

Annex 4.2

Good practice examples

England

Case Study 1 – A National Strategy for Tackling Health Inequalities

Developing a cross government strategy

1. Health inequalities are endemic in England, as in Europe as a whole. As overall health improves, so the health gap between social groups widens. Where a person is born still influences, largely, how long they will live. The Government's response has been to introduce the most comprehensive programme ever seen in England to address health inequalities. A national health inequalities target has been set to narrow the gap in life expectancy and infant mortality, and a national strategy launched. This strategy, '*Tackling Health Inequalities: A Programme for Action*' (signed up to by 12 government departments) in July 2003, signalled the cross-government commitment to deliver long-term improvement to addressing health inequalities. The strategy has been reinforced with the launch of *Health Inequalities: Progress and Next Steps* in June 2008 which announced enhanced and new programmes supported by £34m of funding to improve health and narrow inequalities..

2. The Government's focus is not just on small, specific 'hard to reach' groups. Tackling health inequalities is about major social change. This is shown in the focus for action of the life expectancy element of the target. A Spearhead Group of 70 local authority areas has been established. These areas have the worst health and deprivation indicators in the country and cover over a quarter of the population of England and 44% of the Black and Minority Ethnic population. Data for 2002-04 showed there were 13,700 additional or excess deaths for 30 to 59 year olds in this group, compared to the rest of England.

Setting targets for tackling health inequalities

3. In England, a series of challenging national targets for tackling health inequalities have been set. They are designed to spur action across the NHS and other parts of government.

4. These targets are set in a framework which seeks to increase overall life expectancy at birth in England to 78.6 years for men and to 82.5 years for women by 2010 (latest data for 2004-06 show average life expectancy is 77.3 years for males and 81.6 years for females), and reduce the health gap in heart disease and cancer.

5. The central health inequalities target is "By 2010 to reduce inequalities in health by 10% by 2010 as measured by infant mortality and life expectancy at birth".

6. This target is underpinned by two more detailed objectives:

1. starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between routine and manual occupational groups¹ and the population as a whole;

¹ Defined as per the UK National Statistics Socio-economic Classification
http://www.statistics.gov.uk/methods_quality/ns_sec/default.asp

2. starting with Local Authorities, by 2010 to reduce by at least 10% the gap in life expectancy between the fifth of areas with the “worst health and deprivation indicators” (the Spearhead Group) and the population as a whole. The baseline is 1995-1997.

6. The Spearhead Group consists of the 70 Local Authority areas, and 62 Primary Care Trusts that map to them, that are in the bottom fifth nationally for three or more of five factors:

- Male life expectancy at birth
- Female life expectancy at birth
- Cancer mortality rate in under 75s
- Cardio Vascular Disease mortality rate in under 75s
- Index of Multiple Deprivation 2004 (Local Authority Summary), average score

7. This is supported by other targets to reduce the smoking prevalence rate among routine and manual lower occupational groups, and the obesity rate among children. Cross government targets include reducing teenage pregnancy and child poverty, and improving educational attainment and housing quality.

Monitoring Progress

8. Tackling Health Inequalities: 2007 Status Report on the Programme for Action (March 2008) reported on data to 2004-06. It showed a further slight narrowing of the infant mortality gap, little change in the gap in male life expectancy and a widening gap of the gap in female life expectancy in 2004-06 compared to 2003-05. In addition, it presented an encouraging picture on the cross government indicators with long-term progress in reducing, child poverty and narrowing inequalities in housing quality, educational attainment and uptake of influenza vaccinations. Cancer and circulatory (heart) disease mortality and child road accident casualties show a narrowing of inequalities in absolute terms (but not in relative terms)². Other areas, like smoking, show a general reduction in smoking prevalence, but no narrowing of the gap between social groups.

Latest Progress

9. The Department of Health has concentrated on improving planning and performance management of health inequalities to help meet the life expectancy PSA target. Health inequalities is a key priority for the NHS as set out in the NHS Operating Framework 2008/09 and All Age All Cause Mortality, as a proxy measure for life expectancy, is an indicator in both the NHS Operating Framework 2008/09 - Vital Signs and the New Performance Framework for Local Authorities & Local Authority Partnerships: Single Set of National Indicators.

