A consultation on a new National Public Health body: 'Public Health Scotland'

NHS Health Scotland Response

About Us

NHS Health Scotland is a special health board working to improve health and reduce health inequalities. We are one of the three bodies coming together to form Public Health Scotland on 1 April 2020.

We welcome the reform of public health in Scotland and have been involved in the thinking around this since the 2015 Review of Public Health in Scotland. We have been closely involved in the development of plans for the new public health agency. This has included membership of the strategic oversight groups, the early submission of think pieces, co-leading and/or contributing to the public health reform commissions and projects, and more recently through involvement in the work to develop a Target Operating Model and the establishment of the corporate services needed by the new body.

We very much welcome the opportunity to respond to this consultation. We will not attempt to repeat here everything that we have contributed through the various

channels mentioned above. We will focus instead on the key issues that we feel are of particular importance to Public Health Scotland in fulfilling its potential in improving the health and addressing the inequalities in health that still persist in our society.

If you have any questions or require further clarification on any point, please contact:

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Executive Summary

- NHS Health Scotland welcomes the reform of public health in Scotland and has been involved in the thinking around this since the 2015 Review of Public Health in Scotland.

- We are one of the three bodies coming together to form Public Health Scotland on 1 April 2020 and have been closely involved in the development of plans for the new public health agency.

- We have welcomed the bringing together of the three domains of public health into one organisation from the very outset. We believe that national leadership for each of the domains can be strengthened by being together in one single agency.

- The evidence shows that life expectancy in Scotland has stalled and that in our poorest areas, life expectancy has actually decreased. Therefore now more than ever we need a public health system that can rise to the challenge of reducing health inequalities and improving health.

- We welcome the commitment to PHS being in a position to provide independent advice, assurance and challenge. For PHS to be effective in its mission to make a real difference to the health of the people of Scotland, it is of utmost importance that the organisation can advocate effectively for what will work to improve health and reduce health inequalities.

- We welcome the intention to embed a human rights based approach to health and wellbeing in the new body.

- We support the model of shared leadership and accountability between Scottish Ministers and COSLA. We believe that this will help to ensure that improving outcomes for communities is at the heart of what the new agency does.

- We welcome the emphasis placed on the new body working collaboratively with local partners. We also support the clear statement of the importance of this collaborative working not duplicating or crossing over any established lines of accountability for local partners.

- We agree that PHS should become a statutory community planning partner on the proviso that PHS's role on Community Planning Partnerships is clear and well integrated with the role played by local public health teams.

- We agree that the third sector will be a vital partner for PHS and we recognise the great diversity amongst the third sector and the different ways in which third sector organisations contribute to public health including campaigning, policy advocacy, research, service delivery and community engagement.

Our Response

Question 1: Do you have any general comments on this overview of the new arrangement for public health?

1.	We welcome the new arrangements for public health set out in the consultation document. The emphasis on collective responsibility across the whole system, closer working with local authorities and Community Planning Partnerships (CPPs), strengthened leadership, and effective use of data and intelligence very clearly reflects the themes from the Review of Public Health in Scotland.[1] Specifically, we welcome the creation of a new public health agency that will take forward our work around fairer health improvement as part of its integrated public health remit. As well as the focus on data and intelligence, we would also emphasise the need to focus on the key relationship, partnership and engagement skills that will be central to all parties to public health reform, including Public Health Scotland, making these new arrangements work. We are looking forward to working with colleagues across the other domains of public health in taking forward these ambitions, particularly in supporting action to reduce inequalities in relation to health protection and healthcare public health.

Health inequalities

2.	We welcome the statement in the foreword that tackling health inequalities is a priority for the Scottish Government (SG) and COSLA. The Scottish Public Health Observatory (ScotPHO), of which we are a collaborator, published two reports[2] [3] in February that underline just how important it is

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[1] Scottish Government. 2015 Review of Public Health in Scotland: Strengthening the Function and re-focusing action for a healthier Scotland. February 2016.
[2] Scottish Public Health Observatory. Recent adverse mortality trends in Scotland: comparison with other high-income countries. February 2019.
[3] Scottish Public Health Observatory. Socioeconomic inequality in recent adverse mortality trends in Scotland. February 2019.

that concerted action is taken to improve and protect health and people's right to the highest attainable standard of health, and to reduce health inequalities. The evidence shows that life expectancy in Scotland has stalled and that in our poorest areas, life expectancy has actually decreased. This means that health inequalities are worsening and that socioeconomic position is increasingly impacting on how long we live for, and how long we live in good health.

3. The overview of the new arrangements for public health refers to health inequalities in terms of the integration of health and social care services and in terms of Community Planning Partnerships. However, it is now widely accepted that the fundamental causes of health inequalities are inequalities in income, wealth and power[4]. We would therefore welcome explicit reference to action being taken to tackle the fundamental causes as part of the new arrangements for public health and would be consistent with the findings of the PHR Improving Health Commission, which we were privileged to co-lead. This could include support PHS could provide SG on devolved matters and reference to the role PHS will have in supporting action being taken at a UK level on reserved matters that impact on public health, including social security and employment.

4. We would also commend to SG and COSLA that health inequalities should be framed as both a social justice issue and a human rights issue.

Whole system

5. Given the disturbing trends in life expectancy, now more than ever we need a public health system that can rise to the challenge of reducing health inequalities and improving health. PHS will play an important part in this, but we agree that no single organisation can solve the problems we face. We know from our experience as Scotland's national health improvement

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[4] NHS Health Scotland. Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities. June 2013.

agency that we need meaningful collaboration across the system in order to deliver real change. PHS has a crucial leadership role in supporting this collaboration.

Independence of voice

6.   We welcome the commitment within the consultation document to PHS being in a position to provide independent advice, assurance and challenge. This is a nuanced area as independence of voice and impartiality is not the same as organisational independence. PHS will be accountable to SG and to local government. But for PHS to be effective in its mission to make a real difference to the health of the people of Scotland, it is of utmost importance that the organisation can advocate effectively for what will work to improve health and reduce health inequalities. It will also be important that PHS is able to speak out on what does not work and therefore should be discontinued or changed.

7.   PHS's agreed organisational values, which were developed with staff through the Organisational Development Commission and set out in the Target Operating Model,[5] make reference to "speaking out on uncomfortable truths." This is crucial because PHS's advice and guidance may not always be popular with key stakeholders, including local and national government. We suggest for this reason that independence of voice should be built into the Memorandum of Understanding (MoU) and the sponsorship arrangements.

8.   We welcome the commitment to giving further consideration to "what more needs to be done to demonstrate that the advice and guidance the new body provides is truly independent of Government" and that PHS "…should be able to campaign for those public health objectives and policies which it believes can best improve and protect the nation's health and wellbeing." [page 4, para. 9] We suggest that building clarity into the MoU from the

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[5] Scottish Government. Target Operating Model for Public Health Scotland 2.0. May 2019.

outset around the policy advocacy and influence functions of the new agency will be key to this. It is crucial that PHS is able to advocate effectively for and on behalf of the public's health. We look forward to sharing our experience in this area as part of the consideration of what more needs to be done to secure independence of voice.

Human Rights Based Approach (HRBA)

9.   We welcome the intention to embed a human rights based approach to health and wellbeing in the new body. We set out our rationale for this in a Briefing Note on Human Rights shared with the Public Health Reform Team last year.[6]

10.   The right to the highest standard of health is enshrined in international law, 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. These rights span the social determinants of health and are key to realising the public health reform programme's vision of a Scotland where everyone thrives.

11.   We believe that Public Health Scotland should be an exemplar for Scotland and internationally of how the governance structure of a public body can embed the right to health as duty bearers, as employers and embedded in the services and support we offer as a new agency. It is also our view that PHS has an important leadership role in supporting the wider public health system to take a human rights based approach to public health in the planning, prioritisation and delivery of all its work.   This will require close working with national human rights organisations, including the Scottish Human Rights Commission and the Equality and Human Rights Commission.

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[6] NHS Health Scotland. Sharing power in the new public health body. January 2018.

12. Our interpretation of a HRBA has been developing for several years but became an explicit statement of intent in our 2017 strategic framework.[7] We see this as a progressive, cultural development in planning our work. We have sought to embed human rights concepts and practice through our leadership, communications, strategy, and ways of working with staff, resources and projects.

