




# Building **our future**

**NHS Health Scotland's**  
contribution to public  
health in Scotland



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## Foreword

We have learnt a lot over the last 17 years about how to make a difference to the public's health. We want to share this learning with the public health community and in particular with Public Health Scotland.

There are significant public health challenges in Scotland. Increasing poverty and inequality are having an impact on how long we live. Life expectancy has stalled, and in our poorest areas it is going down. Climate change is threatening the conditions that support health and our public services are under a lot of strain. We need a public health system that is fit to tackle these challenges head on. Public Health Scotland will play a crucial leadership role in doing this and, importantly, in supporting the public health system to work together to create a fairer healthier Scotland.

NHS Health Scotland's contribution to public health is wide-ranging and far-reaching. What follows is an account of our strategic development as an organisation, and an account of some of our work in three key areas – alcohol, place and early years, which are of course three of Scotland's new public health priorities. It is not an exhaustive account of NHS Health Scotland's work and this report does not include our achievements in, for example, smoke-free public places, mental health or good work. But by focusing on a small number of examples, we hope to show what it takes to build the evidence, design the policies and practice, and develop the relationships needed for a national public health agency to contribute to a fairer, healthier Scotland.

The Scotland we live and work in today is very different to the country that the fledgling NHS Health Scotland came into in April 2003 – not least in the knowledge and understanding of what creates and harms health. NHS Health Scotland played an important part in this change. So much of that is of course directly attributable to the excellence of the staff of NHS Health Scotland, both past and present, and also the quality of the working relationships that we have sustained with so many partners and stakeholders. However, since joining the Board as Chair in 2015 I have seen how much our previous Chairs and board members have contributed to bringing challenge, ideas and focus to our work. An organisation performs best when the staff and the Board share such a strong and common purpose and, as the last chair of NHS Health Scotland, I wish the new Board of Public Health Scotland every success.

This is an exciting time for public health in Scotland. Public Health Scotland has the potential to make a real difference to the health of the people of Scotland. I will look back on this current era in public health, not only with pride but also with a strong sense of optimism for the future.

David Crichton  
Chair, NHS Health Scotland

# **Chapter 1: Introduction**

## **The beginning**

NHS Health Scotland was launched on Tuesday 1 April 2003 as 'the strengthened Special Health Board formed by the integration of the Public Health Institute of Scotland (PHIS) with the Health Education Board for Scotland (HEBS)'.<sup>1</sup>

HEBS had provided leadership for the health education effort in Scotland,<sup>2</sup> while PHIS had worked to 'develop the information base, the evidence base and the skills base needed to support health improvement in Scotland'.<sup>3</sup> The newly formed Board therefore brought together expertise in health improvement data and intelligence with expertise in sharing knowledge and skills about health improvement through marketing, public information and training.

The Scottish Executive's health improvement strategy of the time, 'Improving Health in Scotland – The Challenge', had an 'overarching aim of decreasing health inequalities'.<sup>1</sup> This made the reduction of health inequalities part of our role from the very outset. However, our approach to reducing health inequalities was very different then to how it is today. In the early days, our focus was on supporting NHS Boards to reduce health inequalities in lifestyle risk factors such as alcohol, tobacco and diet by supporting NHS Boards. Our first corporate plan described our role as working 'with local NHS Boards and health improvement partners during the implementation of public health improvement and health inequalities programmes'.<sup>4</sup> Early plans highlighted work such as smoking-cessation programmes, support around diet and healthy weight, and alcohol support services.

The subsequent health strategy, 'Delivering for Health', which was published in 2005, retained this focus on at-risk individuals.<sup>5</sup> This resulted in five 'Keep Well' pilots which aimed to contribute to a reduction in health inequalities through the provision of health checks targeting those at particular risk of preventable serious ill health. We were closely involved in the development, delivery and evaluation of the Keep Well programme between 2006 and 2014. A key message from our evaluation of Keep Well was to understand the limitations of interventions that are dependent on individuals opting in to opportunities relating to health behaviour change or reduction in risk factors, even when those interventions are targeted towards those living in the most deprived areas.<sup>6</sup> This was consistent with Professor Dame Sally McIntyre's influential work on the characteristics of policies more likely – and less likely – to be effective in reducing inequalities in health.<sup>7</sup>

## **A Fairer Healthier Scotland 2012–2017**

Health inequalities steadily increased in profile in Scotland over the following years, not least as a result of the leadership given to the issue by the Chief Medical Officer, Harry Burns, when he took up office in November 2005, and Michael Matheson, who became Minister for Public Health in 2011 and went on to lead the Ministerial Taskforce on Health Inequalities.

When the new government took office in 2007, they introduced a new National Performance Framework (NPF)<sup>8</sup> which invited all public services to be part of 'creating a more successful country with opportunities for all of Scotland to flourish'. This approach had outcomes at its heart and NHS Health Scotland fully embraced this direction of travel. We aligned our strategic intent to the five strategic objectives of the NPF and became a leader of outcomes-focused planning and reporting as applied in our work and in our support to partner organisations in the use of outcomes frameworks.

We published our new strategy 'A Fairer Healthier Scotland' (AFHS) in June 2012 (see Figure 1 below). This heralded a marked shift of focus in our organisational purpose away from individual health behaviour change towards actions aligned to tackling the structural and social determinants of health.

Figure 1: A Fairer Healthier Scotland



Our new strategy highlighted the importance of the wider social determinants of health (see Figure 2 below) and the need to tackle inequitable distribution of power, money and resources.

Figure 2: The social determinants of health



Our new strategy chimed well with the Christie Commission on the Future Delivery of Public Services<sup>9</sup> which said ‘radical changes are needed in the way public services are delivered so that they place strong communities at the centre of achieving better outcomes, drawing on their assets’.<sup>10</sup> We committed to supporting this change and contributing to the shift towards prevention.

### The Theory of Causation

The change in strategic direction outlined in AFHS was underpinned by the increasing body of evidence about what was needed to reduce health inequalities. We had been working for some time to understand what the evidence meant for Scotland and for the development of our new strategy and accompanying work programmes. Of particular importance was the sociology research carried out by Columbia University. This introduced the idea that ‘some social conditions may be “fundamental causes” of disease’<sup>11</sup> and that ‘a fundamental cause involves access to resources, resources that help individuals avoid diseases and their negative consequences through a variety of mechanisms’. Our thinking also built on the World Health Organization Commission on Social Determinants of Health, which was clear that ‘the unequal distribution of power, income, goods, and services’<sup>12</sup> was the root cause of health inequalities.

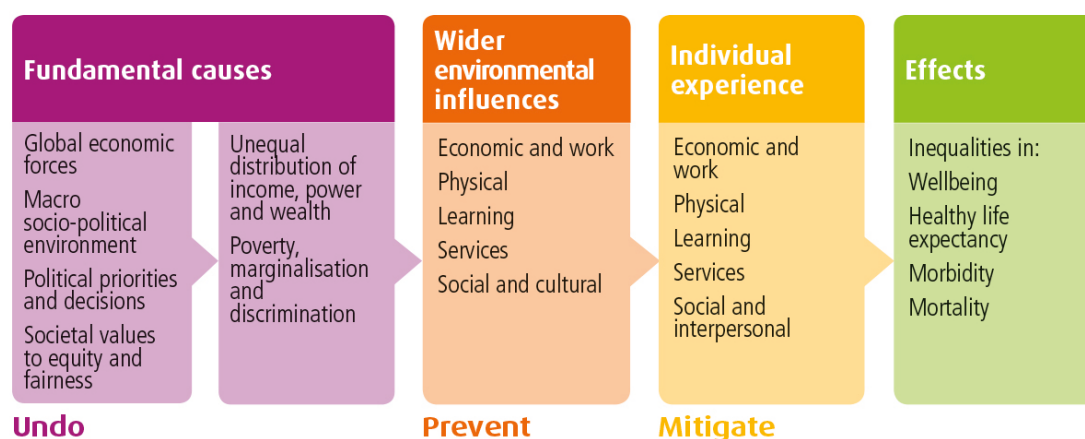
A major milestone at this time was our work to assess whether the strategy set out in Equally Well and associated policies was effective and whether



anything else might be needed. The work was undertaken with advice from a panel chaired by Professor Dame Sally McIntyre, and culminated in the publication of the 'Health Inequalities Policy Review for the Ministerial Taskforce on Health Inequalities'.<sup>13</sup> This set out the current understanding of how health inequalities arise, including building on and testing the fundamental causes theory and putting it into a new conceptual framework, known as the 'Theory of Causation'.

The Theory of Causation (see Figure 3 below) explains how the fundamental causes of health inequalities – the unequal distribution of income, power and wealth – influence the distribution of wider environmental influences on health, such as the availability of quality housing, good work, learning opportunities, access to services, and social opportunities in an area and in society. These wider environmental influences shape people's individual experiences of, for example, low income, poor housing, discrimination and access to health services, which results in health inequalities.

Figure 3: Theory of Causation



We were clear in the Policy Review that action is required at all three levels to reduce health inequalities. This reflects the aforementioned work by Professor Dame Sally McIntyre on what works to reduce health inequalities, summed up well in her briefing paper on health inequalities for the first Ministerial Taskforce:

'Ultimately, the most "upstream" policy would be to reduce inequalities in society. The problem with relying on "downstream" interventions is that, meanwhile, more people are falling into the river upstream, e.g. smoking cessation services would continually have to deal with new cohorts of smokers. This suggests one needs both upstream and downstream interventions; to create an environment in which people do not start smoking in the first place, as well as helping people to stop.'<sup>14</sup>

The Theory of Causation provided a framework within which fairer health improvement could be conceptualised across the system, including within NHS Health Scotland. It underpinned the change in strategic focus brought about by AFHS and the subsequent organisational realignment and reprioritisation of our resources. From a staffing point of view this meant that

the remits of many individuals and teams changed. From a planning and delivery perspective it drove further focus on planning and working across disciplines and across teams on common organisational outcomes.

