NHS
Health
Scotland

HS Paper 25/15

BOARD MEETING: 21ST AUGUST 2015

ANNUAL REVIEW 2014/2015

Recommendation/action required:

The Board are asked to note the plans for the 2014/2015 NHS Health Scotland Ministerial Annual Review, including the narrative on equitable health improvement developed to provide clarity on our strategic intent and to ensure coherency across the various review activities.

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12th August 2015

ANNUAL REVIEW 2015

Purpose of Paper

1. This paper details the confirmed arrangements for the 2014/2015 NHS Health Scotland Ministerial Annual Review and is the cover paper for the following related documents:

   - Annual Review Self-Assessment and At a Glance
   - Equitable health improvement strategic narrative
   - Definitions of the levels of action detailed in the Theory of Causation
   - Annual Review Programme
   - Show case synopses
   - Delegate list

Background

2. The 2014/2015 NHS Health Scotland Ministerial Annual Review will take place from 10.00 – 14.15 on Wednesday 26 August 2015 at our Glasgow office (see Appendix D for the full programme).

3. The public meeting will be attended by a broad range of external stakeholders including Scottish Government, public sector and third sector representatives. The review is an opportunity for NHS Health Scotland to:

   - Be held to account to the Minister for our performance, including progress in delivering our 2014/15 Annual Review Action Plan and our Partnership Forum work

   - Update stakeholders on the significant progress in realigning the resources and functions of NHS Health Scotland and redesigning our workforce to deliver A Fairer Healthier Scotland within a challenging financial climate

   - Confirm how we will work with our partners and stakeholders moving forward, redesigning delivery collaboratively to maintain a focus on addressing behavioural determinants of health inequality whilst integrating this work with action to address the fundamental causes and environmental influences that cause health inequalities.

4. The Annual Review progress is an opportunity to deliver the following key messages to the Minister, our sponsor division and stakeholders:

   - Health must improve equitably, which means it must improve at a faster rate for those experiencing the most disadvantage than for those with the most advantages (see Appendix A for an exploration of this narrative).

   - Action to improve health equitably must be coordinated, coherent and happen in tandem across the theory of causation (see Appendix B for

newly developed definitions of 'fundamental causes', 'wider environmental influences' and 'individual experiences' to support the above narrative).

- Health Scotland can provide the national leadership and resource that can turn knowledge of what works (and what doesn't work) to improve health equitably into action at national and local levels.

Annual Review Self-Assessment

5. The 2014/15 Annual Review Action Plan and end of Year Impact Report for 2014/15 (considered by the Board on 23rd June) formed the basis of planning for the self-assessment exercise for the 2015 Annual Review and for the 2015 Annual Report.

6. The Annual Review Self-Assessment and At a Glance documents provide information on our key achievements and challenges with a specific focus on the progress we have made in achieving the outcomes set in our 2014/15 annual review action plan. We have made significant progress in ensuring that the knowledge of what works and doesn't work, to improve health in a fair and equitable way, is shared with policy and decision makers. The table in Appendix C provides an overview of our key outcome-focused achievements in 2014-15:

Annual Review Programme

7. The constituent parts of the Annual Review (see programme in Appendix D) are:

   - Chair welcomes Minister
   - Partnership Forum Meeting
   - Showcase Presentations
   - Market Place
   - Annual Review Public Meeting: Chair's presentation and Q&A session
   - Annual Review Private Meeting

External Stakeholders

8. 37 external stakeholders have booked to attend the public meeting and will be facilitated to attend in person of through webex. Please see the delegate list in Appendix E).

Showcase Presentations

9. Unlike the territorial Boards, NHS Health Scotland does not have a set of services to select from to showcase to the Minister through a site visit. Instead, NHS Health Scotland has found the idea of showcasing pieces of work by staff during a private session with the Minister very successful. The sessions are informal and this year will use either posters or a 'Prezi' presentation. The session will afford the opportunity for the Minister to ask questions and enter into conversation with the member of staff leading the work.

10. We have chosen areas of work that we believe the Minister will have a personal interest in given his portfolio. The three areas are:

    - Good Mental Health For All
    - Tobacco
    - Physical Activity and Place

11. We are using these illustrations to connect with the narrative of improving health and reducing health inequalities to show case the impact Health Scotland has had in our work and what this means for what we want to do next. Please see Appendix F for synopses of the showcase presentations.