13. There are two frameworks that we would recommend in embedding a HRBA to health and wellbeing in the new body; PANEL (Participation, Accountability, Non-discrimination, Empowerment, Legality) and AAAQ (Accessibility, Availability, Affordability and Quality). In our paper Sharing power in the new public health body[8], we describe how embedding the PANEL principles into the work of PHS would help to ensure that our values and work impact and uphold the rights of the people who need the most help.

14. Building on our experience of developing an internal approach to HRBA in NHS Health Scotland, specific actions that could be considered in the context of establishing PHS include:
    - Framing the vision and first strategy of the new body in explicit right to health terms, across all the domains of public health.
    - Building human rights into the governance structure e.g. recruiting lived experience and expertise on human rights within the Board (see para. 122 below).
    - Developing mechanisms within the operation of the body for a wide range of perspectives, such as lived experience, to be genuinely influential in strategic and operational decision making.
    - Ensuring a collaborative approach to PHS's work and ambition to take a human rights based approach. Having critical friends in the third sector, including the Scottish Human Rights Commission, has been essential to our approach.

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[7] NHS Health Scotland. A Fairer Healthier Scotland: A Strategic Framework for Action 2017 - 2022. June 2017.
[8] NHS Health Scotland. Sharing power in the new public health body. January 2018.

15.   We are part of the group currently reviewing and updating Scotland's
        National Action Plan for Human Rights[9] (SNAP). The group is reviewing the
        latest evidence on human rights in Scotland and identifying draft priorities
        for action. An example has been considering the importance of employment
        to health and the upholding of rights as the employment market changes
        over the coming years. We are helping to support strategic links being made
        between these human rights priorities and Scotland's Public Health
        Priorities, as well as wider public health issues. For example, mental health
        is a key concern for human rights and action in relation to the right to an
        adequate standard of living and the right to life could be tied in with action
        around the aforementioned stall in life expectancy in Scotland. We believe
        that PHS should continue our important work in this area.

16.   An example of practical work in this area is the Lived Experience Collective
        funded by NHS Health Scotland in collaboration with the Centre for Health
        Policy, University of Strathclyde and the Health and Social Care Alliance
        (ALLIANCE). This work was commissioned through the Scottish National
        Action Plan on Human Rights health and social care action group, of which
        we are a con-convenor along with the ALLIANCE. It built peer research
        skills for people who had experience of homelessness and women with the
        status of refugees or asylum seekers on their past experiences of accessing
        public services and meeting their health issues. The original research was
        carried out by peer researchers from Glasgow Homelessness Network and
        the Mental Health Foundation. The project has published annual reports,
        presented the work at Scottish, UK and International conferences and has
        now employed a Peer Research Coordinator to further strengthen the
        collective to influence the human rights approach needed within public
        services in both health and housing.

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[9] http://www.snaprights.info/

Public Health Ethics

17. The application of human rights principles to public health is entirely consistent with the wider social justice framework that underpins public health action in Scotland. However human rights principles are not the only ethical considerations relevant to public health. We note that there is no reference to public health ethics in the consultation document and we suggest that there is merit in exploring and being more explicit about the potential role for PHS in this area.

18. This will include ethical considerations in research commissioning and the ethical considerations inherent in responding to Duty of Candour regulations. However it is our view that the area with greatest potential for impact on a 'Once for Scotland' basis is the development of an ethical framework for public health policy-making.

19. Public Health Ethics in Practice[10], part of the UK Public Health Skills and Knowledge Framework, states that:

     "…ethics should not be viewed as an afterthought to be examined once policy adoption or intervention selection has taken place; it is an integral component of public health decision-making that should be incorporated into all aspects of policy and practice."

20. The development of an ethical framework for public health policy and decision making could support not only PHS's own role in the provision of guidance, advice and information to decision makers and policy makers, but could also support effective and impactful public health decision making across the system.

21. We suggest therefore that explicit reference should be made to public health ethics within the role of PHS, most likely coupled with Public Health Strategy,

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[10] Public Health England. Public Health Ethics in Practice. April 2017.

Planning and Policy. There is significant scope for innovation in the use of ethical concepts in policy and practice development and PHS will be well-placed to take a leadership role in this area, working collaboratively with relevant academics and the Public Health Ethics Forum of the Committee of the Faculty of Public Health in Scotland.

Question 2 (a) What are your views on the general governance and accountability arrangements?

22.   We recognise that the NHS Health Scotland Board will be dissolved and the PHS Board will take on the duties and accountability for the NHS Health Scotland resources, staffing and strategic intent. We recommend that a clear plan for the dissolution of the NHS Health Scotland Board and accountabilities that PHS and/or SG will take on will be required.

23.   We suggest that PHS may need to develop a governance structure and process that incorporates the citizens' voice.   This connects to the work NHS Health Scotland have done around the fundamental causes of health inequalities and power. To begin to redress some of the power imbalances, the creation of an invited space that shares power would be a way PHS could show leadership in putting this evidence into practice. The Commission on Strengthening Local Democracy reported[11] that people are now looking for a different kind of empowerment in which citizens participate to shape their own lives, rather than looking to local or national representatives to shape it for them.

24.   We suggest that the relationships between this aspect of PHS's approach and the Board governance and accountability will need to be carefully thought through and the governance and accountabilities and lines of sight made quite clear. In "collaborative governance" we believe that there are

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[11] Commission on Strengthening Local Democracy. Effective Democracy: Reconnecting with Communities. August 2014.

only a few examples of Boards or organisations that have involved members of the public in decision making and therefore actively involved them in governance. The focus in the majority of organisations is either on informing and/or engaging stakeholders/partners/citizens. We suggest this is something for the PHS Board to mature into rather than attempt to resolve in its initial phase. However, this does mean that the Board's Corporate Governance Framework should be flexible enough to allow for this. For example, the consultation document refers to the PHS Board's responsibility for "engaging with stakeholders" [page 17, para. 2] and the requirement to "involve" communities (page 28).   We suggest that the PHS Board should not aim to become 'representative' through nominated members, but it could formally work with a wider set of advisory partners and/or adopt more participatory / co-production approaches as appropriate.

25.   However, this does not detract from our support of the intention to "… try to build human rights into the governance structure of the organisation, by recruiting lived experience and expertise on human rights onto the Board. [page 43, para. 4]. Please see paragraph 123 below for our comments in this area. Our view is that appointing people with lived experience on to the Board a recognition of the important skills and experience that individuals with lived experience can bring to a Board.

Scottish Parliament accountability

26.   In order to strengthen the proposed leadership and accountability arrangements, we believe it would be helpful to outline the Scottish Parliament accountability. We would suggest this is in line with all Public Sector Boards to the Scottish Parliament Public Audit and Post Legislative Scrutiny Committee. We believe it would also be useful to determine if there will also be a relationship with the Health and Sport Committee, as with other NHS Boards and/or the Local Government and Communities Committee.

Accountability required by other divisions and sections of Scottish Government and the UK

27.   As we understand it, PHS will be responsible for governing areas of work that have some direct line of sight and accountability to SG and also to the UK Government. For example the Head of Profession role is accountable to the UK National Statistician in London as per the UK Statistics Act and Scotland Order. We suggest that it will be important for SG and COSLA and in turn for the PHS Board to understand and agree this aspect of their governance and accountability lines of sight from an early stage.

(b) How can the vision for shared leadership and accountability between national and local government best be realised?

28.   We agree that local authorities hold many of the levers for protecting and improving health and wellbeing and that it is vital for PHS to work closely in partnership with them. We support the model of shared leadership and accountability between Scottish Ministers and COSLA. We believe that this will help to ensure that improving outcomes for communities is at the heart of what the new agency does.

29.   We support the proposal that this arrangement will be outlined in a Memorandum of Understanding or other such document, but disagree that it should "set out how certain functions and activities will be jointly managed" [page 17, para. 1].   We believe that the role of SG and COSLA will not be to "manage" the organisation, rather to hold it account. Therefore we would suggest that there is a requirement to make explicit, the joint accountability arrangements between the two spheres of government i.e. the Scottish Minister and the COSLA Health and Well-being Spokesperson and then reflect this in the subsequent documentation prepared and agreed by SG and COSLA and in turn the Board of PHS. For example we believe the Board Management Statement documentation should be agreed between

SG, COSLA and the PHS Board and further to this, it is then the role of the PHS Board to discuss and approve its own Board Standing Orders; Standing Financial Instructions and the Scheme of Delegation. It is our recommendation that PHS should take full account of the NHS Corporate Governance Blueprint and its associated delivery tools. PHS should seek to develop and adapt the governance framework to best meet the needs of the Board, to enable its functions and culture to reflect a wide range of influences.