## **Evidence into action**

We were explicit in AFHS that our focus must be on promoting and supporting action for change. This required more joined-up working between the areas of the organisation producing and synthesising evidence, engaging with stakeholders to support action being taken and learning from what was happening locally, and our teams providing the expertise in communications, engagement and public affairs.

Our response was to develop and promote a Knowledge into Action (KIA) approach across our teams.<sup>15</sup> This describes a cycle of building up knowledge about an issue, synthesising the knowledge and making it actionable, and facilitating the use of the knowledge within policy and practice.

Taking a KIA approach improved how we plan work across the organisation and how we focus on turning evidence into action. This requires different skill sets in relationship-building and management, negotiation, and engagement. It also requires compromise and an acceptance that at times we need to 'play the long game'. It requires an acceptance that scientific evidence must be combined with other types of evidence (lived experience, learning from systems) to provide the full set of knowledge required to take action. Finally, it presents different challenges in how we demonstrate impact and performance, as many of these skills and processes are harder to measure than hard outputs such as reports.

KIA emphasises the importance of working collaboratively with the end-users of the evidence to understand the context in which they are operating, but also to recognise and learn from the knowledge that they hold about the systems in which they are operating. At the same time as recognising we needed to work differently with our stakeholders, we also recognised that our stakeholder base needed to grow. This was a not insignificant challenge. We sought to expand our contact with Scottish Government and public sector colleagues well beyond health policy. We also sought to develop new and more strategic relationships with a much broader range of third sector organisations working on the social and economic determinants of health including the Poverty Alliance, Child Poverty Action Group (CPAG), and Shelter Scotland.

## **Social justice and human rights**

AFHS set a very clear vision of a socially just Scotland – 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.

Not having access to the conditions that protect health – the social determinants of health – and experiencing social and economic inequalities is a breach of international human rights treaties including the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights.<sup>16</sup> These treaties enshrine in international law the right to the highest standard of health, along with the right to an adequate standard of living, safe working conditions, affordable housing, food, education, and a social security system based on respect, all of which are key to public health. Following this thinking, the injustice of health inequalities experienced at an individual level is a human rights issue.

Our contribution to the realisation of the right to health for all of Scotland's people began with our involvement in the development and then delivery of Scotland's first National Action Plan for Human Rights (SNAP). Through powerful collaboration with the ALLIANCE and others we have supported a number of initiatives and projects including the Lived Experience Collective, which built peer research skills for people with experience of homelessness and women with the status of refugees or asylum seekers.

These new collaborations inspired us to become explicit about underpinning our whole strategy with a human rights-based approach and to start to engage with the wider public health community about what human rights means for public health. This work led to the Scottish Government and Convention of Scottish Local Authorities (COSLA) stating that they 'want to embed a human rights based approach to health and wellbeing'<sup>17</sup> in Public Health Scotland. This is a welcome intent and one which we hope our experience over the past several years will support in the future.

## **Our Strategic Framework for Action 2017–2022**

AFHS provided a robust strategic direction for the five years from 2012 to 2017. When we engaged with stakeholders during 2016 over our next strategy, it became clear that AFHS had been very successful in increasing the understanding of health inequalities and what causes them. What was very clear is that what our stakeholders were looking for from us now was practical advice and support in tackling the issues.

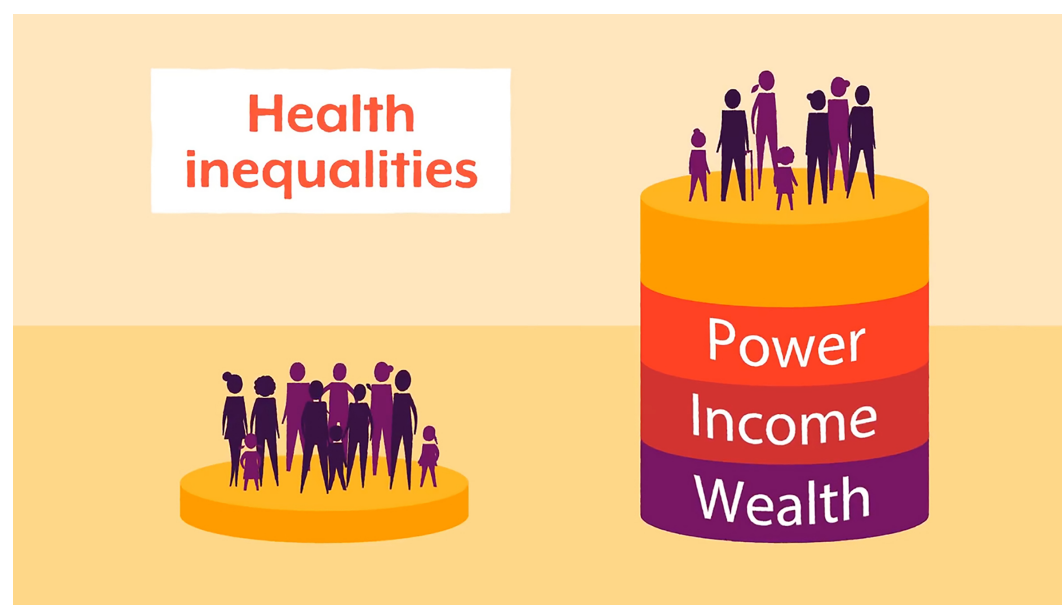
When we prepared our five year strategic framework 2017–22<sup>18</sup> we knew that the framework would outlive NHS Health Scotland. The ambitions under the five strategic priorities shown in Figure 4 below were ambitions we hoped to pass on to Public Health Scotland. It is therefore very encouraging to see now how closely they resonate with the six Public Health Priorities<sup>19</sup> launched in June 2018.

Figure 4: Our five strategic priorities



The work under these priorities spans the three levels of the Theory of Causation. An example of how our work has spread to address the fundamental causes of inequalities is our work on power in strategic priority three. We explored the concept of power as a social justice issue with a range of stakeholders and produced a briefing in 2016.<sup>20</sup> This went on to be the basis of an animation<sup>21</sup> we produced in partnership with the Glasgow Centre for Population Health the following year (see Figure 5 below). We believe this work has been influential in bringing power inequalities into the language of policy in Scotland and most recently into the refresh of the National Performance Framework, which includes the outcome 'We tackle poverty by sharing opportunities, wealth and power more equally'.<sup>22</sup>

Figure 5: Our power animation



Strategic priority four on healthy and sustainable places encompasses much of our work on the wider environmental influences on health, including work on housing and homelessness, community food and health, green space, active travel and climate change. Strategic priority five also contributes to this area through the work to support Community Planning Partners to plan and

deliver services in support of the public's health. We also provide a wide range of services for employers to engage in fair employment and good work, which comes under strategic priority three around a fair and inclusive economy.

Our five priorities also include programmes of work supporting the mitigation of health inequalities at an individual level. We provide services to public and third sector stakeholders who support people who are living now with the detrimental impacts of inequality. This includes training and workforce development support, the facilitation of practice networks and the provision of information and resources for health and social care practitioners.

### **Building an excellent organisation**

In 2003, our operational budget was £17m and at its peak in 2011/12, it was near £23m. Reductions in funding across the public sector after the economic downturn meant that our operational budget was cut by £1m for four consecutive years after 2011/12 and in our final year, 2019/20, our budget is £21m. This in itself tells a story – of the changing public sector funded landscape and the challenges that has brought to every sector. However, it also tells a story of an organisation that has grown in our maturity in response to how to prioritise, how to drive continuous improvement and use evidence to focus on the work that we know will make the biggest difference.

We developed a robust approach to prioritisation, both to respond to the reductions in our budget and also to ensure we were investing resources where our stakeholders, and the evidence, told us we would make the biggest difference. Outcomes-focused planning was key to this, as was our ambition to become an excellent organisation.

We committed to organisational excellence and innovation in AFHS in 2012 in order to ensure we were best placed to deliver our new strategy. Teams from across the organisation worked together to embed the EFQM (European Foundation for Quality Management) principles into our work and as a result we achieved Committed to Excellence accreditation in 2013. Following further work to increase our understanding of who our customers are and what they need from us, we then achieved an NHSScotland 'first' by securing Recognised for Excellence 3 star accreditation organisation wide in 2016. This work to ensure our resources were organised and developed in a way which maximised our effectiveness and efficiency will be valuable experience to take with us into Public Health Scotland.

## **What did we learn?**

Reflecting back over our time as Scotland's national health improvement agency, key areas of learning include:

- To reduce health inequalities and improve health, action is required across the three levels of the Theory of Causation, but if we don't do more to actually 'undo' health inequalities by taking action on the unequal distribution of money, wealth and power, then we won't make the progress we need to make.
- Public health bodies need to support stakeholders to put evidence into action in order to make a real difference to the public's health. This requires credible people with a multifaceted set of skills in relationship management, negotiation and effective influence skills working alongside people developing the evidence.
- An outcomes-focused approach, both for our own planning purposes and in how we work with partners, is essential to delivering the broad and wide-ranging policies and initiatives that are most likely to be effective in reducing health inequalities.

