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The Scottish Government
Riaghaltas na h-Alba

Convenor
Health and Sport Committee
The Scottish Parliament
Edinburgh
EH99 1SP

18 December 2014

Dear Convenor

When we appeared at the Health and Sport Committee on 9 December 2014, we undertook to supply the Committee with further information on a number of issues.

1. Family Nurse Partnership (FNP)

The Committee had asked for details on how the FNP training and caseload is managed and on the planned evaluation.

The training of family nurses is iterative, in line with client recruitment. The training happens in three phases, pregnancy, infancy and toddlerhood. The family nurses are trained in pregnancy phase, then begin recruiting clients. The recruitment period for the first cohort is up to 12 months. Once the caseloads are full, the recruitment period is closed. As clients are only eligible for the programme before the 28th week of pregnancy, there is capacity for family nurses to fill spaces in their caseloads with new clients, but this depends on a number of factors, including the overall capacity of the team. As the family nurses move on to recruit new cohorts, they can recruit clients to their caseloads on a rolling basis, provided they do not exceed the capacity of 25 clients to one family nurse. The rate at which clients leave the programme (attrition) is relatively low, and there is flexibility built into the programme to allow clients who have left or disengaged with the programme to return at any point, provided there is sufficient space in the caseloads. This slightly different from new clients coming onto the programme where they must begin in pregnancy.

In terms of the evaluation of FNP, the FNP Scotland Evaluation and Research Advisory Group was established in 2014. Its remit includes overseeing the development of a co-ordinated FNP research and evaluation programme, in which existing UK and international evidence is supplemented and built on with relevance to FNP implementation in Scotland.

This will entail providing a strategic overview of the evaluation work undertaken, including advice about existing data and evidence sources, project commissioning and reporting.

The aim of the initial evaluation of FNP processes and outcomes will have 2 objectives. It will:
1. Evaluate the impact of FNP on outcomes of interest in Scotland, including inequalities and determine cost-benefit of FNP programme in Scotland
2. Explore the changes (types and mechanisms) that are happening in Scotland and how FNP is adapting to local contexts, including

- Programme implementation (implementation challenges and how might these be overcome)
- Client experience (exploring the FNP client journey in general and with specific reference expected outcomes of the programme)
- FNP workforce experience (exploring the FNP nurse experience of delivering the programme including workloads, training and professional needs)

The first work of the evaluation and research programme will be to consider the requirement for evaluating impact of FNP in Scotland. What are the outcomes of interest to Scotland and what does the FNP English Randomised Control Trial (RCT) tell us about achieving these outcomes in Scotland and the options for evaluating impact in Scotland, including consideration of feasibility and cost. The assessment will be conducted between Jan-March 2015, and will inform how we evaluate impact in Scotland.

2. Baseline data

The Minister for Children and Young People pointed to the Growing Up in Scotland (GUS) longitudinal study as a useful source of baseline data.

Beyond GUS, the evidence base for monitoring health inequalities is summarised in a Scottish Government report published in October 2014 'Long Term Monitoring of Health Inequalities: Headline Indicators'.
http://www.scotland.gov.uk/Publications/2014/10/7902/8

With the regard to the early years, the report summarised the data trend data on **birth weight**. The data show that since 2010, there have been consecutive increases in the rate of low birth weight in the most deprived areas, leading to more inequality in both relative and absolute terms.

ISD publish regular data on **breast feeding**, that includes analysis of differences by area deprivation.
https://isdscotland.scot.nhs.uk/Health-Topics/Child-Health/Publications/2014-10-28/2014-10-28-Breastfeeding-Summary.pdf?29546755553

The data show that there has been an increase in overall breastfeeding rates in the most deprived areas over the last decade though there remains a clear association between breastfeeding and deprivation. Mothers in the least deprived areas were nearly three times as likely to exclusively breastfeed at 6-8 weeks compared with mothers in the most deprived areas.

There are also some useful data in the ISD report on Births in Scottish Hospitals.
http://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/2014-08-26/2014-08-26-Births-Report.pdf

This includes data in **access to antenatal services** – percentage of maternities booking for antenatal care by 12th week of gestation - which is broken down by SIMD (area deprivation). The data show that in 2012/13, the percentage was lowest in the most deprived areas.

The report also includes data on **smoking in pregnancy** (at the time of the booking appointment) broken down by SIMD. This shows a strong relationship with area deprivation.

For the first time the report provides data on **mother's weight** at booking appointment, which shows that the risk of unhealthy weight varies by area deprivation. Mothers from the most deprived areas are more likely to be underweight than mothers from more affluent areas. Mothers from the most deprived areas are also more likely to be obese (but less likely to be overweight) than mothers from more affluent areas.

