in Scotland (many of which NHS Health Scotland has helped to create) can be expected to make a positive difference in the coming years, including the more progressive income tax system and changes to social security arrangements for devolved benefits.

# 3. Our results at an organisational level

The second domain of our Performance Framework examines our impact as an organisation by seeking to understand the experiences of our stakeholders who work with us.

As demonstrated below, we have used stakeholder analysis to identify the organisations and individuals who are critical to our success as an organisation.

- **Low-priority stakeholders:** Not vital to our success.
- **Medium-priority stakeholders:** Potential to raise awareness of equitable health improvement.
- **Medium-priority stakeholders:** Potential to increase positive impact.
- **High-priority stakeholers:** Vital to our success.

We want to be sure that high-impact and high-influence stakeholders are influenced by the knowledge we generate and that they see our leadership as helping to generate action to reduce health inequalities.

# Organisational reputation and credibility

As an organisation that depends heavily on influencing others to take action, our reputation and credibility are key factors in measuring our success. While anecdotal feedback is important and very useful in this regard, our main approach to measurement is through the annual Stakeholder Survey. The results below are from the last survey carried out in September 2017.

**Stakeholder overall satisfaction mean score is greater than 7 or more out of 10**

GREEN

Our stakeholder overall satisfaction mean score was 7.85, which is greater than our target of 7 or more out of 10.

**Stakeholder satisfaction mean score for 'working with us' is greater than 7 or more out of 10 for both partners and customers**

GREEN

The overall satisfaction mean score for 'working with us' was 8, which is greater than our target of 7 or more out of 10.

**We have engaged with 90% of our identified high-impact, high-interest stakeholders**

GREEN

From a combination of data collected on our Customer Relationship Management (CRM) tool and intelligence recorded about engagement with our stakeholders, we know that we have engaged with at least 90% of the stakeholders identified in our Stakeholder Engagement Plan in the last year.

**Stakeholder mean score for 'seeing us as the expert/leader in reducing health inequalities' is greater than 7 out of 10 for both partners and customers**

AMBER

We sought to achieve a score greater than 7 for both customers and partners seeing us as the expert/leader in reducing health inequalities. We met this target for customers, but not for partners. Our mean score for partners seeing us as either the

expert or leader in reducing health inequalities and improving health was 6.8 and 6.88, respectively. However, the mean score for both partners and customers (combined) seeing us as either the expert or leader in reducing health inequalities and improving health was 7.11 and 7.17, respectively. The slightly less positive way in which our partners view us, compared with our customers, will continue to be an area in which we seek to focus improvement.

**The NPS for partners is greater than 0%**

GREEN

The score is calculated from a question that asks the respondent if they would recommend an organisation. We sought to achieve an NPS for partners of greater than 0% and we achieved this with a score of 8%.

**The NPS for customers is +40% or above**

AMBER

Having achieved an NPS score for customers of +40% in 2016/17, we sought to at least maintain this score in 2017/18. Our NPS score for customers this year fell by six percentage points to +34%. While this is disappointing, we believe it is in part attributable to methodological changes to the way we approached our Stakeholder Survey, engaging this year with a greater number and more diverse group of customers than in previous surveys.

# Reach and satisfaction with our products and resources

Measuring our reach is an important part of our impact assessment. Some of this is measured through our Stakeholder Survey and some through other methods, particularly through analysis of reach of our online products.

**Across all of the strategic priorities we have shared relevant products and resources with our identified high-impact/high-influence stakeholders**

GREEN

78% of respondents were satisfied that we deliver the products, services or resources they need.

**Sessions on www.healthscotland.scot that visit at least one core content page**

AMBER

In 2017/18, we measured the percentage of sessions on our new website. We identified that 23% of all sessions on **www.healthscotland.scot** visited at least one page in health inequalities, tools and resources, or improving policy and practice. This figure will be used as a baseline to measure our future performance reporting against.