# Our contribution to **alcohol policy**



## **Chapter 2: Our contribution to alcohol policy**

### **Early context – framing the problem**

Although there was an acceptance within Scottish policy<sup>23</sup> in 2003 that alcohol was causing problems in Scotland, the scale of the problem was not fully understood. This started to change in 2006 when a highly influential study into alcohol-related liver disease in Britain was published in *The Lancet*.<sup>24</sup> The study found that cirrhosis mortality rates in Scotland were amongst the highest in Western Europe, and notably higher than in England and Wales. The study also found that rates were rising in Scotland at a time when they were falling in most other countries. 2006 was also notable as the year in which Scottish Health Action on Alcohol Problems (SHAAP) was formed. The following year, data from the Office for National Statistics on geographical variations in alcohol-related deaths in the UK further emphasised the extent of the problem in Scotland. The data showed ‘the alcohol-related death rate in Scotland was around double the UK rate for both sexes’.<sup>25</sup>

The evidence was therefore clear that the harms caused by alcohol in Scotland were much worse than elsewhere in the UK. In order to understand why, and to formulate effective policy responses, it was necessary to improve the data and intelligence available to public health in Scotland.

### **The importance of accurate data and intelligence**

Information Services Division (ISD), which will also become part of Public Health Scotland in 2020, published biannual compendiums of alcohol statistics between 2005 and 2011.<sup>26</sup> These reports covered the alcohol market, alcohol consumption, social harms and health harms. Alcohol consumption was estimated on the basis of surveys that asked people about their drinking levels and, due to the lack of Scotland-specific data at that time, on UK-level sales data.

We published a highly influential report in 2008 that was to become a game-changer for calculating consumption estimates. Comparing survey estimates with sales data, we showed in ‘How much are people in Scotland really drinking?’ that surveys did not provide a valid estimate of population consumption.<sup>27</sup> We showed that self-reported levels of alcohol consumption tend to underestimate the true figure and that the level of underestimation had increased over time. There were a number of reasons for this, including the increase in strength of many drinks and also the tendency for drinks poured at home to be bigger than pub measures.

As a result of this important study, we worked with the Scottish Government to develop a revised methodology for calculating levels of consumption. In addition, we obtained Scotland-specific sales data, which meant that levels of alcohol sales in Scotland were no longer masked by sales in other parts of the UK and we had a more accurate picture of sales and consumption in Scotland than ever before. We found that people in Scotland may be drinking twice as much as surveys had previously reported.

The following year, this more accurate picture of consumption was joined by a clear picture of the health harms caused by the consumption of alcohol. In



2009 ISD published analysis of the total burden of morbidity and mortality attributable to alcohol, estimating that 1 in 20 of all deaths in Scotland in 2003 were wholly or partly attributable to alcohol.<sup>28</sup>

## **Taking an outcomes-focused approach**

The research and evidence described above meant that when the new government came into power in 2007, it was clear that alcohol was a significant public health issue in Scotland and that new and concerted action was needed. As set out in chapter one, the new government introduced an outcomes-focused planning approach. This aligned with developments in our own thinking about how best to plan policies and programmes, and evaluate their impact on population health and wellbeing.

Our approach, which is now pivotal to all of our work, is to take an outcomes-focused approach, which for planning means being clear about the actions and intermediary outcomes needed to achieve a desired outcome, and for evaluation means identifying the possible chain of outcomes that may result from a policy or programme.

In 2007 the Scottish Government asked us to develop an outcomes framework for alcohol. This was to inform future action to reduce alcohol-related harm in Scotland. We responded quickly to this request and produced a series of linked logic models to set out the sequence of steps that would be most likely to lead towards a population level reduction in alcohol-related harm. This included implementing interventions at a structural level to the environment in which alcohol is sold and consumed and interventions at an individual level for individuals at risk from their own or others drinking.

We shared the outcomes framework with government in December 2007<sup>29</sup> and engaged with policy colleagues in government who were exploring the implications for future policy around alcohol. The government consulted<sup>30</sup> on their plans for a new alcohol strategy in June the following year. When the new strategy, 'Changing Scotland's Relationship with Alcohol',<sup>31</sup> was published in March 2009, it called for a reduction in population consumption – a world first in a government alcohol strategy – and included actions at a structural and individual level aligned to our outcomes framework.

The evidence and analysis we provided played a key part in this, alongside a number of other factors including the presence of real political will for change, and the strength of advocacy from a range of stakeholders who were calling for the same thing. Close-working with analytical and policy colleagues in government was also key; working through the evidence and the options together.

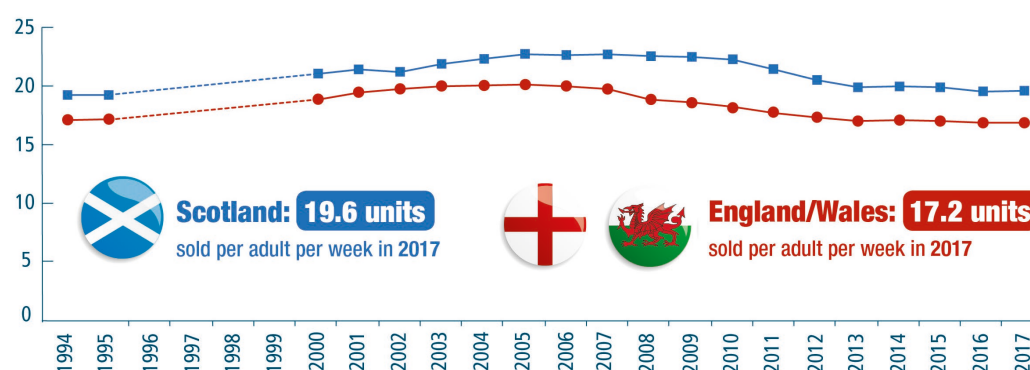
## From policy formulation to monitoring and evaluating impact

In 2008, the Scottish Government asked us to lead the development and delivery of a monitoring and evaluation framework for the alcohol strategy. We established a Monitoring and Evaluation Reference Group on Alcohol (MERGA) to develop a portfolio of studies. We led the reference group, which included representatives from Scottish Government, ISD, health boards, the third sector, the police, and research/evaluation specialists.

Once the evaluation plan was developed, MERGA evolved into one of our flagship evaluation programmes: MESAS – Monitoring and Evaluating Scotland's Alcohol Strategy. MESAS included a range of commissioned and in-house studies covering the important and evaluable elements of the alcohol strategy. We published the first annual MESAS report<sup>32</sup> in March 2011 and year on year our reports have been met with considerable political, industry and media interest.

We have continued to undertake routine monitoring of long-term trends and produce annual reports since phase one of MESAS finished in March 2016. Our most recent report found that population level alcohol consumption, based on sales, is at its lowest level since monitoring began.<sup>33</sup> However, as a nation we continue to buy enough alcohol for every adult in Scotland to substantially exceed the low risk weekly drinking guidelines (see Figure 6 below). The data also shows that significant inequalities persist in the harm caused by alcohol consumption in Scotland. In 2017, alcohol-specific death rates were seven times higher in the most deprived areas in Scotland, compared to the least deprived.<sup>ibid</sup>

Figure 6: Units of alcohol sold per adult and per week in Scotland and England/Wales



## **Support for individuals at risk from their drinking**

The flagship intervention in Scotland for individuals at risk from their drinking is the provision of Alcohol Brief Interventions (ABIs) to help people understand their levels of harmful or hazardous drinking and create an opportunity to reduce their drinking. The 2009 alcohol strategy<sup>31</sup> set out a specific aim to increase the delivery and reach of ABIs. We contributed to this by developing a range of materials to support practitioners in primary care, antenatal services and accident and emergency in the delivery of ABIs, and by coordinating the national network of ABI leads.

When we realigned our resources to implement AFHS (see chapter one), our work around ABIs became more about strengthening the evidence base and less about supporting the delivery of ABIs. Although we did continue to maintain the resources and support government around the annual ABI guidance.

Our work on the evidence base included undertaking evaluations of the ABI programme<sup>34, 35, 36</sup> and exploring the application of ABIs in the criminal justice setting, which included contributing to a WHO report.<sup>37</sup> We found through the evaluation work that ABIs can be effective in helping individuals reduce their consumption and/or change patterns of drinking but we do not know the scale of the impact of ABIs on population health or health inequalities. Recent modelling work using our Informing Interventions to reduce health Inequalities (Triple I) tool found that ABIs could help to reduce health inequalities if they are targeted to the most deprived areas.<sup>38</sup> This targeting is crucial because alcohol-related harm is socially patterned with higher levels of harm in less affluent groups. The latest figures show that alcohol-related mortality rates for those living in the most deprived areas of Scotland are six times the rate for those in the least deprived areas.<sup>33</sup>

The Scottish Government's new Alcohol Framework,<sup>39</sup> published in December 2018, makes a commitment to reviewing the evidence on current delivery of ABIs 'to ensure they are being carried out in the most effective manner'. This includes assessing how far services are targeted to our most deprived areas. We, and in turn Public Health Scotland, will be working with the government on this commitment so will have a key role to play in ensuring that ABIs are as impactful as they can be in reducing the harms associated with alcohol.