30. Another important standard to consider is the Code of Practice for Ministerial Appointments to Public Bodies in Scotland.[12] If non-executive board members of PHS are to be Ministerial appointments then it would seem appropriate to follow this code, albeit perhaps with adjustments to take account of the joint accountability arrangements with COSLA.

31. Further, we recommend that the PHS Board Code of Conduct policy should be developed in line with the Principles of Public Life in Scotland reflected in the Model Code of Conduct for Members of Devolved Public Bodies.[13] We suggest that the joint accountability agreement between SG and COSLA is clear about how this code of conduct applies to non-executive members of PHS and how it will operate across the two spheres of government. This is relevant both to the appointment process and the non-executive appraisal and review processes.

32. We have reservations about the use of the word "control" in relation to the shared accountability arrangements [page 17, para. 1]. This could impinge on the Board's duties and authority as the governing body. We believe the Board Management Statement documentation should be agreed between SG, COSLA and the PHS Board.

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[12] Commissioner for Ethical Standards in Public Life in Scotland. Code of Practice for Ministerial Appointments to Public Bodies in Scotland. October 2013.
[13] Scottish Government. Model Code of Conduct for Members of Devolved Public Bodies. February 2014.

Board Corporate Governance Framework and Board governance improvement

33.   We would stress that the overall quality and approach to Board governance is a very important component of accountability.   All Boards and organisations across the public and private sector must set out their Corporate Governance against a recognised governance framework, assess and report on this annually and develop appropriate improvement plans. Given the recent governance challenges, particularly within the Scottish NHS system, the importance of establishing a robust Board Corporate Governance Framework and approach to Board governance based on tried and tested current standards should not be underestimated.

34.   We suggest that involvement in wider benchmarking approaches with other Boards or organisations would be appropriate and desirable. Currently NHS Boards do this through preparing annual improvement plans against the NHS Corporate Governance Blueprint and submitting these for scrutiny by the Cabinet Secretary for Health and Sport.   We promote the NHS Corporate Governance Blueprint as an excellent framework for PHS to adopt in its early development as it is founded on sound Public sector governance approaches and principles. However our strong view is that flexibility to adapt this in accordance with the Board purpose, over time as the Board matures, should be a principle of the foundation agreement between SG and COSLA.

35.   We further suggest that SG and COSLA will need to agree how PHS will be held to account for their implementation of this Framework and their Board governance annual reports and improvement plans jointly scrutinised.

Board Annual Reviews

36.   We suggest that it is important for the performance reporting arrangements and frequency to be determined for PHS. We recognise that PHS might be expected as a default to conduct an Annual Review like other NHS Boards,

using the guidance set by the Cabinet Secretary for Health and Sport, or if another joint accountability arrangement will be developed.

37. However, we suggest that the vision for shared leadership could best be enacted by developing a different annual accountability arrangement and from this alternative planning processes developed that serve to de-couple PHS from NHS planning and performance approaches. The consultation document describes the NHS Local Delivery Plan (LDP) as the delivery contract between SG and NHS Boards in Scotland [page 22, para. 28]. We recognise that it provides assurance and underpins NHS Board Annual Reviews. Our view is that a different process to that of an NHS Annual Review will be required for PHS.

38. We support the requirement to re-orientate performance reporting. We suggest that firstly a change to the accountability framework by which PHS will report is required, then the re-orientation to performance reporting will naturally follow. It is unlikely that the NHS LDP will enable PHS to frame its whole system planning in a proportionate way to deliver to the joint accountability, using an outcomes focused approach. We suggest that the LDP framework would not fully support the broader public health effort, as it can focus attention on measurable downstream activities (such as Alcohol Brief Interventions, smoking cessation programmes) to the exclusion of upstream interventions which have a hugely important role in public health and whole system approaches.

39. We suggest that it will be necessary to produce a different delivery contract to replace the LDP for PHS with COSLA and SG, which demonstrates the different nature of the work PHS will deliver. From this, PHS should report their performance. Without this the joint aspirations of both spheres of government to show long term whole system upstream preventative action will be much more difficult to achieve.

Question 3: (a) What are your views on the arrangements for local strategic planning and delivery of services for the public's health?

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40.   We welcome the clear statement that local partners will continue to have "responsibility for the local strategic and operational planning, design and delivery of services for the public's health to reflect local need and in accordance with statutory requirements, the Public Health Priorities and relevant National Outcomes." [page 20, para 18]

41.   Local partners are best placed to understand the needs of their communities and to design services together with communities to meet those needs.

42.   We agree that "community planning provides a highly important vehicle for driving local public health ambitions." [page 26, para 44]

43.   We note that although "community planning partnerships are not required to pursue nationally set priorities, on public health or any other theme" [page 25, para 43], PHS will be providing "a national overview of local partnership delivery plans and annual reports in relation to improving and protecting the public's health." [page 20, para. 19] We suggest that further consideration is given to the use of the national Public Health Priorities in the overview of local action. If CPPs are not required to pursue the Public Health Priorities, then the priorities may not be the most appropriate vehicle against which to measure local progress.

44.   We agree that the third sector will be "a vital partner for Public Health Scotland in putting prevention at the heart of health and care services, and supporting local communities to take a greater role in promoting health and wellbeing." [page 25, para. 40]

45.   However the role of the third sector in public health extends well beyond community engagement and the local delivery of services. It will be important

that PHS recognises the great diversity amongst the third sector and the different ways in which third sector organisations – large and small – contribute to public health. This includes campaigning, policy advocacy, and research as well as service delivery and community engagement.

46.   Therefore while we agree that "Third Sector Interfaces will have a key role to play as a conduit to the third sector," [page 25, para. 40] this role is focussed on health and social care. The contribution that the third sector can play in public health extends beyond services and beyond health and social care. Our experience of working with the third sector is that national third sector intermediaries such as Voluntary Health Scotland, the Scottish Council for Voluntary Organisations and the Health and Social Care Alliance, also provide a crucial conduit to the third sector.

47.   National bodies such the Institute of Public Policy Research, the Joseph Rowntree Foundation, Oxfam and the Carnegie Trust will also be key stakeholders for PHS.

(b) How can Public Health Scotland supplement or enhance these arrangements?

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48.   We welcome the emphasis placed on the new body working collaboratively with local partners. We also support the clear statement of the importance of this collaborative working not duplicating or crossing over any established lines of accountability for local partners [page 20, para. 16] nor changing local governance arrangements for the strategic planning and delivery of local services for public health [page 18, para. 10].

49.   PHS should *support* local strategic planning and delivery of services for public health without any diminishment of the roles and responsibilities of local partners.

50.   We note that the description of the new model for public health largely focusses on the delivery of public health *services*. While we recognise the real pertinence of services to some of the public health domains in particular, in health improvement, services tend to focus on people who are engaging in health-damaging behaviours and/or are experiencing the negative health impact of such behaviours. Services like smoking cessation, healthy weight services and drug and alcohol rehabilitation services are important and have their place. However services tend to focus on mitigation of the negative impact of inequality, which should not be the main focus of the public health effort locally, nor of PHS's support of local public health.

51.   It is our view that a key element of PHS's offer to local partners is around information, advice and guidance about what works to improve and protect health and to create the conditions for health. From a health improvement perspective, this will range from actions relating to services for individuals, through to actions impacting on the social and physical environment in which we live, work and play, and also upstream interventions impacting on policy and strategy. There is a risk that an over-emphasis on the delivery of 'services' places the focus too heavily at the downstream end of the spectrum.