**Mean reach of our corporate Twitter posts versus the engagement rate**

GREEN

Our average number of impressions on Twitter was just under 160,000 per month. This is an improvement on 119,000 in 2016/17. It is in line with our growing number of followers, and shows we are being retweeted more and by people with large followings. This suggests our content is perceived as credible. An engagement rate measures the level of engagement that a tweet receives from the audience and refers to the percentage of people who saw a tweet and interacted with the content. In 2017/18 our engagement rate on Twitter was 1.1%, an improvement on 2016/17 (1.0%).

### The reach of our learning products

GREEN

We review five elements in relation to the reach of our learning products, two of which related to our Virtual Learning Environment (VLE) and three of which relate to face-to-face training.

- We engaged with 52 stakeholders from various organisations in the development of our learning products.
- From April 2017– March 2018, we trained 32 trainers in our face-to-face courses.
- We increased the total number of VLE accounts by 18.1% from the baseline.
- We delivered 763 courses to territorial NHS boards and local authority areas.
- 6,614 people attended our face-to-face courses, including Scotland's Mental Health First Aid, Applied Suicide Intervention Skills Training and Scotland's Mental Health First Aid: Young People.

### The reach of publishing products

GREEN

We measure the scope of our publishing products through the following measures.

- We processed all our orders within our target of five days and 80% were processed within two working days.
- By actively managing our stock levels, we reduced the percentage of publications that went out of stock prior to being reprinted to only 3.4%.
- At least 80% of stock ordered by territorial Health Boards was distributed to the identified end users.
- Over 50% of traffic to our publications accessed featured publication(s) on both our new site, **www.healthscotland.scot** (53%), and our older site, **www.healthscotland.com** (64%).
- 80% of the publications hosted online in an alternative language have been accessed.
- We increased the uptake of our Web2Print (W2P) service reach by 261%.
- We increased the number of registered users of W2P by 105% by funding the print for all NHS Scotland Boards and Health and Social Care Partnerships.

**Across all strategic priorities, our high-impact, high-influence stakeholders are satisfied with our products, services and resources**

GREEN

81% of respondents were satisfied that we offer good-quality products, services or resources.

**Stakeholder satisfaction with mean score for 'products and services' is greater than 7.5**

GREEN

We asked our customers and partners to rate our products and services. The satisfaction mean score for 'products, services and resources' was 8.01 for both partners and customers, which exceeded our target of more than 7.5.

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

AMBER

Between April 2017 and March 2018, 83% of delegates rated our conferences as good or excellent, with a positive intention to apply the learning to their work.

**The extent to which learning outcomes were met in face-to-face courses and eLearning modules**

GREEN

An average of 96% of attendees at our face-to-face courses reported that they have put learning into practice. An average of 79% of VLE learners reported that they have put learning into practice and 78% would be likely to recommend the course to others.

**Our inequality briefings resulted in our stakeholders having a better understanding of health inequalities and the actions required to reduce them**

GREEN

We generated over 63,000 Twitter impressions through tweets launching our new inequality briefings. We conducted a survey of stakeholders who received the briefings directly by email. 92% of respondents stated that the inequality briefings were useful to their work.

# 4. Our impact at a strategic priority level

The Strategic Framework for Action 2017–2022 describes the five strategic priorities and three strategic change priorities that our work is set under. The strategic priorities are:

1. **Fairer and healthier policy**
2. **Children, young people and families**
3. **A fair and inclusive economy**
4. **Healthy and sustainable places**
5. **Transforming public services.**

Our strategic change priorities explain how we will improve our work to deliver our strategic priorities, secure the place of fairer health improvement in the new public health landscape and prepare for transition to the new public health body. The strategic change priorities are:

1. **Influencing the future public health landscape**
2. **Making a difference**
3. **Fit for the future.**

The depth and range of work in all of our strategic priority areas is considerable. Inevitably there are variations to planned programmes of work as priorities change for us or our partners, or unexpected issues occur. The delivery performance for the year, which we regard as very satisfactory, is described in detail separately in our Q4 performance report and end-of-year accounts.

Moving beyond performance to impact, we consider evidence of how we worked and why that was effective, or not, in working towards our strategic priorities. With this in mind, we have provided an overview of our strategic priorities and strategic change priorities and the work that they have achieved in 2017/18.