## **Improving knowledge and awareness**

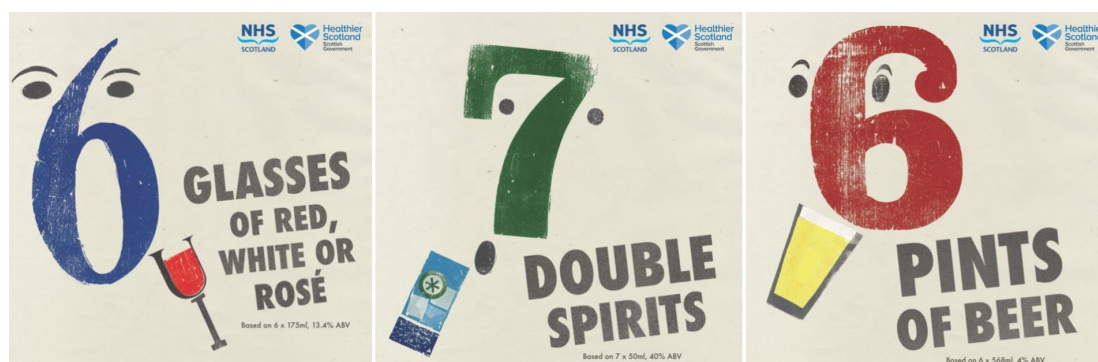
In January 2016 the UK Chief Medical Officers (CMOs) announced new lower-risk drinking guidelines.<sup>40</sup> The revised guidelines are now the same for men and women and state that no more than 14 units of alcohol should be consumed per week to keep health risks low, preferably spread over three or more days, with no drinking at all during pregnancy.

Promoting new CMO guidelines is a specific action in the 2018 alcohol strategy and we convened an expert advisory group to support it. The group has representatives from key third sector organisations, Alcohol and Drugs Partnerships, Scottish Government and academia. The group developed recommendations to raise awareness amongst the general public and health

professionals. The recommendations, which are based on the available evidence and the alcohol outcomes framework, were presented to the CMO in September 2018 and agreed as an appropriate course of action.

The expert advisory group was subsequently asked by the Scottish Government marketing team to guide the development of the national Count14 social marketing campaign (see Figure 7 below).<sup>41</sup> The campaign launched in March 2019 and led to a 236% increase in ordering of our alcohol resources.

Figure 7: The Count14 social marketing campaign



Planning for phase two of the campaign is underway, including targeting of information more towards men and people living in areas of deprivation, which we know is important to most effectively reduce harm.

## Minimum Unit Pricing

One of the highest profile targeted interventions in Scotland is Minimum Unit Pricing (MUP). MUP is both a whole population approach and a targeted intervention, which targets reduced consumption of alcohol which is cheap relative to its strength. MUP applies to the whole population, but heavier drinkers are likely to be affected more than moderate drinkers, in terms of the amount they drink, how much they spend and how much they benefit from reductions in harm.

MUP was first publicly called for in December 2007 when SHAAP published the report of the findings of their expert workshop on price.<sup>42</sup> That same month, we had recommended exploring the introduction of MUP in the outcomes framework developed for government. As stated by SHAAP, the evidence suggests that ‘when all other factors remain the same, an increase in the price of alcohol generally leads to a decrease in consumption, and vice versa’ and therefore price may be an effective ‘policy lever to reduce alcohol consumption and related harm’.<sup>ibid</sup>

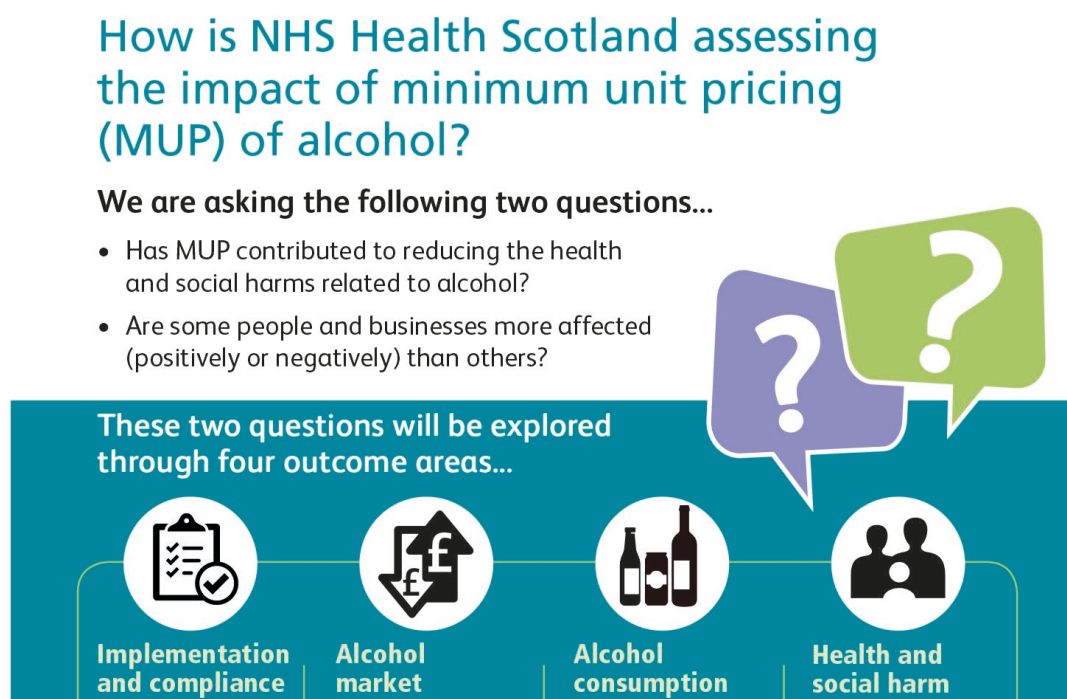
The Scottish Government consulted on MUP as part of the development of the new alcohol strategy the following year and subsequently announced that the establishment of a minimum price per unit of alcohol would be pursued through regulation. The Alcohol (Minimum Pricing) (Scotland) Act received Royal Assent in June 2012 but a legal challenge from parts of the alcohol industry was to prevent the act from coming into force for over six years.

Our role in producing data and analysis through the MESAS programme required us to develop clear and transparent governance processes. This ensured we maintained, and were seen to maintain, our impartiality within the legal and political debate around MUP. The reports from the MESAS portfolio were referenced by stakeholders on both sides of the legal argument. This included the Business Regulatory Impact Assessment<sup>43</sup> undertaken as part of the legal process and the Supreme Court ruling<sup>44</sup> itself made reference to our work, all of which brought with it heightened media interest.

When the Supreme Court ruled in favour of MUP on 15 November 2017, they stated that it was the right of the Scottish Parliament and Government to make the judgement to prioritise benefits to public health over market factors. The judge also noted the essentially experimental nature of MUP and said that was 'a factor catered for by its provisions for review and "sunset" clause'.

As a result of the strength of our work on MESAS and our proven credibility and independence, we were commissioned by the Scottish Government to lead the monitoring and evaluation necessary to meet the requirements of the review clause. The evaluation focuses on two key questions (see Figure 8 below).

Figure 8: How are we assessing the impact of MUP?



We will be taking this important work with us into Public Health Scotland, together with the valuable experience we gained around how to maintain neutrality, how to preserve scientific independence of voice, and how to ensure fair and equitable treatment of stakeholders.

### **What did we learn?**

Reflecting back over our time as Scotland's national health improvement agency, key areas of learning from our work on alcohol include:

- It is important that the work of a public health body, and the recommendations it makes, are firmly based on the best available evidence and clarity of long-term purpose, especially when an issue has become politicised. This is key to maintaining organisational credibility and standing, which is the foundation of all of our work.
- Building and maintaining effective relationships with stakeholders is key to making an effective contribution to public health policy and practice, including relationships with government, third sector organisations and local delivery partners. This requires staff with strong understanding of the evidence, relationship management skills, and honest brokerage expertise.

# Our contribution to **place and health**



## Chapter 3: Our contribution to place and health

### Early context

‘Place’ is where we live, where we learn and play, where we socialise and where we work. It encompasses both the physical environment (the buildings, streets, public areas and natural spaces that make up neighbourhoods) and the social environment (the relationships, social contact and support networks that exist in a community).<sup>45</sup>

Place has an important role to play in our health and wellbeing and in tackling health inequalities. This over-arching agenda is now well recognised and is prominent within our own work and within wider public policy in Scotland. It is also one of the six Public Health Priorities<sup>19</sup> launched in June 2018.

The story of our contribution to the thinking and strategic positioning around the place agenda starts with our own growing recognition of the importance of finding ways to create a shared understanding across partners of how place shapes our health. This early work around place is the precursor to the development of the Place Standard Tool; now a world-renowned tool for engaging communities in maximising the contribution of place to health.

When NHS Health Scotland first came into being in 2003, our work programme<sup>46</sup> was largely set in the context of the Scottish Government’s strategies around health<sup>47</sup> and social justice.<sup>48</sup> Therefore our delivery work was largely organised around health-related topics such as smoking, physical activity and diet, and life-stages such as early years and later life. Our work on these topics did consider place, for example our work on physical activity included looking at traffic-free zones and cycling lanes, and our work on tobacco looked at smoke-free environments. This meant that whilst each behaviour topic embedded environmental factors into planning and delivery, we did not have an explicit overarching programme on place and health.

Our early context also includes our support for the Community Health Exchange (CHEX), which had been established by HEBS in 2000 as a national health intermediary to support community-led health and to tackle health inequalities. We have funded it ever since in recognition of the importance of community development approaches to health improvement. CHEX is hosted by the Scottish Community Development Centre, who are a key partner in our work around place. Similarly, we have directly supported community food initiatives since 2013 when Community Food and Health Scotland (CFHS) became part of NHS Health Scotland. Our work supporting community initiatives therefore predates our place programme, and now runs alongside it.