52.   As mentioned earlier, NHS Health Scotland conducted a review in 2013 to provide information to the Scottish Ministerial Task Force on Health Inequalities. The Health Inequalities Policy Review[14] summarises the best available evidence about measures likely to be effective and ineffective in reducing inequalities in health. It reviewed the 2008 Equally Well strategy and its implementation. The Policy Review provides some important learning for the development of the new arrangements for public health. One of the most important is that:

> "…relying on individual efforts ('downstream' interventions) is likely to be relatively ineffective in reducing inequalities compared to improving the life

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[14] NHS Health Scotland. Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities. June 2013.

circumstances and environments of more deprived people and communities ('upstream' policies)." [page 3]

53. Linked to this, the learning from Equally Well, highlighted in the Policy Review, is important:

"… in the move to considering how to address health inequalities, the balance of attention in Equally Well shifted towards the more downstream consequences of inequalities (such as alcohol misuse, drug treatment and rehabilitation, smoking cessation, healthy weight, depression and anxiety), focusing less on the policy areas which are more likely to be effective in narrowing inequalities. Experience from other countries suggests that this 'lifestyle drift' is not unusual when implementing a health inequalities strategy and may occur for a number of reasons." [page 24]

54. One of PHS's most significant offers to local partners should be to advise and provide guidance on effective upstream action around the Public Health Priorities. As reflected in the quote above, action on the lifestyle based Public Health Priorities can drift towards individual lifestyle behaviour change interventions to the exclusion of the other actions that we know from the evidence are also required to improve health and reduce health inequalities. If PHS is to be "a trusted and impartial champion for the improvement and protection of the health and wellbeing of the nation, free to provide advice based firmly on the science and evidence" [page 18, para. 9] then the focus in health improvement will need to shift away from services to interventions that prevent and undo the negative impact of inequality.

55. We undertook work[15] last year with the Scottish Health Promotion Managers as part of the Improving Health Commission. This involved mapping the work of local health improvement teams and the differing contexts in which they operate. One of the findings was that local teams would benefit from support

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[15] Scottish Public Health Network. Local Health Improvement Teams – Current Landscape. December 2018.

around strategic influencing and being effective advocates within local partnership arrangements.

56.   Therefore both the evidence of what works to improve health and reduce health inequalities, and the reported needs of local public health teams, suggests that PHS should supplement and enhance the local arrangement through the provision of support to build capacity to effectively influence policy and advocate for the most important actions to improve the public's health. This could include support around taking a Health in all Policies approach and in using local data to encourage a more upstream approach to tackling local issues.

57.   One of the other findings from the work with Scottish Health Promotion Managers was that the 12 month nature of SG's Outcomes Bundle Funding was a barrier to moving action more towards prevention. It was reported that to use the funding in the time available, teams often had to resort to funding more downstream interventions. This is a systemic issue. We are pleased to see the reference to PHS's role in "Raising awareness of any potential systemic issues and opportunities which exist to drive improvements, recommending solutions as appropriate" [page 21, para. 22].

58.   We suggest that PHS's role could go further than raising awareness and recommending solutions. PHS could also have a role in monitoring the effectiveness of the solutions implemented and the knock-on effect on other parts of the system. This will be key to effective whole-system working. It is also relevant to the monitoring of PHS's own effectiveness as it will be important for PHS to ensure that the information, advice and guidance it provides is impactful and leads to well-evidenced decision making.

59.   There could also be a role for PHS in monitoring action taken to tackle systemic barriers, i.e., when solutions were identified and recommended but not implemented. Failure to implement a solution could be a systemic issue in itself, requiring further and perhaps different recommendations.

60.   We support the aim of fostering "…a collaborative environment across partnerships by building inclusive networks with the common aim of protecting and improving the public's health and wellbeing." [page 28, para. 54] Networks already exist in many areas, as does extensive experience in setting up and running effective networks. For instance the Scottish Public Health Network (ScotPHN) has many years of experience in this area, supporting networks including the Scottish Managed Sustainable Health Network (SMASH) and the Scottish Health and Inequalities Impact Assessment Network (SHIIAN). In addition, NHS Health Scotland has extensive experience of facilitating networks of health improvement practitioners and networks of wider practitioners working across the system. This is all experience that can be drawn on to support the aim of fostering a collaborative environment.

61.   Lastly, we suggest that PHS will have a crucial role in supporting the whole public health system to gain an increased understanding of the different ways in which collaborative partners undertake prevention work. As highlighted in the recent study The Politics of Institutionalizing Preventive Health,[16] ambiguity around prevention can lead to "false and ultimately unsustainable consensus." It is beneficial for different parts of the system to work at different levels of prevention (primary, secondary and tertiary). For instance, work around the healthy weight Public Health Priority needs to include primary prevention work around the obesogenic environment and secondary and tertiary prevention work around weight management and detection of diabetes. However, the parts of the system involved in the work, the outcome measurements and the overall impact on population health are very different. We suggest that recognition of this issue will be key both to PHS working effectively with different collaborative partners and also in PHS monitoring the performance of the system in realising the Public Health Priorities.

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[16] Boswell, J. Cairney, P. St Denny, E. The Politics of Institutionalizing Preventive Health. May 2019.

Question 4: What are your views on the role Public Health Scotland could have to better support communities to participate in decisions that affect their health and wellbeing?

62.	In our view, PHS has a distinct national role in supporting communities to participate in decisions that affect their health and wellbeing. A large part of this could be to support local partners to, in turn, support local communities to participate in decisions that affect their health and wellbeing. Working effectively with Directors of Public Health will be key to this, as could be supporting the adoption of a human rights based approach to public health across the system.

63.	In addition to supporting local partners, PHS could undertake work nationally to help the Scottish public to understand the breadth of decisions that affect their health and wellbeing. This could include a long term piece of work on challenging the dominant healthcare paradigm and building public support for preventive measures.

64.	PHS could also have a key role in helping communities understand the impact that inequality has on health and wellbeing, thereby encouraging participation in the more upstream decisions that impact on health and wellbeing. When people were asked in the Scottish Social Attitudes Survey 2016[17] for their views on whether people's health was poorer because of 'injustice in our society', only half (51%) agreed that 'certain people's health is worse than others because of injustice in our society'.

65.	We would hope that PHS will support the use of the Place Standard in communities. The Place Standard, a tool developed by NHS Health Scotland, SG and Architecture and Design Scotland, provides a simple framework to structure conversations about place and community. It helps communities

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[17] ScotCen. Public Attitudes to Inequality Scottish Social Attitudes 2016. June 2018.

consider issues around the physical environment and the social environment, both of which impact on health and wellbeing.

66. We would like to see PHS use and support the use of democratic innovations such as 'mini-publics', participatory budgeting and citizens juries in order to support communities to participate in decisions that affect their health and wellbeing. More information on democratic innovations can be found in the think piece on Sharing power in the new public health body[18] that we submitted to the public health reform programme last year. As we said in the think piece:

> "…models of involvement vary and ongoing development work suggests that different models of dialogue and deliberation can operate at different levels of power-sharing, such as advisory, review or with equitable decision-making capacity."

67. We would like to reiterate the offer made in the think piece to undertake a review of different democratic mechanisms to generate concrete proposals for PHS.

Question 5: (a) Do you agree that Public Health Scotland should become a community planning partner under Part 2 of the Community Empowerment (Scotland) Act 2015?

68. We do agree that PHS should become a statutory community planning partner. However this is under the proviso that PHS's role on CPPs is clear and well integrated with the role played by local public health teams. We note that it is specifically highlighted that PHS becoming a statutory community planning partner would "not duplicate or cross over any established lines of accountability for local partners" [page 20, para. 16] and that it would not impact

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[18] NHS Health Scotland. Sharing power in the new public health body. January 2018.

on "local governance arrangements for the strategic planning and delivery of local services for public health". [page 18, para. 10]

69.   Since PHS would provide support and advice to CPPs even if the agency was not a statutory partner, being a statutory partner would need to provide some additional benefit. We suggest that further consideration is needed around what the distinct contribution PHS would have to CPPs and how this would be delivered in a way that is effective and integrated, rather than in competition, with local public health systems.

70.   We would be interested to hear the experiences of other national agencies that are community planning partners under Part 2 of the Act.

(b) Do you agree that Public Health Scotland should become a public service authority under Part 3 of the Community Empowerment (Scotland) Act 2015, who can receive participation requests from community participation bodies?

71.   We do agree that PHS should become a public service authority under Part 3 of the Community Empowerment (Scotland) Act 2015. However in our view, the potential for PHS to support communities to participate in decisions that affect their health and wellbeing goes well beyond accepting participation requests from community participation bodies.

72.   It will be important that PHS is able to support geographical communities and communities of interest to get involved in conversations and help improve outcomes without necessarily using the formal mechanisms. There is a risk that less-advantaged communities may be less well-equipped to engage in the formal mechanism. It is important that the methods for community engagement and participation used by PHS, and indeed the wider public health system, does not reinforce power imbalances or risk increasing health inequalities.