Life expectancy

10. 2004-06 data show Life Expectancy has increased in all areas for both men and women, but more slowly in Spearhead areas. Since the target baseline (1995-1997), the relative gap in life expectancy between England and the Spearhead Group

² Explanation of absolute versus relative terms can be found in Annex 4 (page 100) of Tackling Health Inequalities: 2007 Status Report on the Programme for Action, at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083471

has increased by 2% for males (the same as 2004-05) and by 11% for females (compared to 8% in 2004-05).

Infant mortality

11. Latest figures show the infant mortality rate among the Routine & Manual occupational group was 17% higher than in the total population, compared with 18% higher than in the total population in 2003-05, and 19% higher in 2002-04. This compares with 13% higher in the baseline period of 1997-99. The target to narrow this gap by at least 10% by 2010 is therefore still a challenging one.

Cardio Vascular Disease (CVD) & Cancer Inequalities

12. CVD and cancer are the big killer diseases and they have disproportionately affect lower social groups. Progress is being made with sharp reductions in the overall mortality rates for these diseases, and a narrowing of the health inequalities gap, at least in absolute terms. 2004-06 data shows there has been a 32.2% reduction in the CVD inequality gap since the 1995-97 baseline 2004-06 data shows there has been a 11.3% reduction in the cancer inequality gap since the 1995-97 baseline.

Smoking prevalence

13. There has been an decline in overall adult smoking prevalence from 28% in 1998 to 22% in 2006. This is in line with the 2010 smoking target. There is a persistent gap between the overall rates and those for disadvantaged groups. Among routine and manual groups, the smoking prevalence rates had dropped slightly from 33% in 2001 to 29% in 2006). These figures show progress against the target to reduce smoking prevalence among routine and manual groups to 26% or less by 2010.

Teenage conceptions

14. Teenage conceptions are marked by a strong social gradient. The 2006 England under 18 conception rate of 40.4 per 1000 for girls aged 15-17 shows a decline of 13.3% since 1998. The under 16 conception rate for England in 2003 was 8.0 per 1000 girls aged 13-15. This is 9.9% lower than the 1998 rate of 8.9 conceptions per 1000 for girls aged 13-15.

Breastfeeding

15. Increasing the rates of breastfeeding particularly amongst disadvantaged women is part of the Government's commitment to improving health inequalities. There are inequalities in breastfeeding: in 2005, 88% of women in managerial and professional occupations across the UK breastfed, compared to 65% among mothers in routine and manual occupations. However, progress is being made; between 2000 and 2005 breastfeeding rates in England and Wales among routine and manual occupations increased from 60-67%. Among mothers who had never worked breastfeeding rates increased from 54-67%.

Local Example: Reducing smoking rates during pregnancy in Sunderland

16. Women who smoke during pregnancy are more likely to have babies born prematurely, twice as likely to have low birth weight babies and up to three times more likely to die from Sudden Unexpected Death in Infancy (SUDI).

17. Sunderland, with higher than average smoking rates, used social marketing research to improve smoking cessation services, focusing on providing brief advice training to all staff who come into contact with pregnant women, and parents of young children, to encourage appropriate referrals, and increase client recruitment.

18. The Government's Sure Start Children's Centre programme funded a further specialist adviser (RGN) to work intensively within the Sunderland Sure Start areas. All of this meant that Sunderland increased the number of non-smoking pregnant women from 62.1% (2004–05) to 76.7% (2006–07).

19. The Department's focus now is to provide support to those areas that need it. The National Support Teams for Health Inequalities and Smoking & Tobacco Control are providing tailored, intensive, support to the Spearhead Areas and areas with high infant mortality. DH worked in partnership with the Association of Public Health Observatories to develop the Health Inequalities Intervention Tool. Launched in August 2007, the Tool- is an interactive website to help local health services and councils improve life expectancy in areas with the worst health and deprivation

Case Study 2 - Health Trainers

Background

20. The Health Trainers Programme is an initiative, which was announced in the Government White Paper, 'Choosing Health' 2004. The programme started with the 'Early Adopter Phase' in September 2005, which engaged 78 partnerships made up of Primary Care Trusts, Local Authorities and some Academic Institutions.