In the early days of NHS Health Scotland our data and intelligence work included an element of place in the shape of GoWell, a longitudinal study looking at the ‘impacts of Glasgow’s investment in housing and neighbourhood renewal on the health and wellbeing of individuals, families and communities in Glasgow’.<sup>49</sup> GoWell is a partnership with the Scottish Government, Glasgow Housing Association, the Glasgow Centre for Population Health, and NHS Greater Glasgow and Clyde, and continues to this day.



In summary, while the early days of NHS Health Scotland included a number of areas of work that touched on place, we did not view place as an over-arching concept. This was to change when a leading ecological public health academic came to work with us in 2004.

### **Strategic recognition of the importance of place for health**

The Scientific Policy Adviser to the Chief Medical Officer worked with us between 2004 and 2009, and together we developed a new national policy approach to environment and human health. This culminated in the Scottish Government's strategy 'Good Places, Better Health'<sup>50</sup> (GPBH).

GPBH recognised that 'to deliver on the Government's purpose, themes, and national outcomes there is a need for greater connections around how physical environment influences health'.<sup>ibid</sup> GPBH was published just months after 'Equally Well', (see chapter one) which recognised the need to improve 'the whole range of circumstances and environments that offer opportunities to improve people's life circumstances and hence their health'.<sup>51</sup> There was therefore a growing level of political and policy interest in harnessing the health-nurturing aspects of place.

A central tenet of GPBH is the pivotal role played by effective collaboration between local authorities, health boards, the third sector and communities in creating high quality places. This meant that the strategy gained even more support and traction when the report of the Christie Commission on the future delivery of public services was published in 2011.<sup>9</sup> The 'Christie Report' placed an emphasis on the importance of community in the effective delivery of public services and, in response, the Scottish Government made a commitment to 'sharpen the focus of public services on "place" as a magnet for partnership and as the basis for stronger community participation in the design and delivery of local services'.<sup>52</sup>

We welcomed this focus on communities and committed to supporting the change in the way public services are designed and delivered in June 2012 when we published AFHS. We said 'radical changes are needed in the way public services are delivered so that they place strong communities at the centre of achieving better outcomes, drawing on their assets'.<sup>10</sup> When we realigned our resources to implement the strategy we created a specific team working on place to take forward and address all of the elements that encompass place referred to above. This includes work on housing, homelessness and human rights, greenspace, community justice, active travel and transport, work to support Community Planning Partnerships, and, the most recent addition to the area; active environments. It also includes perhaps our most well-known work on place, the Place Standard.

## Developing the Place Standard

GPBH included a commitment to create a 'model which can frame the complex relationships between environment and human health'.<sup>50</sup> We worked with Scottish Government colleagues in the Planning and Architecture Division, Architecture and Design Scotland and Glasgow City Council to explore the development of the model. Early thinking focused on the use of data and intelligence to map the quality of a place. However, we soon realised that a scientific data-driven approach would not meet the community engagement aspirations of GPBH or Christie.

Our architecture and spatial planning colleagues were at the time developing a strategic position statement on architecture and place. Their thinking aligned well with GPBH, including a focus on engaging with communities and recognising the health benefits of good places. We were able to work together, with our involvement ensuring a focus on health and wellbeing and, crucially, on reducing health inequalities. This is important because the distribution of aspects of place that nurture and promote good health and aspects of place that are detrimental to health is not equal. Those living in areas of greater deprivation are more likely to be exposed to harmful factors, such as poor air quality, and less likely to have access to beneficial and protective ones, such as green space.<sup>45</sup>

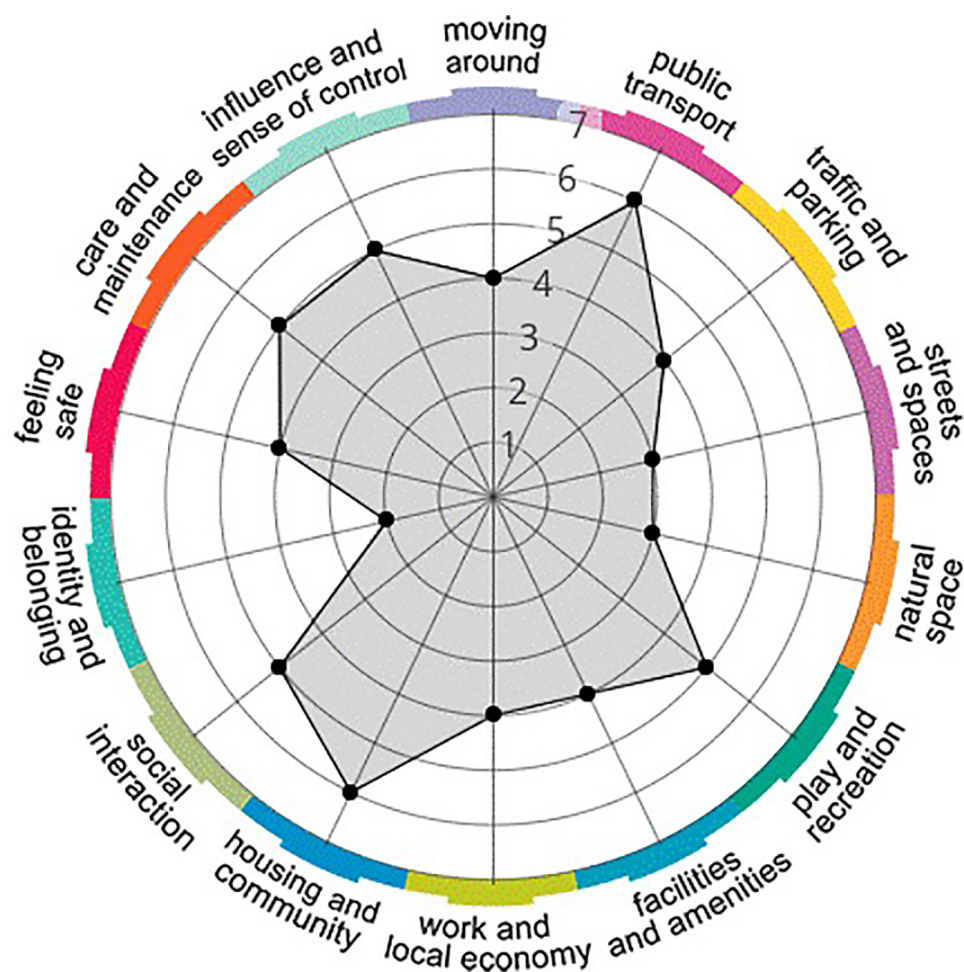
In June 2013 the Scottish Government's policy statement on architecture and place, 'Creating Places', crystallised our joint thinking around how best to model the quality of a place by making a commitment to 'Develop a Place Standard assessment tool, which will be the hallmark of well-designed places'.<sup>53</sup>

We developed the Place Standard tool together with Scottish Government, Architecture and Design Scotland and Glasgow City Council over the following couple of years.

The resulting tool provides a simple framework to structure conversations about place and community.<sup>54</sup> It uses a questionnaire format to help communities to assess both the physical and social aspects of place. It covers the buildings, streets, public spaces and natural spaces that make up a place as well as the relationships, social contact and support networks that make up a community. The questionnaire is designed to be accessible and easy to use, and the results are plotted on a spider diagram (see Figure 9 below) so it's easy to see what the community feels is good about their place, and what could be improved.

Following the successful piloting of the tool with communities in Auchencairn, Greenock and Kirkcaldy, we launched it in December 2015. 18 months later the tool won the Royal Town Planning Institute's (RTPI) award for excellence in planning for wellbeing.<sup>55</sup>

Figure 9: An example of a Place Standard spider diagram



## Implementing the Place Standard

We developed a three-year implementation plan (2016–2019) to provide a clear framework of actions to support the practical application of the Place Standard across Scotland. This was based around four outcome areas, one of which was reducing inequalities by ensuring that application of the tool generates actions to reduce the gap between population groups and communities living within the least and most deprived areas.

Application of the tool in Scotland continues to grow, but because we make it freely available online it's impossible to get a full picture of the level of usage of the tool in communities. This is one of the Place Standard's strengths; it is freely available for communities to use worldwide. It does however mean that activity data cannot be fully accurate. We know, from Place Standard Leads reporting usage in local areas, that 27 local authorities and one national park were using the tool in November 2018. This amounts to 142 separate instances reaching 16,750 individuals. But we know that this is a fraction of the true figure.

The next chapter in the Place Standard's story is the development of three new versions of the tool – a children's version, a young people's version and a version for architects and planners. The children and young people version

will be developed in partnership with Play Scotland and A Place in Childhood and will be co-created with children and young people themselves.

### **International impact and influence**

Scotland is very much seen as a world leader around place and health and this is in no small part down to the Place Standard. Since its formal introduction to the international community in Hungary in March 2017, the Place Standard is now being used in 12 countries across Europe including full translations in Latvia, North Macedonia, Turkey, Denmark, the Netherlands and Norway. Through use of simple language and easily understood concepts, the Place Standard translates easily into others' languages.