Finance and Resource Implications

12. The financial cost of the Annual Review is minimal because we are using Meridian Court as the venue. The main resource implications relate to staff time in preparing for the review and on the day.

Partnership

13. Staff are involved in the showcases and wider staff are being encouraged to participate through the webex on grounds that numbers are limited at the venue and external stakeholder attendance has been prioritised.

Communications

14. The Annual Review Communications and Engagement plan includes:
    - Inviting key stakeholders
    - Posting a news story on the NHS Health Scotland website on 22 July
    - Highlighting in July's edition of *What's Going On*
    - Posting a news story on the NHS Health Scotland website on 19 August with further details of the content of the review
    - Internal communications through the Source and all all-staff email from Gerry McLaughlin
    - Social media before, during and after the event.

Risk

15. There are a number of risks associated with the Annual Review. Risks established which have been entered onto the master risk register are:

    - As a result of showcasing work that is subject to the organisation's transformational change process, there is a risk that we may be asked to undertake further work in an area in which we were planning to transform or reduce our contribution. This may result in a misalignment of our reducing resources towards work that is less effective in reducing health inequalities.

In order to manage this risk we have put considerable effort in ensuring the key messages described in paragraph 4, are explicit within our ARSAR, the Chair's presentation, the showcases and the private meeting In addition we have a focus on shaping the review so that there is a case made for continuing with the improvement themes in our last annual review action plan.

The coherency of message and narrative was developed through the discussion paper developed by the Head of Strategy and Engagement in Appendix A.

- As a result of inviting stakeholders to take part in the annual review, there is a risk that the Chair and Chief Executive may be asked inappropriate, overly-challenging or negative questions during the public session, which will require careful handling in order to avoid a potential negative impact on our reputation.

  It is not possible to completely remove this risk, however Directors, our Chair and the Showcase presenters will have been provided with advice and a briefing containing potential questions integrated with relevant briefing advice prepared for the Minister by our Sponsor Division

16. The gross and net risk scores for each of these risks are within the organisation's appetite for risk.

Equality and Diversity

17. The Annual Review will not have a detrimental effect on equality and diversity. Efforts have been made to make the review accessible to all attendees.

Sustainability and Environmental Management

18. The Annual Review will not impact adversely on sustainability or environmental management and in keeping with attempting to reduce carbon footprint external delegates are being offered the opportunity to attend via webex.

Action/ Recommendations

19. The Board are asked to note the plans for the 2014/2015 NHS Health Scotland Ministerial Annual Review, including the narrative on equitable health improvement developed to provide clarity on our strategic intent and key messages.

Elspeth Molony
Organisational Lead for Communications and Engagement

12th August 2015

APPENDIX A: NARRATIVE ON EQUITABLE HEALTH IMPROVEMENT

Background

This paper starts from the concern that health inequalities and health improvement policy and practice are increasingly being seen as divergent rather than integrated and coherent. Reasons for this concern are, for example: recent ministerial portfolios (public health, health improvement), feedback from our sponsor division and a degree of internal HS staff perceptions and confusions. This indicates a need for us to achieve improved clarity at both external and internal levels so as to maximise the impact of the totality of what we do, and are required to do as an organisation.

As agreed at the CMT meeting in June-this paper is a first **draft** attempt to summarise the key messages which should underpin our narrative for both internal and external use. It focuses on how to ensure that we communicate our strategic intent as one that is to **improve health in a fair and equitable way** thereby **fulfilling our strategic vision of a fairer, healthier Scotland.**

Our key challenge: Ensuring that any narrative, discourse and planned actions relating to healthy behaviours are fully coherent and coordinated with those related to fundamental causes and environmental circumstances.

Intention

This paper is intended to stimulate Director level discussion and agreement about the key messages in preparation for the annual review (and should be useful beyond this primary intention) it is not intended as a product in itself! It provides an analysis of where we need to build on or provide further clarity in our communications and engagement work.

It makes suggestions for narrative development that describes the 'sum total' our work and makes clear the co-dependent relationship between approaches that are likely to reduce health inequalities and improve health and the vital relationship between health equity and our stated approach to health improvement.