# Strategic priorities

## 1. Fairer and healthier policy

In the last 12 months, we identified the leading causes of disease burden in Scotland. We also increased the visibility of power as a fundamental cause of health inequalities by collaborating with partners to create an animation on power, which you can read more about below.

We provided evidence to inform policy development, including:

- our cohort analysis of drug deaths and evidence review on how to keep people safe from a drug-related death
- our evaluation of the previous tobacco policy and bringing a focus on price and availability
- our Informing Investment to reduce Inequalities (Triple I) tool information to influence tax reform
- our evidence reviews on the impact of promotions of high fat, sugar, salt food and how to define foods for legislative action.

We influenced Scottish Government to adopt the World Health Organization (WHO) Global Physical Activity action plan guiding principles in their Physical Activity Strategy. We are continuing to influence alcohol policy by providing up-to-date knowledge on alcohol consumption, related harms in Scotland and evaluating the alcohol minimum unit price legislation.

Our networks have become more impactful by moving beyond identification of issues, to producing evidence of what works to support decision-making for identified priority issues [knowledge into action (KIA)]. We are developing a public health strategy for violence prevention in partnership with a wide range of interested parties including Police Scotland, Community Justice Scotland, Violence Reduction Unit, academia, third sector and other NHS Boards.

## 2. Children, young people and families

We have influenced the Scottish Government's research and practice through our work on children, young people and families. Our economic methodology helped set the direction for the evaluation of the Early Learning and Childcare Strategy and made a strong case for establishing a Health and Wellbeing Census for School Aged Children. As a result of this, we were invited to take the lead role in designing a questionnaire for the new census.

In 2017/18, we contributed to the understanding of adversity in childhood by showing the film 'Resilience' in venues across Scotland and ensuring that every showing included a senior public health colleague on the post-film discussion panel. Alongside this we further developed our Adverse Childhood Experiences (ACEs) Hub by engaging leaders in the public sector and in Scottish Government. This contributed to ACEs being highlighted in the Programme for Government. We also held a successful joint health and education event as the basis for planning action on inequalities in educational attainment.

In the last 12 months, our work on evaluation, data analyses and evidence reviews relating to child poverty have been reflected in the new Child Poverty Act. We have also been identified in the ensuing guidance to lead on establishing financial inclusion referral pathways between the NHS and welfare advice services, and on supporting development of local child poverty action plans.

## 3. A fair and inclusive economy

In 2017/18, the Scottish Government announced funding for citizens' basic income pilots in four local authority areas in Scotland. This followed recommendations made by NHS Health Scotland in our consultation responses and health inequalities briefings. We have since been asked to coordinate and lead the evaluation of pilots in this area.

We contributed to the National Performance Framework through the production of our briefing and animation explaining the importance of power and the widespread dissemination and engagement within this work. Our evaluability assessment on the

Community Empowerment Act has led to the Scottish Government commissioning fuller evaluations.

Following our contributions, the Scottish Plan for Action on Safety and Health has incorporated a series of actions to protect mental health in the workplace and the Single Gateway pilot has identified focused outcomes for clients and improved referral pathways.

There are now 508 Healthy Working Lives (HWL) awards with registrations increasing by 17%. Over 12 months, there have been 1.7 million hits on the HWL website from 3,545 organisations.

We helped create more support for evidence-informed policy through our research into the health inequalities impacts of different tax, social security policies and our dissemination through consultations, parliament and the media. As a result of this, tax and social security policy in Scotland is now more likely to contribute to reduced inequalities.

## 4. Healthy and sustainable places

In 2017/18, we continued to be the lead national partner in the implementation and governance of the Place Standard, which provides a framework to structure conversations about place. At least 16,000 individuals have applied the Place Standard tool, which has been used across 26 local authorities and one national park. The standard was named winner of the 2017 Royal Town Planning Institute (RTPI) Award for Planning and Wellbeing and following successful application in Europe is now being considered for formal accreditation by WHO.

We are increasingly involved and influential in housing and regeneration policy. We jointly organised the Chartered Institute of Housing (CIH) annual conference which is Scotland's largest housing event. Our input in the event meant we were able to ensure health was one of the four conference pillars.

