PUBLIC HEALTH REVIEW

This response is on behalf of NHS Health Scotland. We set out below an introduction, followed by detailed answers to the 6 questions.

**Introduction**

The Public Health Review seeks answers from the public health community to questions on its function. NHS Health Scotland believes that that the best starting point is to form a view about what public health wants to achieve, what resources are available to achieve these outcomes, and then the type and distribution of skills and competencies needed to deliver them.

We believe that a Public Health Strategy for Scotland is necessary. In our view the vision for this Strategy should be to tackle health inequalities, and protect and promote the health of the population. The Strategy should explore the factors that promote and create health and tackle health inequalities. The Strategy would, we believe, emphasise that public health is not just about what happens in the health sector but also requires understanding, influence and leadership across other areas of civic engagement.

In terms of delivery there needs to be a clear, co-ordinated framework and more collaborative working. The role of an organised and effective resource to ensure knowledge is put into action is one of the most important and distinct core functions of public health.

Delivery of a Public Health Strategy for Scotland will require a national resource that supports local delivery in an effective and efficient way. NHS Health Scotland is well placed to take that role to tackle health inequalities and ensure health improvement.

Work is under way nationally to progress opportunities for shared services and public health has specifically been identified for consideration. It will be important that recommendations emerging from that workstream and from the Public Health Review are considered together. Some public health functions can obviously be done “once for Scotland” and some clearly cannot. Careful thought will be required in achieving the correct balance.

Answers to the questions posed in the engagement document follow.

1.How can public health in Scotland best contribute to the challenges discussed?

We believe that the central contribution of public health in Scotland should be to promote the factors that create and protect health and enable action that will tackle both the causes and effects of inequality on people’s health. This should be done through the creation of national and local alliances with clear strategic aims and accountability to improve health, inequalities and its determinants.

We believe that a Public Health Strategy for Scotland is necessary to engender a cohesive and coherent approach across Scotland.

Health Scotland is a national NHS Board working with and through the public, private and third sector to reduce health inequalities and improve the health of people living in Scotland. It works across sectors to translate knowledge into action on what works to reduce health inequalities and improve health.

NHS Health Scotland has linkages and special interests that span the NHS, other public health domains, and many national-level partnerships including –

* in Equalities,
* in association with all Health Boards;
* hosting the Scottish Public Health Network (ScotPHN) that leads and supports national, regional and local Public Health networks, collaborations and professional groups working across all domains of public health practice;
* leading and co-ordinating country-wide health at work services;
* a range of awards systems;
* jointly leading the Public Health Observatory (PHO) which is a multi-agency collaboration that is central to public health intelligence.

2.Specifically, what is your view and evidence of the Strengths, Weaknesses, Opportunities and Threats (SWOT) to the contribution of the public health function in improving Scotland’s health and reducing inequalities?

The engagement document has defined the nature of public health, the public health function and its domains. It has also given an overview of the challenges facing Scotland now and in the future. In addition to the challenges described, there is wide acceptance that the presence of inequality in Scottish society is the most significant challenge to the people of Scotland. Inequalities in the distribution of income, resources and power across the population and between groups results in damage to people’s health and wellbeing, and places a huge burden on families, communities and public services.

This response will focus on the challenge of creating the best conditions in which Scotland can tackle health inequalities and improve health effectively, recognising that the endeavour is complex, that Health Scotland is the national organisation with prime responsibilities in this area, and that relationships and links that seek to work through other organisations at all levels are fundamental to progress. Health Scotland’s aims are contained within its strategy *A Fairer Healthier Scotland* as agreed with Scottish Government and endorsed by the Director General and Ministers. They are fully in line with the Scottish Government’s overall aims, the ambitions contained within the National Performance Framework, and the Single Outcome Agreements on health inequalities, and physical activity.

It is clear that inequalities in society do not only result in health inequalities – inequalities in educational outcomes, and other social outcomes are also apparent. Strengthening the health system alone will therefore not have the impact on public health that is needed – public health needs to inform and influence system wide action to tackle the fundamental causes; the environmental influences and to mitigate against the individual experience of inequality.

A public health function that contributes to the development of a fairer society is ultimately what is required.