21. Following on from the success of the "Early Adopter Phase", Health Trainers, with specific skills and competences, are working to help people improve their health as this government initiative to tackle health inequalities continues to be rolled out nationally. The programme is targeted first at the most disadvantaged areas to make it easier for individuals in these communities to make healthier choices. By early 2008 more than 1200 health trainers have been trained and are in post.

How does the programme function?

22. Health Trainers are there to give support to people in their local communities, and help people set personal goals for improving their health, whether it's stopping smoking, planning a walking route to help someone increase exercise or encouraging a teenage mother to go to a children's centre for support and advice. Health Trainers are visible, accessible and engage local people where they are to be found, for example, libraries, customers at the local pharmacy, members of the tenants' association and crucially, because of their detailed local knowledge, they will be able to 'signpost' people to services that can support their healthier choices.

23. The role of the Department of Health is to provide:

- centralised co-ordination
- governance and project monies
- overall guidance in the project

24. Achievements to date include:

- Competences have been developed and signed off and national occupational standards have been put in place
- Exemplar Job Descriptions have been developed for tailoring by local Health Trainer partnerships
- A national implementation team has been put in place and now provides full regional coverage
- Two national awards based on Health Trainer competences have been developed: City & Guilds (Level 3) and the Royal Institute for Public Health (RIPH) (Level 2)
- A national Health Trainer minimum dataset has been agreed and a data collection system has been commissioned
- Expansion of the programme within prisons and the probation service is well underway

Current Status

25. Most of the NHS has signed up to the health trainer scheme which has now extended out from Spearhead areas (broadly PCTs in disadvantaged areas) into the wider NHS and its partners. Regional partnerships are actively sharing knowledge and information about successful service models and making decisions about where they allocate resources and how many health trainers they will need to meet the needs of their local population.

26. There has been considerable enthusiasm for the programme from third parties-

- the Prison Service currently has in the region of 80 health trainers
- the Army has trained 2450 Physical Training Instructors (PTI's)
- Royal Mail has trained two cohorts of first aid staff to RIPH Level 2 as workplace health trainers
- The programme is also working with organisations such as Inclusive Fitness, Salvation Army and Football Foundation...

Local Example:

Building Community Capacity for Health

Background

27. Bolsover District is ranked 31 in the bottom 50 (most deprived) local authorities (IMD 2004) in England. With such high rates of deprivation and ill health within its boundaries, the populations of Shirebrook, Creswell and Langwith experience the worst health outcomes within the district. The area has higher than national rates of coronary heart disease, smoking related illness and the district as a whole has 25% more people with long term illness than the United Kingdom average.

Programme

28. Health Trainers and the development of a network of community volunteers for health have been seen as a positive step in improving lifestyle within the District and seen as a key strand in driving down the heart attack rate in North East Derbyshire. (for further detail, see Chief Medical Officers Annual Report 2006 – page 64)

29. Health Trainers are a new workforce either employed through the NHS or volunteering to act as health champions within their work role or local community.
30. Health Trainers must have experience and an understanding of what it means to live in, or be part of their community and reflect the diversity of the area they work in. It's a common sense approach, giving communities ownership for health.
31. Clients receive:
- clear, up to date information about lifestyle and health, including what might affect their health and wellbeing
 - help to identify things to improve their health and wellbeing
 - help to identify services/people who might be able to help them, by signposting or referring on
 - opportunities to develop their knowledge and skills about health and wellbeing by enabling access to information, advice and support
 - help to identify how their way of life might effect their health and wellbeing and help them to make the changes they want to.
32. The support of all sectors is integral to the development of Health Trainers within local communities. Bolsover Local Strategic Partnership has been hugely supportive throughout.

Service user comments

Client - Tammy

Jane has supported me from the beginning of my referral programme. Without Jane's presence and guidance, I would have felt unable to attend to begin with because of my low self-esteem. With her help, I feel able to reach my goals of improved health and fitness.