We co-funded GoWell, a research and learning programme, which in 2017/18 produced:

- one consultation paper
- eight reports over a variety of topics including ‘Health and the wider determinants of health over time’ and ‘Achieving a sustainable mixed community’
- three journal articles
- three events.

In the last year, we have also provided evaluation support to the Clyde Gateway Regeneration Programme.

Within our community development programme, we:

- facilitated four national events
- administered two national development funds (which directly supported 61 community groups)
- circulated a number of national newsletters and electronic bulletins to approximately 2,900 network members
- produced a number of relevant reports and briefings
- submitted responses to three formal policy consultations.

We continued to support the long-established training course Health Issues in the Community (HIIC). This programme is designed to increase community capacity and participation, and establish community development approaches to tackling inequalities in health. In 2017/18, 33 HIIC courses were delivered with a total of 236 participants.

## 5. Transforming public services

In 2017/18, we partnered with Scottish Government to develop the forthcoming Outcomes Framework for Primary Care which will contribute to the 10-year monitoring and evaluation strategy for primary care.

We produced the health and social care section on the Improvement Service 'Community Planning in Scotland' website. We published the Reducing Health Inequalities briefing for elected members and produced a briefing on inequalities for Integration Joint Board (IJB) partnerships.

In the last 12 months, we have worked with the Improvement Service and Audit Scotland to review Local Outcomes Improvement Plans (LOIPs) on behalf of the Outcomes Evidence and Performance Board. Also, our collaborative work on the NHS Scotland British Sign Language (BSL) improvement plan was reported to government and has since shown good progress.

In November 2017, the Cabinet Secretary launched the new bowel cancer faecal immunochemical test (FIT) into the Scottish Bowel Screening Programme which is offered to people aged 50–74. Statistics published by Information Services Division (ISD),[9] identified that the lowest uptake of bowel screening was in the least affluent areas in Scotland and among men in these areas. This led NHS Health Scotland to focus testing of the new test and instructions on people living in less affluent areas.

To improve the reach of the new bowel test, we conducted a Health Inequalities Impact Assessment (HIIA), which assesses the impact on people of applying a proposed, new or revised policy or practice. Our bowel screening leaflet, which is available in a range of formats and languages, has since won a Plain English Award for simplicity and accessibility.

# Strategic change priorities

Our strategic change priorities are identified areas that we intend to focus on to provide the organisational development and improvement that underpins the delivery of our strategic priorities within the context of fairer health improvement in the new public health landscape.

[9] Scottish Bowel Screening Programme. Edinburgh: Information Services Division (ISD) NHS National Services; 2018. **http://isdscotland.org/Health-Topics/Cancer/Bowel-Screening**

## 1. Influencing the future public health landscape

In September, we issued the 2017 NHS Health Scotland External Stakeholder Survey to some of our key customers and partners to ask what they thought of our products, services and of NHS Health Scotland as an organisation. Data from our 2017 External Stakeholder Survey can be found in pages 13–17. Overall, the survey results suggested small improvements (in comparison to the 2016 survey results), including increases in:

- the overall satisfaction of stakeholders in relation to our organisational reputation and credibility
- the overall score for NHS Health Scotland as an expert/leader in health inequalities and improving health
- the overall score for likelihood of customers and partners to recommend NHS Health Scotland.

In the last 12 months, we have continued to work closely with a range of third sector partners, including Voluntary Health Scotland (VHS), the Community Health Exchange (CHEX) and the Third Sector Learning Collaborative. We also worked in partnership with the Poverty Alliance on the actions set in the 2016 Fairer Scotland Action Plan.

We maintained membership of the Local Government Information Unit (LGiU) and, through our Network Improvement Project, we have improved the quality of several of the national networks we support. These include Choose Life Coordinators Network, Smoking Cessation Coordinators Group and Health Promoting Health Service Leads Network.

Throughout 2017/18, we published a number of reports, including the health burden attributable to alcohol in Scotland and the results of the obesity module in the 2016 Scottish Social Attitudes Survey.

By March 2018, we engaged with at least 90% of the stakeholders identified as high influence, high impact in our Stakeholder Engagement Plan.