Its focus and imperative at this point is on forming the key strategic messages for the ARSAR and in the materials and discourse relating to the AR itself including the Chair's presentation, the AR showcases and throughout the event. Our principle **outcome** for the review is suggested as follows:

We have achieved a successful performance review and the authority to develop a coordinated, coherent strategy for equitable health improvement in Scotland.

What have we been clear about in our communication and engagement?

A Fairer Healthier Scotland clearly sets out our intention to improve population health in a way that is equitable - **the concept of a 'Fairer' society being inextricably linked with that of a Healthier one**. The fact that there are now two national conversations on fairness and health respectively are important validations of the direct of travel we have pursued in the last three years.

We have built on Whitehead and Dalghren's determinants of health model (the so called rainbow model) **and produced a theory of causation model that illustrates how these same determinants of health can also damage health and cause unequal health outcomes between and across individuals and groups.**

We have said that for reasons of health equity and in line with the principles of fairness and social justice that we want to reduce health inequalities by improving the health of people living with more disadvantages **at a faster rate than those with more advantages**

We have stressed the need to improve health by addressing what harms health or removing the barriers to health as well as responding/reacting to the effects of inequality on the experience and health outcomes for individuals and groups.
We have been clear that action predominantly focussed on the downstream effects of inequality and in particular on promoting healthier behaviours is **not sufficient on its own** either to improve population health or to reduce health inequalities**.**

We have highlighted the so **called policy drift towards downstream health behaviour change.**

We have highlighted that legislation, regulation and fiscal measures that address the fundamental, environmental and individual health behaviours are likely to be more effective and cost effective in improving health **and** reducing health inequalities than interventions that depend only on individual 'agency'.

We are building our narrative around the right to health for all and the barriers to health- firmly linking health improvement with a social justice agenda that goes beyond NHS action.

What do we need to be clearer about?

In making the case for action that goes beyond the NHS we are at risk of minimising the role of the NHS as an advocate for health and therefore inadvertently contributing to it continuing as an 'ill health' service.

We have been less clear about the impact of **other** structural causes of inequality on health- most notably in relation to gender- a serious gap given the impact of welfare reform on women with young children and the political focus on gender equality. **Gender equality should be a critical element of our messaging for the rights of the child programme and for the other core programmes**.

We have been less clear or have had less emphasis on messages that communicate that individuals have the ability to protect, create or harm their own health.
We are at risk of characterising people experiencing multiple disadvantages as passive- without resilience and resource. This is as clearly flawed as the concepts of assets and choice……

We need to challenge stereotypes of the 'unhealthy poor person living in areas of deprivation'…all social groups are generally drinking too much, eating too much and not taking enough exercise.

The key message is the differential impact of social inequality on health outcomes.

We need to be clearer that individual agency is influenced by a complex mixture of individual characteristics (innate genetic characteristics; early experiences and circumstances in utero and in the first three years of life) and the level of income, power and access to other resources – all largely out with individual control.

Crucially we have had less to say about approaches that work to create and protect health and **that are also sensitive and responsive** to individual circumstances including the circumstances of those with protected characteristics- particularly where these groups are also experiencing social and economic disadvantage.
We have said very little about the importance of equity in the quality of care that individuals receive- particularly in relation to NHS care. This means we have not had a strong enough focus on integrating inequalities sensitive approaches to health promotion within clinical care services.

For example the HPHS strap line of *'every healthcare opportunity is a health improvement one'* is focused on the role of the NHS in promoting behaviour change, this is important but **it does not include action to mitigate or prevent further harm to health from social circumstances**. This misses the opportunity for health professionals to advocate for improved living circumstances, link their care with other services in order to mitigate further harm, and to truly explore 'what matters to individuals'.

Policy narrative/discourse re the role of the NHS continues to have a downstream and narrow focus – **we have a key role in stimulating NHSScotland and the people who work within it to be both an advocate and activist for the right of all to health**.

What can we do?

We need to make the case for a coherent and coordinated national strategy that draws together integrated, coordinated activity across sectors, predicated on the principles of fairness, social justice and the right of all to achieve the best possible standard of health.

We need to make much more of the gradient effect of inequality on health improvement as well as the gradient effect on morbidity and premature mortality- this should include a sharp focus on the evidence that inequality affects the health of

us all to a greater or lesser degree depending on our social status, personal characteristics and individual experiences.