Our view and evidence of the Strengths, Weaknesses, Opportunities and Threats (SWOT) is as follows:

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| **Strengths**  Scotland is a comparatively small country with close networks and inter-linkage – a number of the conditions where change and improvement is possible.  The Government programme of work has a strong focus on social justice, equality and human rights  The national performance framework provides a robust set of national outcomes for all public sector agencies to plan and review their performance; these include outcomes relating to population health improvement and inequalities in Scottish society.  The strategic focus on inequalities is a key national theme; health inequalities is a core public health theme.  Scotland has recently been atest bed for innovative policy and has earned an enhanced reputation for following the evidence to take effective measures nationally (for instance, the smoking ban, Minimum Unit Pricing of alcohol, measures to support children in their early years , etc)  In the wider realm of Scottish Public Health, there is a skilled multi-disciplinary workforce and substantial capability, considerable overall capacity and expertise.  Scotland has a highly developed and productive public health academic environment with good agency collaborations and international links. Health Scotland has a portfolio of published work for which it is well known.  Data sets are good-to-very good, and are amongst the important strategic assets on which to improve a public health system.  NHS Health Scotland has developed a model of ‘once for Scotland’ efficiency and effectiveness in its realm of public health nationally, is the home for a spectrum of subject and technical expertise, and is developing its role as a knowledge broker. | **Weaknesses**  The public sector environment is very complex and there is declining leverage and methods of influence in the health sector.  There is a crowded performance monitoring and management environment; short term goals and targets occlude and can conflict with strategic goals.  The NHS and Local Government have different performance management systems and accountabilities-collaborative approaches to improved performance are therefore difficult to achieve.  Across both these systems, reducing health inequalities and improving health has not been core to the accountability of the most senior leaders.  There is evidence of fragmentation, small scale intervention with limited impact, and not always productive networks and relationships. Cross sectoral working and the perceived NHS focus of public health creates tensions and misunderstandings of different roles and responsibilities.  The range of immediate priorities limits sufficient resources to focus on tackling the most important tasks effectively, and to achieving the most important outcomes.  Public health has been restricted in its range of influence. It needs now to support decision-makers well beyond the health sector to improve health and reduce inequalities – exemplified by the work with national Government and Community Planning Partnerships(CPPs).  There is variability in the approach to knowledge influencing strategy, transmission into practical action, and the ability to show results. CPPs are the main vehicle for local partnerships - their establishment is currently virtual, and performance is variable. With the lack of a single strategic vision, there is wide local variability in implementation and evaluation of effective interventions.  Ways of developing the workforce are constrained and do not necessarily reflect modern requirements and diverse positive contributions across sectors and disciplines. There is limited general understanding of the different elements of the public health workforce and what each can offer. |
| **Opportunities**  In Scotland currently, there is a supportive policy environment, with emerging partnerships and new supporting legislation that will create a positive environment. As much as possible, there is focus on longer-term priorities. Prevention is a priority.  Establishment of a national shared service for reducing health inequalities and improving health ( focusing on social determinants as opposed to biomedical factors)could offer a step change in measures to tackle inequalities effectively.  Clear delineation of public health functions that make sense to be situated within the NHS and which have a locus within clinical services - (for example health service planning and care quality) - from functions focused on prevention and protection of the social and environmental influences on health. These functions should be seen as a shared service for local government, the public and third sectors. A National Inequalities Unit or collaboration could emerge as an engine for reform and delivery.  There is an appetite through public sector reform, to simplify performance management, with fewer targets that reflect strategic aims, and with the potential for accountability for public health across local government and the NHS  NHS and Local Gvt CEOs could have one shared performance target e.g, to reduce poverty or a small set of locality-based performance indicators for inequalities overall, Child poverty, Homelessness, Living wage Employment, Child care.  There is the potential for greater focus on evidence-informed policy-making - supporting decision-makers at national and local level to: identify the important problems; use evidence appropriately to implement policy and practice; ensure experimentation/research/evaluation is used where there is uncertainty about whether a policy or practice works; and support implementation including the appropriate use of improvement science.  Evidence for action, and the will to act, is steadily accumulating and improving. One specific opportunity is investment to integrate data systems to inform, study and monitor important challenges in public health. Building on the work of ScotPHN, there is a clear opportunity to develop further its model of collaborative public health delivery on a “once for Scotland” basis, linking directly into local Public Health action. | **Threats**  Fragmentation of effort;  Duplication and repetition of effort that has been shown not to work  Over-simplification of the task, and the context in which individuals and communities can take the necessary measures to transform health and its determinants. The work is complex, requires many simultaneous actions, and suffers frequently from approaches of key informants and influences.  If all of the public health function remains closely identified with the NHS there will be reduced ‘ownership’ or engagement from Local Government or Third Sector.  Public finances are tightening – although this could also be seen as an opportunity to address duplication and fragmentation.  There are still pressing priorities to tackle immediate matters, not least in the health sector. Short-term priorities overwhelm long-term and more important work.  Public health leaders differ, are not sufficiently of one mind over how to achieve change, creating confusion and losing power and influence. Incoherent evidence provided to politicians and civil servants can create mixed messages and diffusion of effort and political will.  Evidence for precise intervention is imperfect. Measuring impact is challenging.  There are risks of a small country and communities of interest without the will to learn outside their boundaries.  There is a fine balance between public support and media-encouraged scepticism and opposition. |