Client - Janet

Jane has helped me in my programme by supporting me in the gym and chair based class, giving me confidence to attend on my own so I can improve my health and fitness. My health is much improved, as my fibromyalgia is a lot better. My weight has also decreased and is an added bonus.

Wales

Case Study 1: Improving Health and Chronic Conditions Management (CCM) in Wales - Model & Framework and Service Improvement Plan

33. The WHO has identified 'managing chronic conditions as the main healthcare challenge for the future'. In Wales, as with many other developed countries across the world, we have an increasing prevalence of chronic conditions, replacing the communicable and killer diseases of the past.

34. Both international and more local evidence indicates that delivering better chronic conditions management will result in a range of benefits. Focusing on prevention, early intervention and appropriate care and support in the community, improved chronic conditions management will provide considerable long term benefits in terms of better health for patients as well as gains in health and service capacity through reduced admissions to hospital and length of stay.

35. Services are currently unsustainable with an over reliance on traditional, and often inappropriate, models of care; action is needed to ensure all resources in the community are used to best effect to prevent admission to hospital, to support better care and self-care within the community. Action to improve community services is necessary if we are to provide high quality services supported by a workforce for sustainable primary and community based models of care.

36. Wales committed to developing a national policy, model and implementation plan to support organisations and individuals in designing and delivering integrated services for preventative, early intervention, care and complex cases. The Welsh CCM Model and Framework was developed and published in 2007; the CCM Service Improvement Plan 2008-11 was then published in 2008.

37. Specific objectives of the Improvement Plan are:

- Improve healthy lifestyles and well-being in the community
- Prevent and/or delay the onset and early deterioration of chronic conditions
- Improve the quality of life for people living with chronic conditions
- Reduce the impact of chronic conditions on secondary care
- Increase self-management, independence, and the participation of people with chronic conditions and their carers
- Improve the quality of patient care closer to home
- Improve prescribing and medicines management
- Reduce inequalities and improve economic activity.

38. The delivery of co-ordinated, comprehensive and consistent Chronic Conditions Management (CCM) services in the community is not another initiative but an integral part of effective mainstream service delivery in the community. This is a key Ministerial priority.

39. A proactive, planned and integrated approach is needed to achieve this, based on anticipatory care and evidence based interventions. The service improvements needed are extensive and complex. The *CCM Service Improvement Plan* (2008) helps clarify the actions needed to implement the CCM Model and Framework, strengthen CCM Services in the community and improve the prevention and care of those living with chronic conditions.

40. The CCM Service Improvement plan aims to improve the health and well being for those living with a chronic condition while supporting and empowering people to maximise their independence; through improving service planning and delivery -and therefore meet the above objectives.

41. All national developments and use of resources are matched against the objectives and baseline indicators specifically measure their realisation.

42. LHBs in partnership with all stakeholders are producing 3 year CCM Local Action Plans in response to the CCM Service Improvement Plan, in order to guide and support the progression towards achieving better CCM in local communities, using all resources to best effect.

43. Financial resources plus the support of national agencies and newly developed tools have been made available to ensure a comprehensive approach is taken across Wales to support more integrated local services.

44. This work is reinforced by a range of more detailed guidance and targets relating to specific chronic conditions. The Minister has supported a series of Service Development and Commissioning Guidance for Arthritis and Muscular Conditions, Respiratory Conditions, Pain and Epilepsy.

Monitoring Progress

45. Unique evaluation processes and expertise were used and considered as policy was being developed and continues into implementation phase. Evaluation of processes to date will focus on evaluation of the CCM Local Action Plans; outcomes and benefits from use of transitional funding; patient experience

46. Performance Management Framework developed and agreed between all parties. Baseline report to regional offices (of Welsh Assembly Government) and Local Action Plans to be reviewed on quarterly basis within the on-going performance reviews of NHS Trusts. Progress in development and service improvement to be monitored through the LHB Modernisation Assessments undertaken on an annual basis by NLI AH.

47. Transitional funding allocation for 2008/09 to 2010/11 dependent on evidence based application and yearly review .

48. National, regional and local processes are being aligned and resources in place to support consistent approach across Wales. It is currently too early to measure the specific objectives – evaluation processes are in place to measure through CCM Local Action Plans and patient experience surveys.