## 2. Making a difference

The Impact Assessment Report itself has helped NHS Health Scotland to demonstrate the impact of our work, legacy and the effectiveness in contributing to improving population health. This is an outcome of our strategic change priority, making a difference, which also focused on the continuous development of our products, services and satisfaction from our stakeholders (please see pages 15–17 for detail).

## 3. Fit for the future

In 2017/18, a Change Oversight Group (COG) was set up to coordinate all NHS Health Scotland's aspects of change and transition towards the new public health arrangements. We also began to reposition some staff resource to ensure that we would be ready to project manage and coordinate the major programme of change facing NHS Health Scotland over the next 18 months.

In the last 12 months, we have improved internal leadership practice by encouraging supervisors to attend workshops on 'Leading through change' and by promoting and facilitating 'Leadership call to action' discussions. Peer support groups and team resilience sessions were also implemented to provide staff with guidance on adapting to change.

We made significant improvements to our Corporate Planning Tool (CPT) which allowed staff to better access performance, resource and staff time data, leading to improved accuracy in financial and time recording.

The impact of this work was tracked through our annual iMatter survey, which aims to improve overall staff experience. Positive results were received from our 2017 iMatter survey, with more staff showing increasing levels of satisfaction across a range of factors such as training, development and involvement in decision-making.

# Stories of our performance

## Childhood poverty

In the 2016 Fairer Scotland Action Plan, we made a pledge to support the Scottish Government in its ambition to end child poverty in Scotland. In the last 12 months we have achieved a number of our identified key actions. These were to:

- develop and deliver training resources and events (in partnership) to raise awareness of child poverty and its impact on health and wellbeing among public services staff
- work in partnership with NHS Boards to develop national referral pathways between NHS services and local advice services to maximise the incomes of patients
- promote the importance and adoption of routine enquiry about money worries by NHS staff to help patients maximise their incomes and referral to advice services where necessary.

We continue to provide leadership and advocacy on the impact of child poverty by:

- sharing knowledge of the impact of child poverty (e.g. it damages children's experiences of childhood and harms their future chances)
- evaluating interventions to reduce child poverty to identify what is effective
- providing data analysis and evidence reviews
- offering coordination and networking opportunities to share learning on child poverty with key stakeholders
- further developing partnership approaches at a national and local level to take action to tackle child poverty
- providing advice on workforce learning and development needs on raising awareness of child poverty and implications for practice.

In 2017/18, we fostered good working relationships with key policy leads in Scottish Government Social Justice, Social Security and Learning Directorates. This has continued to develop opportunities to help shape recommendations for action. Our efforts illustrated above have influenced the Child Poverty (Scotland) Act 2017, the **Scottish Government's Tackling Child Poverty Delivery Plan**, the **Scottish**

**Government's Local Child Poverty Action Report guidance** and the **Best Start Grant**.

We worked with the Scottish Health Promotion Managers Group to improve financial inclusion referral pathways between midwifery, health visiting and advice services. We have been involved in the development of a mapping report of current activity in Scotland, including providing recommendations and the creation of an action plan. The Scottish Government made reference to this work in their Tackling Child Poverty Delivery Plan and invited us to submit a proposal on how the £500,000 allocated fund should be used. This proposal was accepted.

We held an event bringing local authority, NHS and third sector representatives together to share practice on financial inclusion in early years.

## Power animation

As part of our KIA approach, the animation '**Power - a health and social justice issue'** was developed through the Public Health Evidence Network (PHEN), in collaboration with Glasgow Centre for Population Health (GCPH). The animation is based on our development work on power inequalities and aims to inform understanding and build motivation to redistribute power.

In its design process, we engaged with and sought feedback from partners at the Scottish Community Development Centre (SCDC) and What Works Scotland. The publication of the animation was widely supported by our stakeholders including the Improvement Service Knowledge Hub for Community Planning Partnerships, Holyrood magazine, the ALLIANCE and CHEX.

Following the successful launch of the power animation in August 2017, we identified an increase in the percentage of visitors who engaged with the Power Inequality page on our website (rising from 26% to 63%). We also monitored social media activity and found that the power animation performed considerably higher than the corporate average in impressions (with 4,596 per tweet) and engagement rates, which was sustained into November 2017. This evidence suggests that the reach of

the animation has raised the profile of NHS Health Scotland as a knowledge advisor on the distribution of power as a fundamental cause of health inequalities.