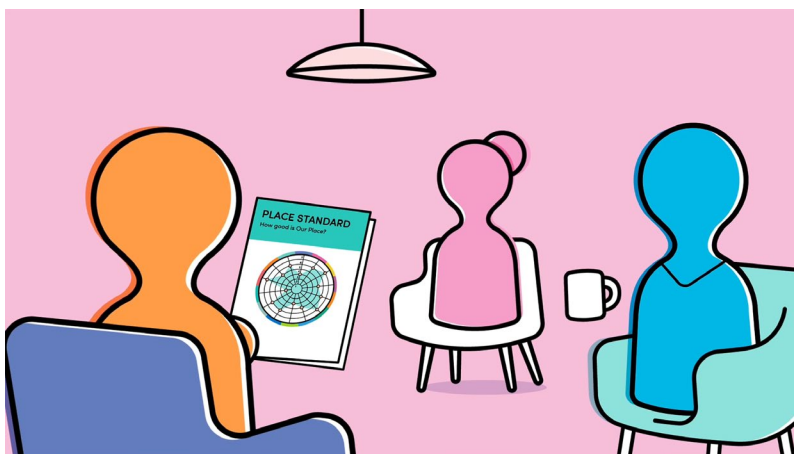
One of the reasons the Place Standard has international appeal is that each dimension of the Place Standard maps on to at least one of the UN Sustainable Development Goals<sup>56</sup> and use of the tool supports the objective to 'engage local communities and stakeholders in designing and managing places, settings and communities consistent with the needs of their people throughout the life-course'.<sup>57</sup>

It is testament to our work on place and to the profile of the Place Standard that we were invited to chair and coordinate the Place, Health, Inequalities and Well-being Working Group of the WHO European Healthy Cities Network. As a result of subsequent conversations, the group now includes a strong focus on inequality, and their work programme includes the piloting of tools to address place, health, inequalities and wellbeing across the WHO European Healthy Cities Network and the sharing of lessons, knowledge, and good practice on designing and creating places to improve health, inequalities and wellbeing for all.

### **The Place Standard and Public Health Reform**

Public Health Scotland will have a role in better supporting communities to participate in decisions that affect their health and wellbeing and we believe that the Place Standard could be used to great effect here. By providing a simple framework to structure conversations about the physical and social aspects of place, it helps communities consider what needs to change and describe this to planners and decision makers.

Figure 10: Using the Place Standard to have a conversation



There is currently no requirement for the results of Place Standard conversations to be acted upon by the relevant authorities. The work we undertook with partners on Scotland's excess mortality recommended that the results of Place Standard conversations should be 'a "material consideration" in the spatial planning system for private and public sector development' and that investment should be made in 'support for communities from deprived areas to use it'.<sup>58</sup> In 2018/19 the government's 'Making Places' initiative provided funding for 21 community groups across 16 local authorities to use the tool. However it has not yet become a 'material consideration'.

The Place Standard can also contribute to realising the Public Health Reform ambition of taking a human rights approach to public health. By providing a practical tool with which to engage communities in improving their physical and social environment, the Place Standard can help communities claim their right to the highest attainable standard of physical and mental health.

### **Preserving a viable environment for future generations**

Action to improve environmental sustainability presents a significant opportunity to improve population health and reduce health inequalities. This is becoming an increasingly important element of our work on place and health. Our work includes contributing to Scotland's second Statutory Climate Change Adaptation Programme<sup>59</sup> and being a member of the Sustainable Scotland Network, which supports the implementation of the public body climate change duty.

Climate change is threatening the healthy natural systems and environments that we all rely on for our health. Continued degradation of the environment through, for example, greenhouse gases emissions and pollution poses a significant threat to population health now and for future generations. It also threatens to increase health inequalities because we are not experiencing the impact of climate change equally. There is international evidence<sup>60, 61</sup> that the impact of climate change on population health is not evenly distributed and will more negatively impact on those with the least resources and power.

## **What did we learn?**

Reflecting back over our time as Scotland's national health improvement agency, key areas of learning from our work on place and health include:

- Initiatives designed to engage communities in public health issues must be live to inequality issues and well resourced in order to overcome barriers to participation in poorer communities. Without this, there is a risk of increasing inequalities as a result of more affluent communities being better equipped to take up the opportunities.
- Public health is a collaborative endeavour and national agencies have a pivotal part to play in facilitating collaboration nationally and locally. This requires the investment of staff time in building and maintaining relationships and understanding the needs of different stakeholders.

# Our contribution to **early years policy and practice**



## Chapter 4: Our contribution to early years policy and practice

### Early context

When we came into being in 2003, the importance of good health and wellbeing in the early years was already well recognised in UK and Scottish policy as the starting point for good health throughout life.

Early years was one of the four areas of 'special focus' in the Scottish Executive's health improvement strategy, launched just a fortnight before our inception.<sup>1</sup> Actions largely focused on the provision of support for parents and our role in this was the provision of evidence-based information resources for healthcare practitioners to use with parents, along with training for healthcare practitioners. There was, and continues to be, significant demand for these resources, which became part of the Early Years Information Pathway.<sup>62</sup> This includes 'Ready Steady Baby!' which we refreshed and relaunched in March of this year.

We have made efforts to move away from the mass provision of information for the whole population as there is evidence that this is not effective. As Sally McIntyre said in her briefing paper for the Ministerial Taskforce:

'...information based approaches such as food labelling, pamphlets in doctors' surgeries, and mass media campaigns, or those which require people to take the initiative to sign up for, may be less effective among more disadvantaged groups.'<sup>14</sup>

However, in contrast to information designed for the whole population, there is evidence that the provision of health information as part of an integrated care pathway can 'contribute to efforts to improve health outcomes and reduce health inequalities'.<sup>63</sup> Access to health information of this kind is an entitlement of the right to the highest attainable standard of health.<sup>64</sup>

In addition to the provision of evidence-based information resources for healthcare practitioners to use with parents, we were also responsible for ensuring Scotland-wide dissemination of the lessons learned from the national health demonstration project for early years, 'Starting Well'. We established the Early Years National Learning Network in order to do this, which embedded an evidence into practice approach to our early years work from the very outset.<sup>65</sup>

Therefore prior to the development of AFHS (see chapter one), our approach focused on supporting the provision of a universal approach to support in early years with more targeted support where needed. This is known as 'proportionate universalism'<sup>66</sup> and included contributing to the evidence base to improve policy and practice around the building blocks of early years such as infant nutrition, play, and parenting.



## **The increasing profile of inequality**

As we saw in chapter one, Scottish policy recognised the existence of health inequalities and the need for action to be taken from well before NHS Health Scotland came into being. Poverty and inequality were known to undermine efforts to give children the best possible start in life, which Professor Sir Harry Burns repeatedly highlighted when he became Chief Medical Officer in November 2005, including in his first annual report.<sup>67</sup>

2008 was a significant year in social policy in Scotland as we say in chapter one and this was particularly so for early years. First 'Equally Well'<sup>14</sup> recommended that 'children, particularly in the early years' should be a priority area for action on reducing health inequalities and then the 'Early Years Framework'<sup>68</sup> called for transformational change to deliver a 'radical improvement in outcomes'. This was supported by the financial case being made for early years interventions in an important study published by the Scottish Government in 2010. This provided evidence of the 'potential savings from early years investment in a Scottish context' and found that 'investment in the early years can yield savings in the short, medium and long terms'.<sup>69</sup> Both The Early Years Framework and the economic modelling report stressed the importance of tackling 'cycles of poverty'.

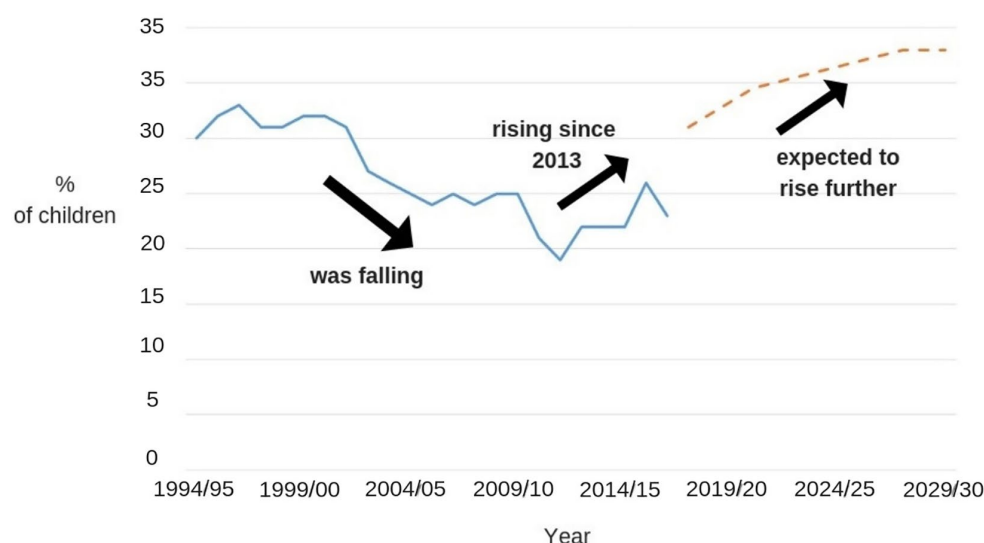
This set the context for our early years work moving upstream after the publication of AFHS in 2012. Early years, and specifically the right of every child to good health, became a corporate priority<sup>70</sup> and programmes of work were developed around child poverty and childhood adversity.