(c) Do you have any further comments?

73. The issue of community participation links to our earlier point about taking a human rights based approach. If the PANEL principles are embedded into how PHS works, then the 'participation' element of PANEL would see PHS developing policies and practices that ensured that people were able to voice their experiences and take part in decision-making.

Question 6: (a) What are your views on the information governance arrangements?

74. We agree with the stated intention around the accessibility of the data and the ambition "that all parts of the system should work together to gain maximum value from data" [page 31, para. 71].

75. Day one readiness around information governance is key to ensuring there is no gap in service delivered and that data is kept safe and secure when service responsibility moves from the legacy bodies to PHS. This is particularly important considering the recent changes to data protection legislation resulting from the General Data Protection Regulation, and the significant increases in the penalties available to the Information Commissioner's Office as a result of non-compliance.

(b) How might the data and intelligence function be strengthened?

76. We have been closely involved with the Underpinning Data and Intelligence (UDI) Commission and share the view that "the innovative use of knowledge,

data and intelligence will be a key tool in achieving the ambition for Scotland to be a world leader in improving the public's health."[19]

77.   We support the recommendations set out in the final deliverable of the UDI Commission, including the need for more joint working across teams and organisations and greater use of visualisation of data, interpretation and advocacy. This will build on existing successes in this area such as our collaboration with the Glasgow Centre for Population Health to produce an animation on power.[20] The aim was to increase understanding of the impact of power inequalities on health and raise awareness of how people working across all sectors can support communities to have more power.

78.   We also support the recommendation in the Target Operating Model[21] that given the importance of the data and intelligence function and the need to be innovative by "using data to generate insights and disrupt(ing) the current approaches" [page 7], the data and intelligence function requires strong leadership at director level.

Question 7: (a) What suggestions do you have in relation to performance monitoring of the new model for public health in Scotland?

79.   We suggest that there are three distinct but linked elements to the performance monitoring of the new model for public health in Scotland:

- Performance monitoring of PHS
- Performance monitoring of the public health system
- Performance monitoring of progress towards the Public Health Priorities

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[19] Paper shared with Public Health Reform Team during the Commission process
[20] http://www.healthscotland.scot/news/2017/august/new-animation-power-as-a-health-and-social-justice-issue
[21] Scottish Government. Target Operating Model for Public Health Scotland 2.0. May 2019.

Performance monitoring of PHS

80. We welcome the intent, set out in the Target Operating Model, to judge PHS's performance on the basis of the impact the agency has on the wider system. This will result in tangible performance indicators that can be robustly measured and reported on annually.

81. We also welcome the reference to the National Performance Framework being used to measure "progress against the Public Health Priorities, including the specific contribution of Public Health Scotland." [page 16, para. 23] We would welcome further detail/discussion about how the indicators will be used to do this.

Performance monitoring of public health system

82. The Target Operating Model states that:

    "The success of the public health system is judged against (1) Scotland's health relative to other comparable countries, (2) the inequalities in Scotland's health and (3) the demand on Scotland's health and social care services. Public Health Scotland will help the public health system track its progress against them." [page 45]

83. The consultation document [page 33, para. 1] refers to three actions that PHS should take in performance monitoring the public health system. The first is:

    "Encourage and facilitate collaborative working on performance management at community planning level related to both the National Outcomes and the Public Health Priorities." [page 33, para. 2]

84. Whilst we support the intent behind this, we are not clear how this will work in practice when CPPs are "not required to pursue nationally set priorities, on public health or any other theme." [page 26, para 44] We have concerns about the impact on PHS's relationships with local areas if PHS undertakes

performance monitoring of local partners against outcomes and priorities that they are not required to meet.

85.   The second action listed in relation to PHS's performance monitoring of the public health system is:

"Enable effective benchmarking between local partnerships and help them share good practice and identify differences/inequalities in performance across Scotland." [page 33, para. 2]

86.   We agree that PHS should have a role in working to support effective benchmarking and helping best practice to be shared. However, we know from recent work[22] undertaken to map the local health improvement landscape across NHS board areas that there is a high degree of variation in the context in which local areas are operating, in local governance arrangements and in involvement in local partnership arrangements. In practice therefore identifying differences in *performance* might not be helpful as one would not be comparing like with like. We would suggest that the focus should be on identifying differences in *outcomes*. This also applies to the issue of inequalities – we suggest that the focus should be on inequalities in outcomes rather than performance.

87.   The second action listed in relation to PHS's performance monitoring of the public health system is:

"Identify steps and potential action to better share good practice and highlight good performance and address poor performance." [page 33, para. 2]

88.   We have concerns that "addressing poor performance" introduces an element of scrutiny that would not necessarily complement the advice, guidance and

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[22] Scottish Public Health Network. Local Health Improvement Teams – Current Landscape. December 2018.

advocacy element of PHS's role. In our view, the greatest potential for impact on the public's health is through the provision of support and that action should be taken to avoid this being negatively impacted upon by also introducing a scrutiny function within PHS.

Performance monitoring progress towards the PHPs

89.   We support the suggestion that PHS should have a role in performance monitoring progress towards the Public Health Priorities. However we are conscious that this would involve an element of self-monitoring given that PHS will itself be taking action to progress the Public Health Priorities. We would welcome further discussion around:

"…what additional short/medium term outcomes and performance indicators may be required in order to capture short and intermediate term progress against the Public Health Priorities and the specific role and impact of Public Health Scotland." [page 33, para. 1]

(b) What additional outcomes and performance indicators might be needed?

90.   We note the reference to the need for "… new measures of success that reflect how organisations work together and how citizens feel." [page 33, para. 5]

91.   We agree with the need for measures of success that reflect how organisations work together.

92.   With regards how citizen's feel, the Warwick-Edinburgh Mental Well-being Scale[23] (WEMWBS) could be used. WEMWBS is the result of work we commissioned from Warwick and Edinburgh Universities in 2006. It is a scale of 14 positively worded items for assessing a population's mental wellbeing.

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[23] http://www.healthscotland.scot/health-topics/mental-health-and-wellbeing/wemwbs

Question 8: What are your views on the functions to be delivered by Public Health Scotland?

93. NHS Health Scotland has welcomed the bringing together of the three domains of public health into one organisation from the very outset. We believe that national leadership for each of the domains can be strengthened by being together in one single agency.

94. We have been closely involved in the development of the Target Operating Model for PHS, and we support the ambition that PHS "will not be a continuation of the status quo." [page 29]

95. We welcome the agreement that the new body should have a leadership role in relation to "public health research, data science and innovation, and for the development of the specialist and practitioner workforce within the whole system". [page 34, para. 2]

96. We believe that the reduction of inequality should be a golden thread running through all of PHS's functions. NHS Health Scotland has significant experience in this area and we look forward to working across all the directorates within PHS to support the development of and/or enhancement of approaches to reducing inequality beyond the domain of health improvement.

97. We agree that providing national, professional and strategic leadership for public health in Scotland will be a key function of PHS. We are pleased to see the reduction of health inequalities mentioned in the first bullet of the subsequent list [page 35, para.3]. However, in the second bullet, we would suggest that PHS should act as more than the "voice and champion for public health *services.*" We would suggest, linked to our point above (paras. 50 – 54), that PHS should be a champion for the public's health and for wider public health *action*, not just a champion of public health *services*. Championing the

public's health could be providing support to local partners in advocating for preventive policy, or working with organisations in the wider system to embed health in all policies and strategies. Being a champion for public health *action* would also include ensuring that the action is impactful and makes a difference. This links to our earlier point about ensuring that the information, advice and guidance PHS provides is impactful and leads to well-evidenced decision making (para 51 above).

98.   Given what we know about the interventions that will make the biggest difference to population health, we fully support the reference to systemic barriers in the third bullet in the list:

> "Identify and recommend actions to address, as appropriate, institutional, legal, financial, workforce and any other systemic barriers to progressing improving and protecting health and wellbeing." [page 35, para.4]

99.   Some of the levers to address systemic barriers sit with SG, some with local government and some with the Westminster Government. It will be important that PHS is able to work effectively with government colleagues across the system to identify and address these barriers. As the sponsors of the new landscape, it will be important that SG and COSLA take swift action to tackle any aspects of their own involvement in the public health system that creates barriers.