49. The main obstacles posing a risk to the initiative are:

- Whole systems issue: differing language, involvement and priorities across relevant agencies
- Aligning national agencies to deliver together against priority
- Acquiring additional transitional resources
- Engagement of all stakeholders

50. These are being addressed though the following measures:

- Engagement of stakeholders: brain's trust; regional workshops; expert panel (including patients and carers); medical director masterclass; meetings with medical directors, CEOs, pharmacist, therapists and other senior personnel
- SLAs with national agencies (NLI AH; IHC) and commissioned work (AWARD) to ensure national agencies working to WAG priority and policy direction
- Formation of national CCM Implementation Group with representation and involvement of WAG and service officials from all sectors and professional groups
- Approval of CCM transitional funding to support service improvement and 'double running costs' of strengthening community services

51. Learning from the initiative so far has reiterated that sound evidence based policy provides a firm framework within which:

- all necessary dialogue can take place
- different agencies can consider wider service improvements – e.g. community services; integration of consultant led services
- performance can be consistently monitored and evidence base collected
- resources can be aligned and gained

Case Study 2: Building Strong Bridges

52. *Building Strong Bridges (BSB)* published in October 2002, identified opportunities to strengthen links between the NHS and the voluntary sector at national and local levels. The Welsh Assembly Government made £3 million available for three years (2003-2006) to support the actions. Following the independent evaluation additional funding of £3 million was provided (2006- 2009) to support the work and *Designed for Life*. BSB identified the need for the appointment of local Health & Social Care Facilitators for each LHB area and a national Facilitator to help strengthen the interface working between the statutory and voluntary sectors.

53. BSB contains twenty-three recommendations outlining how partnership working should be delivered to ensure that the voluntary sector's contribution is strengthened to underpin the new roles and relationship of the voluntary sector and its partners at all levels in the restructured NHS in Wales. These include:

- identifying opportunities to strengthen voluntary sector partnerships to reduce health inequalities
- supporting disadvantaged groups to be involved in the planning process
- supporting innovative developments between the Health & Social Care and the voluntary sector
- strengthening local and national support structures so that the voluntary sector can play its full part in the planning, development, commissioning & delivery of services
- strengthening partnership working with the statutory Health & Social Care organisations and the voluntary sector and between the voluntary sector itself.
- the development of local and national Volunteering for Health & Social Care initiatives

54. The key recommendation to take forward the recommendations was the appointment of 22 local and one national Health and Social Care Facilitators across Wales.

Monitoring progress

55. The University of Glamorgan undertook an independent evaluation of the role of the Health & Social Care Facilitator posts in 2006. The findings from the evaluation informed the decision to fund BSB phase II 2006-9; the evaluation found that the 23 recommendations in BSB have all been met but highlighted that if BSB was not to be funded for phase II then the achievements to date would not be realised.

56. BSB provided a sound framework and basis for improving partnership working between statutory health and social care services and the voluntary sector. The need to continue supporting the key role that the voluntary sector plays in H&SC has been recognised and *Designed to Add Value- a third dimension* has been produced to inform the next steps for BSB from 2009.

Scotland

Some examples of current Health Improvement activity are detailed below:

Tackling health inequalities

57. *Keep well* addresses the health inequalities that are evident in Scotland's population by strengthening and enhancing primary care services in the most deprived areas of Scotland. It focuses on Cardiovascular Disease in 45-64 year olds and its contributory risk factors, including smoking, weight, and lack of physical activity.

58. The target population are offered an appointment to attend a health check by their local GP practice. They are screened to identify potential/existing health risks and offered treatments designed to improve their health and prevent future ill health. The programme is being monitored and evaluated to identify lessons/best practice learned which will form an evidence base to inform general and widespread application of anticipatory and preventative care across Scotland.

59. To date, 69% of the eligible population have been contacted offering an appointment to attend a health check. Individuals have been contacted through a variety of methods including open letters, fixed letters, phone invitations and home visits. Of those contacted, 39% have already attended a health check.