What follows in this chapter is not an exhaustive account of our work on early years. Other areas in which we made a contribution include the delivery of early years HEAT (Health Improvement, Efficiency, Access and Treatment) targets, Play@Home,<sup>71</sup> and providing data on a range of child health indicators as part of the Scottish Public Health Observatory (ScotPHO).<sup>72</sup> We also helped to develop and implement a number of national strategies and frameworks including the Parenting Strategy,<sup>73</sup> the Play Strategy,<sup>74</sup> the Maternal and Infant Nutrition Framework<sup>75</sup> and the Maternity Care Framework.<sup>76</sup>

## **Our work on child poverty**

Child poverty is a significant public health issue, with 2017/18 figures indicating that just under a quarter (24%) of children in Scotland live in relative poverty (see Figure 11 below).<sup>77</sup> This is expected to rise further unless concerted action is taken, and that's what we are working to support.

Figure 11: Percentage of children living in relative child poverty in Scotland (after housing costs)



Our contribution to work on child poverty has been to bring public health leadership to the issue. This means taking a population-based approach, emphasising collective responsibility for health, focusing on the underlying socio-economic and wider determinants of health, and emphasising collaborative partnership working.<sup>78</sup> We support our partners and stakeholders to understand the health implications of child poverty and we work to facilitate collaboration and the sharing of evidence about what works to reduce child poverty. This includes providing a conduit for engagement between local and national stakeholders, conducting evaluability assessments, advocating for effective policy and supporting the development of ‘once for Scotland’ approaches to child poverty. This means developing an approach once and sharing the learning to avoid the same development work being replicated in different areas of the country.

An example of this is our work with the Child Poverty Action Group (CPAG) on The Cost of the School Day. CPAG and partners developed the initiative in Glasgow in 2014 looking at the financial costs associated with attending school. The aim of the programme was to mitigate the impact of poverty on schoolchildren and contribute to closing the attainment gap by reducing or removing financial barriers to full participation in school. We provided national support for the project, including conducting an evaluability assessment<sup>79</sup> and supporting the programme to become nationwide through the provision of funding for a post and the development of a toolkit.<sup>80</sup> We produced a film to accompany the toolkit, which shows a range of people, including teachers, parent councils and community planners, sharing their current experiences and insights on some of the impacts of poverty on school life and barriers to participation in it.<sup>81</sup>

Linked to this is our leadership of the Facing up to Child Poverty in Schools Practice Network. This is a network for local authority education representatives who have a strategic remit to lead on and progress actions to address the cost barriers of school. The network provides a structure through

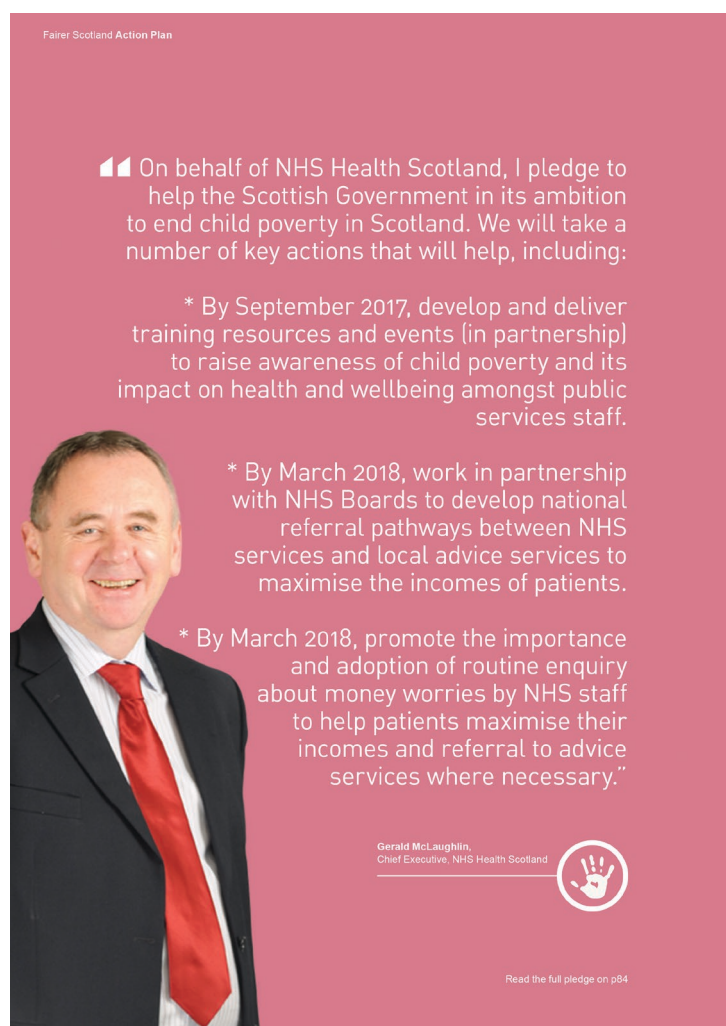
which peer support, the exchange of practice and national level support is facilitated. It engages with relevant national partners to exchange perspectives, enable collaboration and take action.

## A Scotland-specific approach to child poverty

The 'Fairer Scotland Action Plan',<sup>82</sup> published in October 2016, sets out the government's overall strategy for tackling poverty and inequality in Scotland. This included a commitment to introduce new child poverty income targets for 2030, which was necessary after the UK-wide income-based child poverty targets were dropped by the UK Government in 2015. The new targets were introduced into legislation through the Child Poverty (Scotland) Act 2017.<sup>83</sup> Our Chief Executive was a member of the Ministerial Advisory Group on Child Poverty, which helped to shape the new act.

We made a pledge in the action plan to 'help the Scottish Government in its ambition to end child poverty in Scotland'<sup>82</sup> (see Figure 12 below).

Figure 12: Our Fairer Scotland Action Plan Pledge



Our commitment included two actions around income maximisation: working in partnership with NHS Boards to develop national referral pathways to

maximise the incomes of patients, and promoting 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.

Supported by the Scottish Public Health Network (ScotPHN), we undertook work with the Scottish Health Promotion Managers to fulfil this aspect of the pledge. This involved first assessing the 'extent to which NHS Boards and Integration Authorities are developing or delivering financial inclusion referral pathways between midwifery, health visiting and welfare/money advice services' and then making recommendations to Scottish Ministers on how to 'extend, and scale up, the referral pathways in every NHS Board area across Scotland'.<sup>84</sup> The recommendations were accepted, which led to the Healthier Wealthier Children<sup>85</sup> approach first developed in Glasgow being rolled out across Scotland.

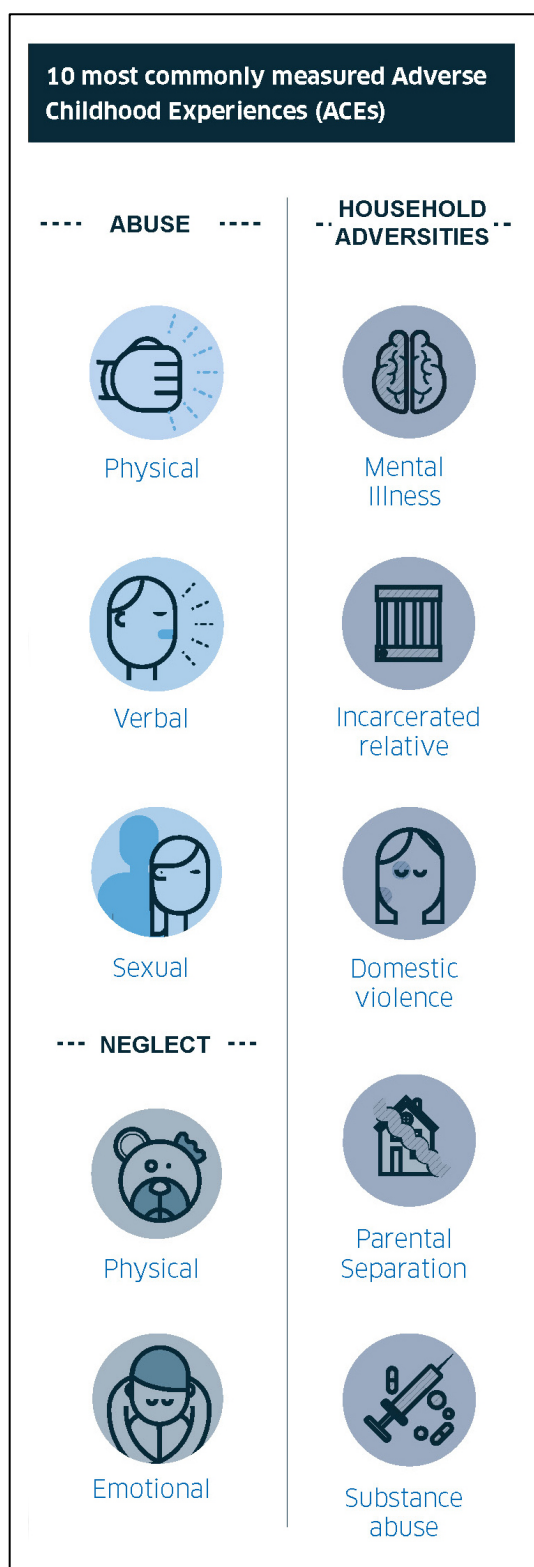
Another key element of our work around the Child Poverty (Scotland) Act 2017 is our work to support compliance with the local reporting duty. Local authorities and NHS Boards must jointly report annually on the activity they are taking, and will take, to reduce child poverty. We have been working to support local partners in the development of the reports, both as a 'critical friend' and through leadership of the Local Child Poverty Coordination Group. This group brings together the national partners, including the Improvement Service, Scottish Government, and COSLA, in order to provide national coordination of local support and to facilitate two-way engagement between local and national partners.