100.   We would like to see explicit reference to engaging with the public as a function of PHS. We see a role for PHS in engaging the public in their right to health and the need to take action on the social determinants of health. Effective public engagement could generate increased levels of support for the regulatory and legislative interventions that we know are most effective in improving health and reducing inequality. This is a different sort of public engagement than might traditionally be expected of a public heath body around engagement on unhealthy behaviours. It is an area in which PHS could demonstrate real leadership and innovation.

101. In order to realise the Public Health Priority around eating well and having a healthy weight, PHS will need to collaborate closely with Food Standards Scotland. There will be significant areas of commonality between the work of PHS and Food Standards Scotland in a range of public health areas, most notably in health improvement and health protection. It will be important that the two bodies collaborate effectively in food-related public health matters and provide consistent advice to SG and wider public health stakeholders, whilst avoiding duplication of effort. It may be beneficial for SG to be explicit about the expectations of the two agencies in this shared area.

Environmental Sustainability and Climate change

102. We believe it is critical that environmental sustainability and the important links between climate change and health are embedded into and further developed within the work of the new public health body. This will build on work already being undertaken in Health Protection Scotland and by the Scottish Managed Sustainable Health Network (SMASH).

103. The Lancet Commissions on Climate Change[24] and Planetary Health[25] and the World Health Organization COP24 Special Report: Health and Climate Change[26] underlined the importance of aligning public health and environmental sustainability. Human health depends on healthy natural systems and environments. Continued degradation of the environment through, for example, emissions of greenhouse gases and pollution, poses a significant threat to population health now and for future generations. The impacts of climate change, for example, are already being felt in Scotland and these effects as well as changing climates in other countries will affect the health and wellbeing of Scotland's population.

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[24] N Watts et al. Health and climate change: policy responses to protect public health. Lancet, Vol. 386. 2015.
[25] S Whitmee et al. Safeguarding human health in the Anthropocene epoch: report of The Rockefeller Foundation Lancet Commission on planetary health. Lancet, Vol. 386. 2015.
[26] World Health Organization. COP24 Special Report: Health and Climate Change. December 2018.

104. The impact of climate change is likely to be felt more strongly by those who are on low income or socially disadvantaged. There is international evidence 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. For example the WHO COP24 Special Report[ibid] says:

> "It is widely recognized that, while everyone will be affected by climate change, the poorest and most vulnerable populations will suffer the greatest health impacts."

105. Further, a report from the Joseph Rowntree Foundation[27] on climate change and social justice says:

> "Factors causing vulnerability to direct climate change impacts are at their most acute among particular groups, typically the elderly, lower income groups and tenants. For example, older people are at most risk of extremes of heat and cold. Socio-economic and geographical factors also interact to create spatial distributions of vulnerability. For example, lower income groups are disproportionately impacted by coastal flooding by virtue of living in poorer quality housing in coastal locations."

106. SG supports the international agreement that urgent action is needed to limit global temperatures rises through the reduction in greenhouse gas emissions. It has declared a climate emergency and has proposed a target for net zero greenhouse emissions by 2045. This will involve transformational change across all sectors with associate social and economic opportunities, risks and challenges. An independent Just Transition Commission has been established to provide advice on how this transition can achieve social cohesion and equality.

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[27] Joseph Rowntree Foundation. Climate Change and Social Justice: an Evidence Review. February 2014

107. Action to improve environmental sustainability and achieve net zero emissions presents a significant opportunity to improve population health and reduce health inequalities across the Public Health Priorities for Scotland. We believe PHS should be integral to this transformational change. For example to achieve vibrant, healthy and safe places and communities we need to support the development of policies and actions that enable a 'triple win' of improved health and wellbeing, reduced health inequalities and improved environmental sustainability; and, we need to collaborate with colleagues working for a low carbon economy to ensure we maximise the opportunities for sustainable and healthy diets.

108. As a public body, PHS will be required to meet the duty outlined in the Climate change (Scotland) Act 2009 to contribute to climate change mitigation and adaptation, and to act sustainably. We believe that as part of meeting this duty PHS should also embed the principles of environmental sustainability in all its public health work. By doing this, PHS will play an essential role in securing policies that contribute to the 'triple win'.

109. PHS could also play a key role in supporting NHS Boards to meet the sustainability requirements of Realistic Medicine[28] and the National Clinical Strategy[29], both of which have implications for environmental sustainability.

110. In summary, we would welcome explicit reference to PHS's role around climate change and environmental sustainability, which could involve: evidence and support which PHS could provide to SG on the health and equity implications of policies to achieve net zero carbon; consideration of the implications for environmental sustainability of public health actions advocated by PHS; support to increase the resilience of health systems and populations to environmental change.

Public Health Priorities

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[28] Scottish Government. Practising Realistic Medicine: Chief Medical Officer for Scotland annual report. April 2018.
[29] Scottish Government. A National Clinical Strategy for Scotland. February 2016.

111.	We agree that providing support to and oversight of the delivery of the Public Health Priorities will be a key function of PHS, especially the development of "a support programme and toolkit for effective partnership approaches to improve and protect the public's health." [page 36, para. 4] It will be important for PHS to work closely with the Directors of Public Health in this regard.

112.	The type and level of support required will differ across the Public Health Priorities and across the system. We know from the aforementioned work[30] with the Scottish Health Promotion Managers, that the priority local health improvement teams feel least well-equipped to progress is the sustainable, inclusive economy priority.

113.	The Institute of Public Policy Research recently published the results of work they conducted on inclusive growth in Scotland on behalf of the Poverty and Inequality Commission.[31] The report does not mention public health reform nor the inclusive economy Public Health Priority, but it does state that they found:

> "… significant levels of confusion, particularly at the practitioner level, as to what inclusive growth looks like in practice and how best to deliver it. This reflected a broader difficulty in translating national ambitions into designing local interventions. Equally, there was not always a recognition that inclusive growth, by definition, requires a change in approach - not just for in specific policy areas, but for themselves, their organisations and across the breadth of government and beyond."

114.	It is our view that PHS could have a significant role in delivering inclusive growth in Scotland. This would include providing support for local partners but also working with national and UK stakeholders including SG and the Department for Work and Pensions around social security and advising the Office for the Chief Economic Adviser on the forms of economic activity which

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[30] Scottish Public Health Network. Local Health Improvement Teams – Current Landscape. December 2018.
[31] Institute of Public Policy Research. Delivering Inclusive Growth in Scotland. June 2019.

are more and less likely to contribute to inclusivity, sustainability, health and health equity.

Question 9: (a) What are your views on the health protection functions to be delivered by Public Health Scotland?

115. We agree that "in establishing Public Health Scotland it is important current protections are not compromised." [page 38, para.1] and that "Future health protection effectiveness will depend on how well Public Health Scotland links with the many key stakeholders in health protection." [page 39, para. 6]

116. We support the clear resonance with the Protecting Health Commission's themes of leadership, connectedness and innovation, which are common to other areas of work of the new body and Health Protection's commitment to reach across the whole organisation and the whole public health system to make a positive impact.

117. We are pleased to see the Scottish Health Protection Network (SHPN) highlighted as "a model for the cross-system collaboration that Public Health Scotland will seek to support and promote more generally." [page 39, para. 7] We a member of the SHPN and we have found the multi-disciplinary and cross-sectoral nature of the network to be highly beneficial.

(b) What more could be done to strengthen the health protection functions?

118. By bringing health protection and fairer health improvement together in one agency, together with healthcare public health, there will be great potential in PHS for strengthening the links between health protection, and action on the social and environmental determinants of health and health inequalities.

Question 10: (a) Would new senior executive leadership roles be appropriate for the structure of Public Health Scotland and, (b) If so, what should they be?

119.   We support the PHR Programme's Board's ratification of the senior management arrangements laid out in the TOM and the approach to filling these posts recommended by the HR Steering Group.

Question 11: What other suggestions do you have for the organisational structure for Public Health Scotland to allow it to fulfil its functions as noted in chapter 6?

120.   We support the outline organisational arrangements set out in the Target Operating Model and welcome the ongoing involvement that we have had through the recent desktop exercises and now through the shadow Executive Management Team.

Question 12: What are your views on the proposed location for the staff and for the headquarters of Public Health Scotland?