We need to develop messages that clearly communicate that integrated, coordinated action is needed at fundamental, environmental **and** individual levels and that this **has to be seen to be of value to all in our society.**

We need to be much clearer in our discourse with policy and decision makers about the limitations of action that focus only on addressing behaviours that damage or create health without concurrent and coordinated action to remove the fundamental and environmental barriers to health.

We need to articulate our continuing transition or journey from a focus on health education and information to one that clearly makes the case that a fairer society will be a healthier society

We need to continue to develop cross organisational work so that delivery is not seen as predominantly about **behaviour change or downstream actions whilst public health science focuses on upstream fundamental causes and environmental circumstances.**

We should stop conflating mitigation of the impact of inequality on health with interventions focused solely on individual behaviour change- instead we need to clearly articulate that mitigation is much wider than this and includes improving access to and equity in the quality of services people experience and practical support to manage the daily lived experience of disadvantaged circumstances.

We should be clear that this kind of integrated action is necessary in order to improve the health of those individuals and groups experiencing multiple disadvantages at a faster rate than those with more advantages.

How can this approach be articulated in our annual review:

- Weave the key messages into the introductory narrative to make our position on achieving an integrated approach to improving health through a focus on fairness much clearer.
- Demonstrate that we are providing knowledge and delivery support across the spectrum of action at fundamental, environmental and individual levels by providing evidence re our progress in implementing our annual review action plan
- Demonstrate how we are making the transition from a focus on promoting health behaviour change to one that uses as an integrated approach based on the principles of fairness and the right to health for all. Demonstrate this transition via our Chair's presentation, our responses to the review of our ARSAR and our show cases.

Christine Duncan
Head of Strategy and Communication

APPENDIX B: THEORY OF CAUSATION DEFINITIONS

'Fundamental causes' refers the political and social decisions and priorities that result in an unequal distribution of income, power and wealth across the population and between groups.

- **Income**: money received by individuals or groups over a specific time period, and may include income from employment, welfare benefits, pensions or other sources.
- **Power**: This is a complex concept which includes the ability or capacity to do (or not to do) something and control, force or influence through a variety of means. Power can also arise from additional resources such as knowledge, prestige, beneficial connections and other necessary social resources that protect health, no matter what mechanisms are relevant at any time.
- **Wealth**: Accumulated material goods and capital assets which provides a reserve of financial resources, i.e. savings, investments, pensions, and property, and often provides an income stream (e.g. from interest, rents and share dividends).

'Wider environmental influences' refers to the economic, physical, learning, service and social environments in which people live and learn. So it is about the availability of good quality housing, work, education and learning opportunities, as well as access to services and social and cultural opportunities in an area and in society.

'Individual experiences' refers to how an individual experiences the wider environment. So for example a person living in an area with low availability of good jobs (the wider environmental influence) is more likely to experience low pay (individual experience)

Action across all three levels is necessary and important to tackle the determinants of health inequalities. For example, excess alcohol consumption is an individual behaviour, the negative effects of which are disproportionally experienced by the most deprived. Action to address the environmental influences (e.g. to restrict the availability of high strength low cost alcohol though minimum unit pricing and individual level (e.g. provision of alcohol brief interventions delivered in a way that is sensitive to inequalities and ensures equitable access) are required. Addressing the fundamental causes would be through generic work on income, power and wealth. The corporate power of the alcohol industry and how that influences decisions about alcohol policy could be considered a fundamental cause. The work of NHS Health Scotland should legitimately and necessarily include work at all three levels and in order to ensure a balance cross the three, programmes of work should be clear at which level they are operating.

APPENDIX C: KEY OUTCOME-FOCUSED ACHIEVEMENTS IN 2014-15

Outcome	Performance
Improved and more equitable **Policy-making**.	Our *Informing Investment to Reduce Health Inequalities in Scotland* report and the *Monitoring and Evaluating Scotland's Alcohol* Strategy have **provided the Scottish Government with evidence to underpin their work to promote the living wage and to defend minimum alcohol price policy at the European court**.
Improved performance and quality in **practice**.	We have succeeded in **integrating efforts to alleviate the effects of welfare reform into *Health Promoting Health Service* work** and **led the *Smokefree Grounds Campaign* for NHSScotland.** The Fit for Work advice service went live in January 2015. Since then **275 employers have accessed support through the service**
Stronger support for **action** for prevention and better, fairer health.	We have substantially increased the accessibility of knowledge-our briefings are now extensively cited, quoted and used by the media and policy and decision-makers. **Requests from partners to discuss engagement opportunities increased by 50% in 2015 compared to 2014.**
Organisational **excellence and innovation**.	We have engaged extensively with our staff – the **proportion of staff who said they were well informed increased from 49% in 2013 to 69% in 2014 (13% above the NHSScotland average).**