NHS Health Scotland's approach and advocacy on power continues to be welcomed by its partners. Organisations including Edinburgh Tenants Federation, CHEX, Third Sector Interfaces, SCDC, Health and Social Care Academy, and The ALLIANCE have embedded the animation in their resources, training and events. This demonstrates that an understanding of the role and importance of inequalities in power has been integrated into the public narrative. In future, we hope that this positively contributes to achieving progress towards the new national outcome to 'tackle poverty by sharing opportunities, wealth and power more equally'.

## Screening and immunisation (2017 flu campaign)

The 2017/18 flu immunisation campaign aimed to raise awareness and improve vaccine uptake among 'at risk' target audiences, which were identified as:

- people aged 65 and over
- everybody with a health condition
- pregnant women
- healthcare workers
- children (ranging from the age of 2 to 11).

To reach these target audiences a variety of channels were used, including:

- adverts and content-led communications on television and radio
- digital advertising on platforms including Facebook and YouTube
- distribution of printed information and marketing materials
- public relations activity in print, broadcast and online media.

NHS Health Scotland worked to develop and deliver the campaign with a range of partners through the Scottish Immunisation Programme. We engaged with key partners including Scottish Government, all 14 NHS Scotland local Boards and Health Protection Scotland (HPS). We also undertook partnership work with public, private and third sector organisations to extend campaign reach through our

partners' communication channels. Examples of our partnerships include Age Scotland, British Heart Foundation and Morrisons.

Compared to previous years, overall awareness and recognition of the flu campaign increased, despite a reduced media spend. This suggests that our 'at risk' target audiences were more likely to have engaged with our marketing materials and recall the key messages they contained. This also implies that the mix of marketing channels used were effective at reaching those we wanted to encourage to get the vaccine.

Of those who engaged with the campaign, a significant proportion said they had either made an appointment to get their flu vaccine or had already had it. It is likely that this is a direct result of people having seen the campaign (from 28% in 2016/17 to 38% in 2017/18 among childhood audiences, and from 21% in 2016/17 to 43% in 2017/18 among seasonal audiences).

Although the 2017 flu immunisation campaign gained high recognition and encouraged positive behavioural change among our 'at risk' target audiences, the uptake of flu vaccine has remained low in many of the groups specifically targeted by the campaign, for example people aged under 65 with health conditions. We are now looking into why this is.

# 5. Our organisational enablers

## People and workforce

The quality, pace and successful delivery of our work very much depends on the productivity of our staff. We consider staff experience, measured through the Employee Engagement Index (EEI) from the iMatter survey, to be a useful proxy indicator of productivity. The results below are drawn largely from our 2017 iMatter survey results.

**We aim for all teams to meet or exceed an iMatter EEI of 74**

GREEN

An iMatter EEI is generated from the responses to questions within the iMatter staff survey and provides an overall score of an organisation's level of positive staff experience. The EEI score for the organisation was 81 with a range of 79–85 across directorates.

**Staff feel well informed**

GREEN

The results indicated that 81% of staff agreed they get sufficient information to do their job effectively.

**Staff are appropriately trained and developed**

GREEN

96% of staff completed a Personal Development Plan on e-KSF by 31 May 2017 and 81% of staff responded positively to the question on if they are given the time and resources to support learning and growth.

**Staff are treated fairly and consistently**

GREEN

87% of staff responded positively to the iMatter question on being treated fairly and consistently. Our staff turnover rate was lower than previous years at 4.83%. We had one formal grievance.

**Staff feel involved in decisions**

GREEN

78% of staff responded positively to iMatter questions on involvement in decisions.

**Healthy and safe working environment**

GREEN

In assessing our working environment, we identified that in 2017/18:

- there were seven accidents, seven incidents and one near miss
- our staff absence rate was 3.56%
- 96% of staff completed display screen equipment modules, 94% completed risk assessment training and 93% completed the fire safety module.

We see all of the above results as well within the norms of a safely operating organisation.