121.   We support the decision that on vesting day "the majority of staff will be based in current accommodation (predominately Gyle Square in Edinburgh and Meridian Court in Glasgow)." [page 41, para.8]

122.   We agree that "Details such as the location for the headquarters for Public Health Scotland and location of staff" should be "determined as part of the establishment of the body." [page 41, para. 8]

123. We strongly support consideration being given to extending PHS's reach across the country through where staff are based. From all our work with stakeholders, the ability to "host(ing) staff as appropriate to their remit and local needs and circumstances"[page 41, para. 9] will be a very important feature of PHS's ability to be effective across the whole system and we are keen to ensure that the organisation is set up to fully enable these aspirations.

124. We have been closely involved with the Accommodation Project and would like to highlight aspects of PHS's office base that go beyond issues of location. The look and feel of the new body's offices, including branding and location of staff teams within the building, can be impactful in helping staff feel part of a new organisation, despite their office base not changing.   We support the suggestion made by the Accommodation Project that staff in the legacy bodies should be encouraged to work from areas within the offices that were historically occupied by one of the other legacy bodies. We would like to see this happening prior to vesting day.

Question 13:   Are the professional areas noted in the list above appropriate to allow the Board of Public Health Scotland to fulfil its functions?

125. We agree that these are important skills and experiences to have on a Board. We especially welcome the commitment to:

> "… try to build human rights into the governance structure of the organisation, by recruiting lived experience and expertise on human rights onto the Board. [page 43, para. 4]

126. We are thoughtful about what kind of lived experience should be prioritised for recruitment onto the board. There is a wide range of potential lived experiences that would be relevant to the board. This includes people with experience of relying on foodbanks, people experiencing fuel poverty, people

living in unsuitable housing, and people experiencing barriers to health and social care. We suggest that one approach could be to focus on the right to an adequate standard of living quite broadly. Having people with lived experience of poverty on the board of PHS could help maintain a focus on the biggest public health challenge of our generation – the aforementioned stall in life expectancy [see para. 2].

127.   We would also suggest that it would be beneficial to add "change and transition experience/knowledge" to the list of skills because we know from the Target Operating Model that PHS will continue to change and develop as an organisation into at least its third year of operation. Further, given the significance of data and intelligence to the work of PHS, it might be helpful to add "strategic information and data analysis" to the list.

128.   Further, we suggest that it will be helpful for the PHS Board skills, experience and diversity matrix to pull out the most important areas required. We are mindful of recent observations and learning from John Sturrock in his report to into Cultural Issues related to allegations of Bullying and Harassment in NHS Highland[32] that states that the recruitment of non-executives should be based on their skills and abilities to do the job of governance rather than their specific knowledge of sectors and interests. The NHS Health Scotland Board have developed over the last four years to strengthen generic governance amongst all Board members and we believe this is the foundation of well-functioning Board.

129.   We would recommend connecting the values and principles PHS would also expect to see in Board members conduct and behaviours. Our view is that it will be important to include The Principles of Public Life in Scotland (Duty, Selflessness, Integrity, Objectivity, Accountability and Stewardship, Openness, Honesty, Leadership, and Respect).[33] Please also see paragraph 135 below.

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[32] John Sturrock QC. Report to the Cabinet Secretary for Health and Sport into Cultural Issues related to allegations of Bullying and Harassment in NHS Highland. April 2019.
[33] Scottish Government. Model Code of Conduct for Members of Devolved Public Bodies. February 2014.

Question 14: What are your views on the size and make-up of the Board?

130. We agree with the proposal that a Board functions best with relatively small numbers. We suggest that the Board quorum for NHS Boards would apply to PHS as specified in legislation and would therefore be deemed to meet only when there are present, and entitled to vote, a quorum of at least one third of the whole number of members, including at least two members who are not employees of the Board. Consistent with NHS Board practice, it is the explicit expectation that all Board members will attend all Board and Committee meetings of which they are members, unless there are exceptional circumstances.

131. We suggest that the number of Board members should be based on serving the Board and the four Committees (Audit/finance and risk; Staff Governance, Remuneration and Clinical/Health/Information Governance) with some flexibility, should in due course the PHS Board decide to delegate authority to an additional Committee for example connecting Community Planning or citizen involvement.

132. Based on the above the numbers we suggest are nine non-executive Board members including Chair, Vice-Chair and Employee Director and three Executive Board members including CEO, Director of Partnership, Engagement & Corporate Services and Director of Public Health/Medical Director.

133. In terms of make-up, our view is that the UK Code of Corporate Governance[34], On Board[35], the Code of Practice for Ministerial Appointments to Public Bodies in Scotland[36] and benchmarking with Boards and joint Boards provides clarity

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[34] Financial Reporting Council. The UK Corporate Governance Code. July 2018.
[35] Scottish Government. On Board: a guide for members of statutory boards. March 2017.
[36] Commissioner for Ethical Standards in Public Life in Scotland. Code of Practice for Ministerial Appointments to Public Bodies in Scotland. October 2013.

that a well-functioning Board relies on excellent Board room dynamics and a healthy mix of different skills, experiences, diversity and common values.

134.   Across Scotland, the NHS appointment of non-executive members is now conducted using a Values Based approach, using the values of NHS Scotland that were set out in Everyone Matters: 2020 Workforce Vision.[37] Our view is that this is a "work in progress" approach and there remain some questions as to whether this approach is successfully measuring the values sought. It is our suggestion that if a values-based approach is used for non-executive recruitment then these values are based not only on NHS values, but the wider values of the Public Sector in Scotland as per the values set out in the National Performance Framework:[38]

>   "We are a society which treats all our people with kindness, respects the rule of the law, and acts in an open and transparent way".

135.   We also suggest that appointment process takes cognisance of the aforementioned values developed with staff through the Organisational Development Commission and set out in the Target Operating Model[39] (collaboration, integrity, respect, innovation and excellence). These values align well with the The Principles of Public Life in Scotland (see para. 129 above).

136.   In our view, the creation of the new PHS Board is a unique opportunity to optimise the non-executive recruitment and appointment process and this should be taken forward against an agreed matrix for the "skills, experience, values set and diversity" the Board requires to fulfil its duties and to meet legislative requirements, for example 50:50 by 2020.   We suggest that this would also enable the accountability required by SG and COSLA, in terms of their joint appointments and give scope for a good governance culture to develop. We strongly advise that this mix of non-executive Board members

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[37] Scottish Government. Everyone Matters: 2020 Workforce Vision. June 2013.
[38] https://nationalperformance.gov.scot/
[39] Scottish Government. Target Operating Model for Public Health Scotland 2.0. May 2019.

should include some non-executive Board members who have previous experience of governing organisations and therefore provide scope for the PHS Chair to make a nomination to COSLA and the Cabinet Secretary for a Vice-Chair and for the Chair to select Committee Chair roles.   We suggest that alongside this it is helpful to bear in mind that it is possible to co-opt specialist skills and expertise to certain Committees, but these members would not have Board membership status and cannot form the quorate. This could include public health academics for instance.

137.   Our recommendation is that the make-up of the Board should include non-executive "independent members" and "executive" employee board members. The number of Board members should be sufficient to govern the business of the Board and ensure that there are adequate non-executive Board members for the Board Committees to be quorate. Board Committees should be made up of non-executive members who on behalf of the Board fulfil the agreed holding to account of executives and that processes provide the necessary governance assurance.

138.   Our view is that the PHS Board should follow the Scottish Public Finance Manual.[40] The 2018 Audit Handbook advises that Audit Committee should comprise of at least three non-executive members, with at least one non-executive member having recent and relevant financial experience. It is therefore our recommendation that this requirement should be incorporated into the "make-up" of the PHS Board and reflected in the skills, experience and diversity matrix.

139.   Our recommendation is that PHS will require a Remuneration Committee. The UK Code of Corporate Governance states that the Board should establish a Remuneration Committee of independent non-executive directors, with a minimum membership of three, or in the case of smaller companies, two. In addition, the Chair of the Board can only be a member if they were independent on appointment and cannot Chair the Committee.   Before appointment as

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[40] https://www.gov.scot/publications/scottish-public-finance-manual/

Chair of the Remuneration Committee, the appointee should have served on a Remuneration Committee for at least 12 months. Staff Governance Standard as outlined here advises that the Employee Director should be a member of Remuneration Committee and that there is a direct relationship between the Remuneration Committee and the Staff Governance Committee. It is therefore our recommendation that this standard should be considered alongside the make-up of the Board and in the creation and population of the Board, skills, experience and diversity matrix document.