NHS ISD have recently published Child Health 27-30 Month Review Statistics.
https://isdscotland.scot.nhs.uk/Health-Topics/Child-Health/Publications/2014-12-16/2014-12-16-Child-Health-27m-review-Summary.pdf?91270083190

This is the first time this data has been published and the report does not yet provide data on inequality but the intention is that it will in future.

ISD also plan to use the data from the 27-30 month review to publish a report in 2015 on **child weight** (measured by BMI) . This will include an analysis of the social gradient in healthy weight.

ISD data on **child dental health** shows that there is a link between poor dental health and area deprivation.
http://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2014-10-28/2014-10-28-NDIP-Report.pdf

The reports shows that 53% of P1 children had no obvious experience of tooth decay in the most deprived areas compared with 83% in the least deprived areas.

3. Measuring the wider impacts of policy development on health inequalities

There are a number of ways in which the Scottish Government determine and measure the impacts of policy development on health inequalities. Some are prospective, others more retrospective.

Impact Assessments

NHS Health Scotland co-ordinate the Scottish Health and Inequalities Impact Assessment Network (SHIIAN) and is open to anyone working or planning to work on Health Inequalities Impact Assessments in Scotland. The network has been running since 2001. Health Inequality Impact Assessments are commonly conducted for new and revised Scottish Government policies in advance of implementation.

The HIIA guidance can be found at:
http://www.healthscotland.com/documents/5563.aspx

A list of reports can also be found here:
http://www.healthscotland.com/about/EQIA/EQIAFinalReports.aspx

Modelling
Modelling the likely impacts of policy, based on existing data and evidence is another approach. Colleagues in SCOTPHO recently modelled the effects of a range of interventions on health and health inequalities.

The analysis includes numerical models of the potential impact of 11 interventions across the determinants of health (including 'upstream', 'downstream', individually-focussed and population-wide), on overall population health and health inequalities. They supersede the previous intervention tools published in 2009 and 2012. The interventions were chosen for analysis based on the highest quality and most generalisable evidence linking the interventions to changes in mortality and hospital admissions. It uses available data and evidence to estimate reductions in hospitalisation, years of life lost (YLL) and health inequalities over a 20 year period. The work and the accompanying tool can provide some advice to decision makers as to the likely benefits/impact of proposed or current interventions.

As with all modelling, the results are only as robust as the data and assumptions underlying them. The model is likely to be quite sensitive to these assumptions.
http://www.scotpho.org.uk/comparative-health/health-inequalities-tools/intervention-tools/informing-investment-to-reduce-health-inequalities-iii

Evaluation
Where it is considered feasible and of value, policies and programmes are often evaluated. This is usually a systematic assessment of whether a policy has achieved its outcomes, goals or objectives, and whether any unintended benefits or consequences are observed. Scottish Government, NHS Health Scotland and other organisations are actively involved in a wide range of evaluations in health, for example, the Monitoring and Evaluation of the Scottish Alcohol Strategy.

There are occasions where the Scottish Government or partners commission evaluation support for programmes or project to build capacity in organisations to self-evaluate their work. For example, 'Go Play' was run by Inspiring Scotland on behalf of the Scottish Government to grow the play sector in Scotland and offer more chances for free play. Evaluation Support Scotland (ESS) and Inspiring Scotland worked with a group of funded play charities to undertake evaluation.

Child Poverty Strategy
Specifically with regard to poverty, the revised Child Poverty Strategy for Scotland, published in March 2014, introduces a full measurement framework which provides the current position on key outcomes against which progress will be measured in future annual reports.
This framework brings together key indicators from across the Government and enables a strong focus on the three key outcomes identified in the strategy. These are the "3 Ps":

- Maximising financial resources of families on low incomes (Pockets);
- Improved life chances of children in poverty (Prospects); and
- Children from low income households live in well-designed, sustainable places (Places).

We recognise the wealth of evidence available that indicates getting things right in the early years has long-lasting benefits to children in terms of future outcomes. That is why the measurement framework includes outcomes on "Children from low income households have improving levels of physical and mental health", "Children from low income households experience social inclusion and display social competence" and "Children from low income

households have improving levels of educational attainment, achieving their full potential"; and includes indicators that will help to measure progress.

In addition, as announced in the Programme for Government, all new and revised Scottish Government policies will be subject to a new poverty impact assessment, with trials of the approach beginning in 2015. The expectations is that impact assessment generally will be reviewed and streamlined, enabling poverty assessment to be appropriately built into the Scottish approach to policy making to strengthen the quality of decision making.