Health Inequalities Funding

60. The Scottish Government is providing an overall investment of over £100m extra a year in health improvement and better public health, much of which will tackle inequalities in health through spend on alcohol problems, smoking, healthy weight and other aspects.

Health Inequalities and Poverty

61. The links between poverty and health inequalities are central to the Task Force's thinking. There is a clear, consistent relationship between the distribution of poverty and that of poor health outcomes. Tackling poverty, inequality and multiple deprivation will improve health and contribute directly to delivering the Government's overall purpose of sustainable economic growth.

62. Poverty influences poor health and inequalities in a number of ways. It affects the environment in which children are born and is likely to increase damaging stress on both parents and children which will set patterns for children's future development and life chances. People on low incomes and those living in the most deprived areas are most likely to rate their general health as poor and to be more susceptible to mental ill health. Poverty drives much of the inequality in mortality due to the "big killers": cardio-vascular disease and cancer. Poverty also worsens the outcomes for individuals after the onset of chronic disease: increasing chances of losing employment and shortening life expectancy. Socioeconomic disadvantage underlies the increasing inequalities in the harm caused by drugs, alcohol and violence, particularly among younger adults.

63. The Scottish Government is currently consulting on a framework for tackling poverty, inequality and deprivation to be produced later in 2008. This is within the context of the Government's economic strategy.

64. A discussion paper, issued in January 2008, seeks to build on action tackling poverty in 3 main ways:

- prevention of poverty and tackling the root causes.
- helping to lift people out of poverty.
- alleviating the impact of poverty on people's lives.

65. Current action to tackle the root causes of poverty includes the Government's Fairer Scotland Fund (£145m per year for the 3 years from 2008-09). This is a new fund to be deployed by community planning partnerships, with a strong emphasis on interventions at an early stage, helping people towards and into employment and also addressing the problems faced by those for whom work is not a realistic option.

66. A number of current initiatives are seeking to lift people out of poverty. These include the Government's Multiple and Complex Needs initiative which aims to improve public services for people who find it difficult to access them or to get what they need. Many of the pilot projects being funded are seeking to improve health outcomes specifically.

Tobacco control

67. The ban on smoking in enclosed public places, introduced in March 2006, has been the biggest single advance in public health in a generation and has been a key milestone. A study of nine hospitals has found a 17% fall in admissions for heart attacks in the first year since the smoking ban came into force. This compares with an annual reduction in Scottish admissions for heart attack of 3% in the decade before the ban.

Raising the age of purchase of tobacco products from 16 to 18

68. A wider programme of action will be set out in a new 5-year Smoking Prevention Action Plan to be published in Spring 2008. The raising of the minimum age for purchasing tobacco from 16 to 18 in October 2007 will help discourage young people from starting to smoke in the first place. The Scottish Government will continue to invest £33m over the next 3 years in smoking cessation services.

Alcohol

69. The Scottish Government is not anti alcohol – we are anti alcohol misuse. We want people to think about their consumption and take responsibility for it. Far too large a proportion of Scottish adults – across all walks of life – drink far too much. It's these drinkers who are driving the shocking rises in alcohol related deaths and disease across Scotland.

70. The alcohol-related death rate in Scotland has more than doubled since 1990. One Scot dies every 6 hours as a direct result of alcohol. Liver cirrhosis rates are 2.5 times higher than in England and Wales. The Scottish Government has is aware that a long term strategic approach is required if we are to tackle Scotland's complex relationship with alcohol, and deliver sustainable change in attitudes. That approach will be published during 2008. It will be supported by the allocation of an unprecedented £85 million over 3 years to increase access to early intervention and treatment for people with alcohol problems.

71. The Scottish Government recognises the connections between alcohol and other substances and mental ill health and will be publishing clear guidance and recommendations in May 2008 on better awareness, screening and assessment to drive forward improvements in managing and treating this population.