# Finance and resources

Successful delivery of our work depends on effective allocation of our finances and resources.

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

GREEN

We have met all statutory targets while keeping our resources within our limit. 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.

**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**

GREEN

In 2017/18, 100% of our available resources were allocated to signed-off projects in our business plan by Q2. This is an increase from 2016/17 when 96.2% of our resources were signed off by Q2.

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

GREEN

Our budget expenditure was measured by reviewing the following:

- We achieved our committed spend by 31 January 2018 at 98% (costs incurred and outstanding committed spend to 31 March).
- By 28 February 2018, we achieved our target with 89% spent (costs incurred). Although our actual spend was lower than target at 28 February, taking into account our planned year end outturn and budgeted costs in March, our actual spend on this basis was 89%.
- We achieved a 99% spend by closure of accounts (costs incurred).

**Efficiency savings: NHS Health Scotland's contribution to national Board target of £15,000,000**

GREEN

We made an appropriate contribution to the shared national Board target of £15 million, consisting of an individual contribution of £325k and a joint contribution of £568k working with NHS Education for Scotland (NES) and NHS National Services Scotland (NSS).

We see all of the above results as well within the norms of an organisation working safely within its financial parameters.

# 6. Our impact on sustainability and the environment

In addition to its scheme of mandatory reporting, the Scottish Government encourages public bodies to disclose our sustainability and environmental performance.

In 2017/18, NHS Health Scotland's Sustainability Group was chaired by the Director of Public Health Science, with membership drawn from across the organisation. Throughout the year the group continued to deliver actions identified in response to our Good Corporate Citizen Model self-assessment. More broadly, we worked with colleagues in Health Facilities Scotland (HFS) to develop a Scottish approach to updating the Corporate Green Code reporting system. Overall, this work aims to streamline NHS activity and reporting for Scotland into a single system. Our activity and reporting during 2018/19 will be revised to reflect this new approach.

During the year we developed our approach to reducing business-related activities that contribute towards carbon release and creation of waste using its benchmarking process. We made notable progress on intra-office (and wider) travel, paper usage in printing and copying, and waste reduction. As in previous years, the Board has been commended by the World Land Trust programme for carbon offsetting in our work on paper saving in the publishing service.

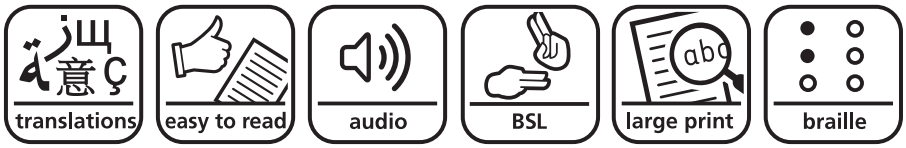
The group has continued to pursue improved sustainability through a focus on issues common to other tenants of our two premises, maintaining a close link with experts in NSS. Our staff have also become more active in supporting NSS develop and deliver its corporate sustainability actions and its environmental monitoring. We also made progress this year in encouraging NHS suppliers and partners to pursue environmental aspirations through procurement as part of the implementation of the new duty of sustainable procurement duty. This development represents a significant step forward in national collaboration to support sustainable procurement.

The group has also continued to progress a broader programme of discussion and encouragement for action that exerts greater influence on sustainability programmes across the NHS. The Scottish Managed Sustainability Network (SMaSH), hosted from ScotPHN, is part of this endeavour. During 2017/18, SMaSH and NHS Health Scotland were co-organisers of a national event on sustainability and health, and made significant contributions at the event. From this, we will explore working more closely with other national agencies, notably Scottish Natural Heritage and the Scottish Environment Protection Agency in 2018/19.

Finally, we started to implement the Climate Change Adaptation Plan, first developed in 2016/17. This details ways in which the organisation will ensure business continuity and help our work to support population health in response to realistic climate change scenarios. We also worked collaboratively with NSS and the Scottish Ambulance Service (SAS) on actions taken to protect and promote biodiversity.

**The Impact Assessment Report for 2017/18 describes NHS Health Scotland's performance as a Health Board and illustrates the impact we have had over the last 12 months.**

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

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