4. Nursing staffing complement

Last year following stakeholder feedback a Nursing and Midwifery Student Intake reference group was established. While acknowledging that workforce planning is undertaken within NHSS Boards, the primary aim of the Group is to review the outputs from the student intake modelling on an annual basis and reach a consensus for each of the 4 fields of nursing practice and midwifery. The Group then makes a recommendation to both Cabinet Secretaries for Health and Wellbeing and Education and Lifelong Learning.

This group includes representatives from Scottish Government, NHS Boards, relevant Royal Colleges and trades unions, the Scottish Funding Council and Higher Education Institutions.

Whilst the student intake numbers reduced in academic years 2011/12 and 2012/13 these numbers increased in 2013/14 and again in 2014/15. We understand that the consensus recommendation for 2015/16 will be made to Ministers shortly.

The following table shows the recommended nursing and midwifery student intakes since 2010/11.

Intake Year	2010/11	2011/12	2012/13	2013/14	2014/15
Total	3060	2700	2430	2530	2698

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5. Proportionate universalism

We are of the view that proportionate universalism is what will deliver improve outcomes. A universalist approach reduces stigma and gives entitlement to be part of the mainstream. Alongside this we need a recognition that effort to help people to engage with the universal services should be proportional to need and that barriers to engagement need to be addressed.

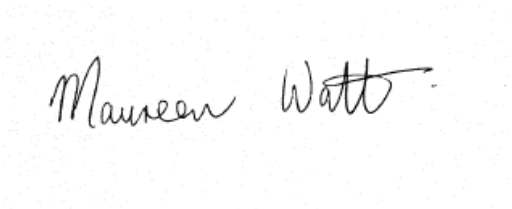
6. Public Health Review

The Committee also asked about the membership of the Public Health Review. The current membership of the group is attached at Annex A. This includes representation from the public health medicine workforce with a Consultant in Public Health Medicine. There is a wide breadth of experience on the group, including in public health, to help guide and take the review forward. The group also includes a recently retired Director of Public Health. Officials, acting as secretariat to the group, will continue to liaise closely with and seek input from the current Scottish Directors of Public Health.

Conclusion
We hope that you find this further information helpful and look forward to the publication of the report on this very important subject.

In the meantime, we send our very best wishes for Christmas and the New Year.

AILEEN CAMPBELL
Minister for Children and Young People



MAUREEN WATT
Minister for Public Health

ANNEX A

Public Health Review Group Membership

1. **Dr Hamish Wilson (chair)** (Vice Chair Healthcare Improvement Scotland).
2. **Dr Aileen Keel CBE** (Acting Chief Medical Officer)
3. **Prof Sir Lewis Ritchie** (James Mackenzie Professor of General Practice, Centre of Academic Primary Care, University of Aberdeen; former Director of Public Health, NHS Grampian)
4. **Angela Leitch** (Chief Executive of East Lothian Council and representing SOLACE)
5. **Prof Carol Tannahill** (Director of Glasgow Centre for Population Health)
6. **John Carnochan OBE (**39 years' experience of policing including co-founder of the Violence Reduction Unit awarded the Queen's Police Medal in 2007. Technical adviser to the World Health Organisation)
7. **Dr Elizabeth Bream** (Consultant in Public Health NHS Lothian)
8. **Mr Grant Sugden** (Chief Executive, Waverley Care - Third sector representation as agreed via VHScotland)
9. **Dr Derek Cox** (Retired Director of Public Health)
10. **Ron Culley,** COSLA (Chief Officer Health and Social Care**)**
11. **Professor Marion Bain** (NSS Medical Director previous experience includes clinical practice, public health medicine and medical management)
12. **Margie Taylor** (Chief Dental Officer)
13. **Calum Campbell** (Board Chief Executives' Group nomination from NHS Borders, moving to NHS Lanarkshire)
14. **Scottish Health Council** Public Partner Representation
15. **Dr Kevin Woods** (Former Director-General for Health at Scottish Government)
16. **John Ross Scott** (Chair of Orkney NHS Board)

Secretariat Support at Scottish Government

1. **Donald Henderson** – Deputy Director, Public Health Division
2. **Heather Cowan** – Policy Lead , Public Health Division
3. **Dr Duncan McCormick** – Senior Medical Officer
4. **Fee Goodlet** – Business Manager, Public Health Division

First Meeting

The initial meeting of the Public Health Review Group was held on 2 December following announcement of the Public Health Review on the 6 November. The Review Group has asked for an engagement paper to be drafted to enable the Group to seek input from stakeholders on a number of key questions.