Obesity

72. [The Scottish Government recognises that obesity is an increasing problem and poses a serious threat to health. Levels of obesity are rising, reaching 18% in boys and 14% in girls \(2-15 yrs\), 22% in men and 26% in women in 2003. Scotland has one of the highest levels of obesity among OECD countries, second only to the USA.](#)

73. The Scottish Government are currently delivering a wide range of initiatives contributing to children and adults achieving and maintaining a healthy weight through our two existing strategies, the Scottish Diet Action Plan and our National Physical Activity Strategy 'Let's make Scotland more Active'. These are supported by the ongoing implementation of the Schools (Health Promotion and Nutrition) Act.

74. [Government, and other stakeholders, have an important role to play in helping to create environments that support people in maintaining a healthy weight by making it easier for them to be more active in their everyday lives and make healthier choices in what they eat. That is why the Scottish Government are making tackling the problem, particularly early in life, a high priority.](#) Over the next 3 years £56.5 million (of which £40 million is new money) will be invested in initiatives dedicated to tackling obesity, healthy eating and physical activity. This includes ring-fenced funding to support the delivery of a childhood healthy weight intervention programme which will benefit 20,000 children over 3 years.

75. A new national performance framework, agreed between the Scottish Government and the Confederation of Scottish Local Authorities, includes a new indicator to reduce the rate of increase in the proportion of children outwith the healthy weight range by 2018. In addition a new NHS target in Scotland will monitor the number of children successfully completing family-focused programmes that address the multiple causes of unhealthy weight as part of that the Scottish Government has recently announced £6m to support NHS Health Boards achieve the new target.

76. Both the NICE and the SIGN obesity guidelines provide advice for GPs and Health Boards to assess the suitability of interventions to prevent and treat obesity. To complement these, the Scottish Government will publish guidance for NHS health boards on the treatment and referral pathways for patients with unhealthy weight and on the provision of weight loss services later this year.

77. An obesity action plan will be published in Spring 2008 to provide further details of the initiatives to be supported by this additional funding. The healthy weight elements of this will place an emphasis on childhood obesity and community-based interventions. This action plan will build on, not replace, the continued delivery of the Diet Action Plan and Physical Activity Strategy.

Physical activity

78. [We are doubling our investment in initiatives supporting more people to take part in physical activity as part of their everyday lives.](#)

Mental Health

79. Mental health is a priority for the Scottish Government. The Scottish Government has also made dementia care a priority, including setting a new target for NHS Boards to ensure earlier detection, intervention and support for all affected. Progress made on improved mental health services is encouraging and supported by record spend by partner agencies.

Improving Health in Schools

80. All schools in Scotland are now health promoting environments and a wide range of innovative practice is underway locally to encourage healthy and active behaviour. The Schools (Health Promotion and Nutrition) Act places a duty on Ministers and Local Authorities to seek to ensure that all schools embrace a whole school approach to health promotion, including the existing *Hungry for Success* and *Active Schools* programmes which ensure children receive nutritious school meals and a wide range of opportunities to be physically active. The Act will ensure that food and drink supplied in schools meets defined nutritional standards, and identifies unhealthy food and drink which will be banned or restricted from school canteens and vending machines. Free school meals are provided to children in primary 1-3 across Scotland.

Social Marketing Strategy – Health Improvement

81. The Scottish Government are adopting a strategic approach to the social marketing of health improvement. The new approach recognises that health improvement communications benefit from a coordinated, integrated process, one which takes proper account of the interdependency of health issues, maximising their impact and reducing duplication of effort. The Strategy will cover physical activity, healthy eating, smoking in adults, alcohol use among adults, breastfeeding, positive mental wellbeing, sexual health among adults and there will be a multi-topic 'Youth Brand'.

82. Topics will be treated as part of a complete 'healthy living' message recognising the multiple interests of the general public. Emphasis will be placed on addressing health inequalities across all topics and empowering and enabling people to make healthier changes in their own lives and those of their families. Strategic communications will bring to the fore two unifying themes: the emphasis will be on health *benefits* of behaviour change and the role of *positive mental wellbeing* (as both enabling and resulting from healthier choices).

83. A distinct communications and information strand directed at young people who may be excluded by motivators aimed at adult target groups is being created. This would present a range of health topics in a way that is relevant and accessible to young people and resonate with their interconnected needs as they progress through key transition periods.