3. How can public health leadership in Scotland be developed to deliver maximum impact?

Leadership in this context could be defined as all those who hold core or specialist roles; however it could better be defined to encompass people, groups, organisations that have a contribution to make to influencing Public Health in Scotland positively.

Public health needs to be seen as a shared responsibility for leaders in the public sector. Leadership should therefore not be defined in narrow ‘professional’ terms but more in terms of what leaders can do. As described earlier accountability for public health should span boundaries and professional disciplines – ultimately, it sits with political leaders, Chief Executives of organisations in the public sector, decision makers and advisers, within a simplified performance management system. For leaders with core or specialist public health roles, the key task is to shape and influence others effectively on issues that span many sectors – the role of a public health leader is to understand the issue and its context, promote other people’s understanding, to influence change by influencing decision makers and influencing practice.

Our call for clear national strategy would make the task more straightforward, whilst accepting the complex tasks that are necessary, and inter-relationships of organisations and stakeholders.

Currently, a spectrum of individuals and organisations share leadership for many agendas. A smaller group who have clear and shared accountabilities should emerge, with others supporting in a variety of capacities.

Leadership should be better aligned and consistent within a clear framework, organised, connected internally and externally, quality assured and accountable.

* **Aligned and consistent** – aligned with the people and the levers that influence the determinants of public health, specifically health inequalities and social justice; and aligned through forming behind a clear strategy that assigns roles and responsibilities to local and national levels.
* **Organised** – the public health endeavour requires recognised and clearly delineated local and national responsibilities, consistent and clear lines of authority, messaging, and accountability but within a positive spirit of collaboration; sharing common problems and problem-solving; and also sharing common good practice and applying it. Within a substantial national and local resource, there should be an efficient, well managed ‘once for Scotland’ arrangement where this is justifiable.
* **Connected internally** – there should be real and constructive engagement between organisations with public health roles and responsibilities, sharing out the work, with outcome-orientated facilitated problem solving. There should be recognition and respect for roles for heads of functions, voluntary organisations; assigned national responsibilities to local experts and leaders, and assigned spokesperson roles.
* **Connected externally** – there should be a strategic approach to good linkages with partners and stakeholders; erosion of competition and encouragement to collaborate and share endeavour. There must be more respect and encouragement for the contribution of other leaders and influencers.
* **Quality Assured:** Leaders will need to be confident that planners and managers are able to access specialist support to utilise public health information and evidence and this support should be available to each locality- the leadership for the development and continuous improvement of this specialist function should sit at a national level and be a shared service for public, third and employment sector organisations.
* Impact and leadership needs a clear framework of **accountability**, setting out roles and responsibilities of key stakeholders. National and local government accountabilities need to be reconciled with professional and individual duties to be impartial and independent of view, based on evidence and context, as well as recognition of codes that enshrine freedom and responsibility to advise with independence.

Fundamental to future success will be continued investment in collaborative leadership measures. A sustainable future relies on tomorrow’s leaders and decision makers building trust and confidence in each other now, for local and national roles alike.

NHS Health Scotland is well placed to fulfil a national leadership role and to contribute to the development of a Public Health Strategy for Scotland in alliance both with other public health organisations and those organisations able to take action to address the social determinants of health.

4. How do we strengthen and support partnerships to tackle the challenges and add greater value? How do we support the wider public health workforce within those partnerships to continue to develop and sustain their public health roles?

The task of achieving public health aims is complex. A range of partnership endeavours is essential in the task of making progress. One of the distinct qualities of public health practice is skill and investment in partnership, recognising that working through others will create the opportunities and the environment in which change and implementation can happen.