APPENDIX D: ANNUAL REVIEW PROGRAMME

Time	Meeting	Venue
09:55 to 10:00	Chair welcomes Minister Mr Jamie Hepburn & Margaret Burns	Ground Floor Reception
10:00 to 10:45	Partnership Forum Meeting	6th Floor Room 6.5
10:45 to 11:30	Showcase Presentations • Mental Health for All Emma Kennedy • Tobacco Journey Celia Gardner • Physical Activity and Place Flora Jackson	5th Floor Project Area
11:30 to 11:50	Market Place • Healthy Living Award • MESAS • General Health Scotland information	Situated by the Aroma Café Ground Floor Hub
11:50 to 12:00	Break	
12:00 to 12:45	Annual Review Public Meeting: Chair's presentation and Q&A session	G1 and G2
12:45 to 13:15	Lunch	Ground Floor Atrium
13:15 to 14:15	Annual Review Private Meeting	G1 and G2
14:15	Minister departs	

APPENDIX E: DELEGATE LIST

Name	Job Title	Organisation
Douglas White	Head of Advocacy	Carnegie UK Trust
John Wilson	Church and Society Council	Church and Society Council
Paula McLeay	Chief Officer	COSLA
Allan Clifford	Scottish Partnership Manager	Department for Work and Pensions
Sandra Cairney	Head of Planning and Health Improvement	East Dunbartonshire CHP
Fiona Moss	Head of Health Improvement	Glasgow City CHP
David Hazle	Principal Policy Officer	Glasgow Council
Ruth Bennett	Health Promotion Manager	Health Promotion
George Valiotis	Chief Executive Officer	HIV Scotland
Stuart Hay	Director	Living Streets Scotland
Elaine Young	Assistant Director of Public Health	NHS Ayshire & Arran
Donald Cameron	Associate Director (Acting)	NHS Education for Scotland
Dr Neil Hamlet	Consultant in PH Medicine	NHS Fife
Chris Littlejohn	Head of Health Improvement	NHS Grampian
Claire Curtis	Health Improvement Lead - Acute	NHS Greater Glasgow & Clyde
Linda Wolfson	Maternal and Infant Nutrition Lead	NHS Greater Glasgow and Clyde
Dr Kerry Milligan	GPwSI Child Protection Unit/Homeless Families Healthcare Team	NHS Greater Glasgow and Clyde
Russell Robertson	Health, Housing and Homelessness Lead	NHS Greater Glasgow and Clyde
Steve Bell	Strategic Director	NHS Health Scotland
Aileen Simpson	Assistant Director/Head of Delivery	NHS Health Scotland
Sarah Jones	Health & Safety Executive	Policy (Scotland) & LA Liaison
Roddy Duncan	Head of Branch	Scottish Government
Nicola Scammell	Policy Manager	Scottish Government
Matt Howarth	Policy Officer for Homelessness	Scottish Government
Kim Atkinson	Chief Executive Officer	Scottish Sports Association
Ruchir Shah	Head of Policy	SCVO
Diane Cameron	Social Enterprise & Sport Coordinator	Senscot
Tim Pogson	Service Co-ordinator	SHBVN

Lindsay Dougan	Business Development Manager	Shelter Scotland
Ann Gee	Executive Director	South Lanarkshire Council
Kate Campbell OBE	Deputy Director (Behaviour Change)	Sustrans Scotland
Calum Irving	Chief Executive	Voluntary Action Scotland
Claire Stevens	Chief Officer	Voluntary Health Scotland
Jacqui McGinn	Health Improvement & Inequalities Manager	West Dunbartonshire Health & Social Care Partnership
Lorraine Gillies	Community Planning Development Manager	West Lothian Council
Louise Macdonald	Chief Executive	Young Scot
Alison Hardie	Information Research & Strategy Director/Depute CEO	Young Scot

APPENDIX F: SHOWCASE SYNOPSES

Good Mental Health for All

Improving mental health outcomes can help us create a Scotland where children have the best start in life, communities are resilient, inequalities are tackled, we have improved life chances and we live longer, healthier lives. GMHFA, 2015.