## **Our work on Adverse Childhood Experiences**

Linked to child poverty is our work on Adverse Childhood Experiences (ACEs). The term 'ACEs' was originally developed in America in a large population study in 1998 looking at links between a range of adverse childhood experiences and risk of a range of health outcomes and health-harming behaviours.<sup>86</sup> ACEs refer to stressful events occurring in childhood (between 0 and 18 years), as shown in the Scottish Government infographic below.<sup>87</sup>

This first study found that as the number of ACEs increased in the population studied, so did the risk of experiencing a range of negative health outcomes. This has been repeatedly found in subsequent studies. For example a similar study on ACEs carried out by Public Health Wales found that at a population level, compared to people with no ACEs, having four or more ACEs increases the risk of a number of health-harming behaviours and the risk of developing a number of health problems in later life. This includes developing heart disease, being a victim of violence and engaging in high-risk drinking, smoking, and drug use.

Figure 13: The ten most commonly measured ACEs



Child poverty and ACEs are linked because while ACEs are found across the population, there is more risk of experiencing ACEs in areas of higher deprivation. Part of our public health leadership role has been to support the implications of these links being understood locally and nationally.

The foundation of our work on ACEs was the research carried out by ScotPHN into the implications of ACEs for Scotland. The report 'Polishing the Diamonds – Addressing Adverse Childhood Experiences'<sup>88</sup> set out a number of areas for action in Scotland across research, policy and practice. The report had implications for stakeholders working across a variety of sectors including education, public health, health care, and employment. For our own part, our focus has been on establishing public health leadership around ACEs. A key component of this was establishing the Scottish ACEs Hub in 2016. This brings together leaders from public health, mental health services, education, police, social work and third sector organisations. It aims to 'encourage debate and build consensus on the causes and consequences of childhood adversity, as well as discuss appropriate individual, community, organisational and societal responses'.<sup>89</sup>

We have used a variety of methods to work collaboratively across the system, both directly and with the ACEs Hub. This includes supporting

Scotland-wide screenings of a documentary on ACEs<sup>90</sup> in order to prompt discussion with a wide range of stakeholders about the actions required to prevent and respond to adversity. We have also led and been involved in a number of high-profile events and seminars, including two events chaired by Professor Sir Michael Marmot, a joint event with Education Scotland and the Scottish Government to explore the implications of ACEs for the attainment gap, and a seminar on childhood adversity and trauma.

As well as face-to-face engagement, we have used a range of media to raise awareness of ACEs. We launched an animation<sup>91</sup> on ACEs in May 2018 in order to further stimulate discussion. This generated significant engagement through social media and drove a high volume of traffic to our website where our reports are available including, most recently, a briefing to set out a number of principles to inform cross-sector work on ACEs.<sup>89</sup> As can be seen below, the subtitle of the animation linked to the Scottish Government's ambition for Scotland to be the best place for children to grow up.

Figure 14: ACEs animation title screen



Commitment to tackling ACEs has been made at a national level, both in the last three consecutive Programmes for Government<sup>92,93,94</sup> and in Scotland's Public Health Priorities where tackling ACEs is recognised as key to creating a Scotland where we flourish in our early years.<sup>19</sup>

### **Our work to support early learning and childcare expansion**

The Scottish Government committed to expanding their provision of funded early learning and childcare (ELC) from 600 hours per year to 1,140 hours per year in 2016. We have supported this programme in a number of ways including undertaking an evaluability assessment of the expansion programme,<sup>95</sup> developing an evaluation framework and providing support to the development of the actual evaluation.

In addition to various internal reviews of certain aspects of ELC such as use of outdoor space, family resilience and child development, we have also produced two rapid evidence briefings, one looking at the likely impact on parents<sup>96</sup> of their preschool children attending ELC and the other on impacts for the child. We found widespread agreement that quality ELC can have a positive impact on both parental and child outcomes. ELC is seen as being particularly beneficial for children from disadvantaged backgrounds although all children have the potential to benefit.<sup>97</sup> Early results from the baseline study of the evaluation indicate that the policy for eligible two-year-olds is appropriately targeted at the children who would most benefit from ELC.

However, it also shows that parents and families as a whole have the potential to benefit from good-quality, family-focused ELC. In particular these studies have shown the importance of taking a holistic approach to ELC and focusing on health and wellbeing of all members of the family. Government policy is now beginning to reflect this focus.

Basing the framework for the evaluation on firm evidence helped shape the policy as it was implemented. The close partnership we have with Scottish Government meant that existing evidence was used to formulate the policy and that early findings were acted upon quickly. In addition, considerable efforts were made to involve all parties in a very practical way in the early learning and childcare sector in both implementation and evaluation including local authorities, ELC settings, the Care Inspectorate and other national bodies. This has encouraged a sense of ownership around the evaluation which in turn supports implementation. The independent assurance gateway review for the ELC programme was very positive about the analytical support being provided to the programme and the extent to which the policy is being developed through evidence.

### **International impact and influence**

We have made a significant contribution to the development of early years policy and practice internationally through our work with the WHO European Office. We host the WHO Collaborating Centre<sup>98</sup> for Health Promotion and Public Health Development with a focus on Child and Adolescent Health in the WHO European Region.<sup>99</sup> Having been set up in 1982, it is one of the longest standing Child and Adolescent Health Collaborating Centres in the world. It has been in our stewardship since our inception, having passed to us from two of our predecessor bodies; first the Scottish Health Education Group and then the Health Education Board for Scotland.

As a WHO Collaborating Centre, we carry out activities in support of the WHO's work programme. We provide professional and technical assistance to help to develop and monitor regional strategy, with a particular emphasis on reducing inequalities in child and adolescent health outcomes. We also work with WHO to support member states in implementation of strategies. We are currently helping WHO to write the next WHO Child and Adolescent Health Strategy for the 53 member states of Europe.

We also undertake evidence work for the WHO European Office, including contributing to evidence reviews and guidance. Specific examples include leading the development and writing of 'Adolescent health and development in the European Region: can we do better?'<sup>100</sup> and contributing the case study on Scotland and helping with country profiles in the 'Situation of Child Health in Europe' report.<sup>101</sup>

We have a strong relationship with the WHO European Office based on mutual respect and the credibility and track record of our technical skills and expertise. We recognise the importance of maintaining this longstanding close working relationship and we prioritise time every week to engage with the WHO lead in Europe over videoconferencing. The closeness of the



relationship has opened up new opportunities for us to collaborate extensively with other European institutions as well as helped to drive forward our agreed work programme.

Our involvement in the Collaborating Centre has extended the reach and impact of our evidence and expertise well beyond our national boundaries. This means that other countries are benefiting from what we've learnt over 17 years as Scotland's health improvement agency. It also means that Public Health Scotland has a secure place on the European stage from its inception.

### **What did we learn?**

Reflecting back over our time as Scotland's national health improvement agency, key areas of learning from our work on early years include:

- Providing national leadership around a public health issue emphasises collective responsibility for health and highlights the need for a focus on population health outcomes, the social determinants of health and the importance of taking action on the unequal distribution of money, wealth and power in order to reduce health inequalities.
- We are at our most effective when we work collaboratively internally as well as externally. By planning and delivering programmes of work together, we can make the most of expertise from across the organisation around data and evidence, getting knowledge into action, stakeholder engagement, relationship management, network facilitation, and communications, events and marketing.



# **Overview of what we have learnt**

## **Chapter 1: Introduction**

- To reduce health inequalities and improve health, action is required across the three levels of the Theory of Causation, but if we don't do more to actually 'undo' health inequalities by taking action on the unequal distribution of money, wealth and power, then we won't make the progress we need to make.
- Public health bodies need to support stakeholders to put evidence into action in order to make a real difference to the public's health. This requires credible people with a multifaceted set of skills in relationship management, negotiation and effective influence skills working alongside people developing the evidence.
- An outcomes-focused approach, both for our own planning purposes and in how we work with partners, is essential to delivering the broad and wide-ranging policies and initiatives that are most likely to be effective in reducing health inequalities.

## **Chapter 2: Our contribution to alcohol policy**

- It is important that the work of a public health body, and the recommendations it makes, are firmly based on the best available evidence and clarity of long-term purpose, especially when an issue has become politicised. This is key to maintaining organisational credibility and standing, which is the foundation of all of our work.
- Building and maintaining effective relationships with stakeholders is key to making an effective contribution to public health policy and practice, including relationships with government, third sector organisations and local delivery partners. This requires staff with strong understanding of the evidence, relationship management skills, and honest brokerage expertise.

## **Chapter 3: Our contribution to place and health**

- Initiatives designed to engage communities in public health issues must be live to inequality issues and well resourced in order to overcome barriers to participation in poorer communities. Without this, there is a risk of increasing inequalities as a result of more affluent communities being better equipped to take up the opportunities.
- Public health is a collaborative endeavour and national agencies have a pivotal part to play in facilitating collaboration nationally and locally. This requires skilled staff and the investment of time in building and maintaining relationships and understanding the needs of different stakeholders.

## **Chapter 4: Our contribution to early years policy and practice**

- Providing national leadership around a public health issue emphasises collective responsibility for health and highlights the need for a focus on population health outcomes, the social determinants of health and the importance of taking action on the unequal distribution of money, wealth and power in order to reduce health inequalities.
- We are at our most effective when we work collaboratively internally as well as externally. By planning and delivering programmes of work together, we can make the most of expertise from across the organisation around data and evidence, getting knowledge into action, stakeholder engagement, relationship management, network facilitation, and communications, events and marketing.

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