140. NHS Boards also have a Clinical Governance function and NHS Health Scotland have adapted this to govern the health inequalities function using a Health Governance Committee. Our suggestion is that the PHS Board will need to determine if a combined Committee will receive assurance for health inequalities, data and intelligence work and health protection. We suggest that it will be necessary to understand how the organisational duty of candour provisions of the Health (Tobacco, Nicotine etc. & Care) (Scotland) Act 2016 and The Duty of Candour (Scotland) Regulations 2018 will apply. We therefore believe that there are implications for the governance of this Committee that relate to the "make-up" of the Board and connect to the Board skills, experience and diversity matrix.

b) How should this reflect the commitment to shared leadership and accountability to Scottish Ministers and COSLA?

141. We agree that the makeup of the board should reflect the commitment to shared leadership and accountability to Scottish Ministers and COSLA. We recommend that this should be through an equal appointment process.

142. The appointment process should be overseen jointly by SG and COSLA and be in line with the standards set by the Commissioner for Ethical Standards in Public Life in Scotland. This would embed the values and principles of Public

Health Reform at the core of the PHS Board in terms of equality, fairness and human rights.

143. There are secondary legislation requirements relevant to NHS Boards which relate to the Staff Governance Standard introduced by the NHS Reform (Scotland) Act 2004. This includes the requirement for NHS Boards to include a nomination of a staff side Employee Director as a non-executive Board member on all NHS Boards. We suggest that this will be an important component of the PHS governance, as all of the staff employed by the Board will be on NHS employment contracts and further it brings with it standards and approaches that if applied appropriately serve to ensure that staff are well informed; appropriately trained and developed; involved in decisions; treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

144. It may be that other parts of the system seek to nominate onto the PHS Board as per the intention outlined in the consultation document for COSLA to nominate one or more elected members. Our caution is that this process can significantly skew the Board room dynamics required for a successful well-functioning Board and can lead to Board members representing single views as opposed to the rounded governance approach a successful Board requires. This issue was highlighted in the aforementioned Sturrock report into Cultural Issues related to allegations of Bullying and Harassment in NHS Highland, which outlines caution in diluting the role of Board members with for example political appointments and the subsequent changed dynamic of the Board. He also highlights that large Boards seeking to accommodate many interests comes at a cost to Board effectiveness. Our recommendation is that nominations to the PHS should be kept to the minimum of the staff nominated Employee Director.

Question 15: What are your views on the arrangements for data science and innovation?

145. We support the innovative use of "Digital technology and data …to help plan and improve public health services; enable research and development; and ultimately improve public health and wellbeing outcomes." [page 45, para. 4] We believe that the arrangements for data science and innovation should focus on using data as a vehicle to inform strategic decisions.

146. An example of an existing tool that does just that is our Informing Interventions to reduce health Inequalities[41] (Triple I) tool. Using the best data available, Triple I estimates and compares the potential impact of different policies and interventions that can affect health and health inequalities in Scotland. This helps decision makers work out which actions will have the biggest impact on population health and health inequalities, before implementation.

147. We have reservations around the use of technology "to enable people to make better decisions about their health and wellbeing." [page 45, para. 1] Delivering health information through digital technology is still, fundamentally, the delivery of health information. As stated in Equally Well:[42]

    "Information-based approaches (such as health information campaigns) tend not to influence the most disadvantaged groups and individuals, who often find it harder to change behaviour."

148. Information-based approaches to health improvement therefore run the risk of increasing health inequalities. Furthermore, as set out in the Health Inequalities Policy Review:

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[41] http://www.healthscotland.scot/reducing-health-inequalities/take-cost-effective-action/informing-interventions-to-reduce-health-inequalities-triple-i/overview-of-triple-i
[42] Scottish Government. Equally Well: Report of the Ministerial Task Force on Health Inequalities. June 2008.

"A sizable minority of the Scottish population does not have home internet access, with many not using the internet at all. Those on lower incomes, not in work, with a disability or long-term illness and/or living in the most deprived areas are the least likely to have access or to use the internet. The potential exclusion of such groups through new interventions that use digital media to deliver information, advice, services and benefits may increase health inequalities rather than reduce them."

149.   We therefore suggest that data science and innovation can be most impactful by focusing on providing decision makers and policy makers with the evidence they need to tackle the social, economic and environmental determinants of health and wellbeing.

Question 16: What are your views on the arrangements in support of the transition process?

150.   As one of the existing bodies that will transfer to PHS, NHS Health Scotland has been – and continues to be – closely involved in the arrangements in support of the transition process.

151.   One of our key change and transition priorities is effective staff engagement and communications. It continues to be vitally important to us that adherence to the NHS Staff Governance Standards of staff being 'well informed' and 'involved in decisions' is consistent and robust. We are therefore working closely with colleagues in NHS National Services Scotland, and with SG, to ensure that our staff engagement and communications are as timely and joined up as possible.

152.   We know from staff feedback that one of the priorities of our staff is knowing what is happening and when. For this reason, although we understand that dates for key decisions being made and key actions taken are dependent on a

range of factors, a centrally held and updated timetable of at least indicative dates would be helpful for staff.

153. We are delighted to have been so closely involved in the range of projects and commissions and in the development of the Target Operating Model for PHS. We support the pragmatic approach being taken to day one readiness, as long as day one forms the strongest possible basis from which PHS can continue to develop its offer to partners and contribution to the wider system from day one and beyond.

Question 17: (a) What impact on equalities do you think the proposals outlined in this paper may have on different sectors of the population and the staff of Public Health Scotland?

154. Supporting the public health system to reduce inequalities in the social determinants of health and in the fundamental causes of health inequalities – inequalities in the distribution of income, wealth and power – will be a crucial part of PHS's work. Therefore the proposals outlined in the paper should by their very nature have a positive impact on equalities.

155. Further, as a public body, PHS will be subject to the legal duties stemming from the Equality Act 2010, including the Public Sector Equality Duty and the Fairer Scotland Duty. Therefore PHS will actively consider the need to eliminate discrimination, advance equality of opportunities, foster good relations and reduce inequalities of outcome caused by socio-economic disadvantage in planning and decision making.

156. The proposals should also have a positive impact on equality considerations relevant to staff. Both NHS Health Scotland and PHI have achieved accredited standards in a number of areas that support staff wellbeing and equality such as the Gold Healthy Working Lives Award, the Two Ticks Positive About

Disabled People symbol and Living Wage Accreditation and we look forward to these being maintained and celebrated by PHS.

157.   The Public Health Review[43] highlighted equality issues for staff working in public health that PHS will need to be particularly cognisant of:

> "The multi-disciplinary nature of public health raises equality issues also. Despite the progress made to date with support for multidisciplinary public health, there are still historical barriers in Scotland relating to appointments, and to equal pay and performance structures for specialists from a non-medical background. During the review the Specialist Group in Scotland argued for a more systematic and equitable structure for career development that links across disciplines, and practitioner and specialist career pathways. It argued that this evolution would better utilise the existing resource, create standardised practice and strengthen succession planning." [para. 130]

158.   We would like to see these issues surfaced and dealt with in such a way that the new agency does not reinforce inequality in pay structures, and also that the matter of gender equality in pay in general is given due attention as the organisation is created.

(b) If applicable, what mitigating action should be taken?

159.   The PHR HR Steering Group could examine the issue of inequality in pay for specialists from a non-medical background and make recommendations to the shadow Executive Management Team.

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[43] Scottish Government. 2015 Review of Public Health in Scotland: Strengthening the Function and re-focusing action for a healthier Scotland. February 2016.

Question 18: What are your views regarding the impact that the proposals in this paper may have on the important contribution to be made by businesses and the third sector?

160. PHS will work to support the whole public health system in Scotland and as set out in the Target Operating Model, this includes:

- Employers, who are responsible for the health and safety of their employees and able to provide them with good work
- Business and industry, which influences health by providing products, services and information to the public
- Community and voluntary sector, which provides services to the public, supports the development of communities and advocates on specific public health issues

161. The proposals in the paper should therefore have a positive impact on the important contribution to be made by businesses and the third sector.

162. With regards to employers and businesses specifically, the services currently delivered by NHS Health Scotland's Health and Work Directorate, will provide an excellent base on which to grow further support for employers and businesses across the three domains of public health.

163. With regards the third sector, in addition to the support PHS will provide the third sector as a key component of the public health system, we also believe that PHS will be able to learn a lot from the third sector and will be supported by the third sector in the realisation of its ambitions.

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