Good Mental Health for All (GMHFA) is Scotland's national vision of the future of public mental health. There is no health without mental health.

GMFA marks the beginning of a collaborative approach to raise the profile and benefits of mental health improvement activity in Scotland. The work prioritises the promotion of mental health and wellbeing across the life course, the prevention of mental health problems and inequalities in mental health, with particular focus on the physical health of those with mental health problems. It encourages and enables local strategic planners to be more effective in their local collaboration towards achieving good mental health for all. It does this by providing evidence informed principles and priorities for action.

Our mental health is influenced by the socio-economic circumstances and broader social and physical environment in which we live, as well as our individual attributes and characteristics. As a result of this a combination of actions is required to tackle the fundamental causes as well as mitigate the impact in a systematic way. This needs agencies across all sectors to work together.

GMHFA provides a vision for a public mental health approach in Scotland in which Health Scotland can offer national leadership. The current development of a new mental health strategy for Scotland provides the opportunity for greater integration of GMHFA in a refreshed national policy.

The poster contains the message - **"Mental Health problems in Scotland cost £10.7 billion per year".**

Tobacco

The Tobacco showcase consists of four posters showing the progression of Health Scotland's tobacco work from the introduction of smoke-free legislation in 2006 to the present day.

The first poster consists of the Tobacco timeline, showing the transition from population health through mass media public awareness-raising to the present day renewed focus on tobacco related inequalities and priority groups such as pregnant women who smoke, smoke-free NHS settings (including mental health) and prisons.

The second poster illustrates how smoking inequalities compound over the life course. These start in childhood with exposure to second-hand smoke and smokers as role models. This influences smoking initiation, particularly in the 16-24 age

group, and through the life course heightens the impact of any social disadvantage already being experienced.

The third poster suggests a comprehensive approach to reducing inequities in tobacco-related harm is required that combines policies to address inequities in the root social determinants with policies that treat the symptoms. For instance, short term actions to improve access to smoking cessation support for low-income groups need to be supported by policies with a long-term focus of reducing poverty and promoting resilience.

The poster contains the message - **"Smoking costs the NHS alone up to £500million per year in Scotland".**

Physical Activity & Place

The design of place in shaping human behaviour is well documented. This relationship is fully reflected in Active Scotland's 6 National Outcomes and the focus of delivery themes within the National Physical Implementation Plan *A More Active Scotland.*

NHS Health Scotland has played a key role in the development of both the outcomes and national plan and in particular negotiating an overarching commitment to equality sensitive policy, plans and service delivery. HS's contributions have also been pivotal in the development of a national structure that oversees this work.

At the annual review these achievements will be briefly touched on before outlining our business deliverables and future focus around the successful delivery of the Health & Social Care Delivery Theme of *A More Active Scotland.* It will spell out HS's drafting of a 3 year plan and co-ordination of a multi-partnership national delivery group chaired by the President of the Royal College of Surgeons before describing our specific lead responsibilities. These will include our development of a PA pathway within clinical and care settings, developing a greener more active NHS estate and the testing of exemplar physical activity workplace standards within health and social care settings. Our broader functions that are critical to the overall national programme such as the Active Scotland website, the Physical Activity Health Alliance and our staff learning programmes will also be referenced.

The impact of inactivity on NHS Scotland's front line services is estimated at £0.3 billion per annum.* The work stream emphasises HS's commitment to focusing our resources and business efforts on settings that support our most vulnerable populations, one that bolsters our other priority programmes such as HPHS and one that is fixed on generating more equitable access to healthy behaviour opportunities.

*British Heart Foundation. The Economic Costs of Inactivity. "In developed countries, physical inactivity accounts for 1.5% – 3.0% of total direct healthcare costs"

"NHS Scotland spends an extra £0.3 billion on health care services as a consequence of physical *in*activity".

The last poster message on the way out of the Showcase session reads **“Fairer, Healthier action across these three areas alone could help save £11.5 billion per year in Scotland”**