There is an extensive literature on the nature of effective partnerships, and applying that knowledge in each instance and context is a founding principle. With respect to health inequalities and health improvement, each partner in a partnership must appreciate that reducing health inequalities and improving public health should be at the heart of planning and delivery processes across all sectors. In order for that to occur, partners need to know and understand what creates health and what damages it. They need to know what works and what doesn’t. Each organisation needs to appreciate what it can achieve for public health, and its commitment should be clear through forming strategy, planning and ensuring implementation of practical measures.

As described in the SWOT analysis a collaborative approach to performance management would be helpful with high level accountability for a concise set of outcomes.

Health Scotland has a reputation for creating links with key organisations and networks, and its reputation is strengthening on national level partnerships, in the spirit of the Christie Commission report and with focus on outcomes and delivery and the importance of recognising existing assets within communities which do or can contribute to improved health and wellbeing.

We recognise the importance of maintaining the ability to reach up to national and reach down to local, encourage bottom-up community-led endeavors to meet top-down. Our ambition is to arm people locally to make best use of available knowledge, information, evidence, knowledge brokering as part of the skill set that PH in partnerships brings, and key skills. Having a Public Health Strategy shared by all agencies in Scotland would help.

Challenges ahead include ways to relate effectively to key public and voluntary sector institutions to achieve and inspire results jointly. There are distinct issues for each public health domain, addressing the challenges of health protection as distinct from improvement and inequalities.

In addition it would help to be clear about those elements that sit comfortably within the NHS and those that would sit better in an arrangement that works on behalf of the whole system and focuses on the wider social determinants of health. There are several possible forms:

* Making best use of the current structures, maximizing their strengths with minimal changes
* Aligning public health functions in more closely integrated and related national arrangements whilst remaining in the health sector
* Aligning social justice support functions more closely across sectors, with a distinct but integrated health inequalities and health development contribution to a shared service, less closely aligned with health sector functions.

We believe that a shared service approach may have merits in seeking to achieve greater and improved partnership approaches to support this domain of public health, set within a national strategy or framework. This set of options, not least the accountability and governance of such arrangements, need further consideration. Collaborations across sectors are, meantime, productive and already in place in specific areas – e.g. the Public Health Observatory and ScotPHN, and they circumvent practical and inter-sector hurdles through reaching across structures rather than demanding change. However, voluntary arrangements that rely on lending resource are more challenging to operate, especially as resources decline in individual organisations that host people with public health skills.

Beyond public services, the development of collaborative approaches and partnerships with the private sector such as with employers in relation to health in the work setting or with food and catering outlets through the Healthy Living Award, provides important opportunities to extend the sphere of public health influence into every community in Scotland.

Turning to the second question within this section - How do we support the wider public health workforce within those partnerships to continue to develop and sustain their public health roles?

Across the domains of public health, Health Scotland is keenly aware of the role of the wider workforce and the value of its contribution. Support needs to be in several forms, depending on its purpose.

Support might involve professional support; education and training; knowledge services and resources for decision-making; or finding ways to prioritise work that has a public health outcome focus. One issue of increasing importance is the use of knowledge into action approaches to influence changes in practice in all areas of activity.

All the wider workforce have important work to achieve and might be best supported by ensuring that their work is evidence informed, following policy and practice which is most likely to be successful, and where priority is given to the most impactful activities. NHS Health Scotland has substantial capability devoted to supporting and developing the wider workforce, across sectors, and is committed to further these efforts towards continuous improvement.

5. What would help to maintain a core/specialist public health resource that works effectively, is well co-ordinated and resilient?

Public health faces a variety of challenges across the domains. The question poses issues about three contrasting qualities of the resource. Our focus in this contribution will be on health inequalities and health improvement, but with reference to the whole public health endeavour.

The first step would be to look at options across the domains of public health, both functional and geographic. If the key challenge (certainly in Health Scotland’s domain) is health inequalities, then we need to (re-)define the vision and challenge, gain consensus and shape change in the most effective way.

**Effective** - Whilst focus and delivering results are key, the challenge of achieving gains in health equity requires breadth, experience and skills. Public health domains range widely, and there are both pro-active, creative, strategic services to deliver, and reactive, response services too. Some functions are common; others are distinct. The specialist and practitioner resource is filled with people and teams that have real potential and ambition, coming from a wider range of backgrounds that are currently accepted. We need to recognise that evolution and diversity, coming together as an integrated professional workforce.

Well supported leadership should encompass programmes for succession to senior and influential positions - see section 5. Such leadership needs to span a range from the highest level political skill to influence long term change; it needs to extend far beyond a medical model of public health; it needs to understand, lead and inspire long term and multi sectoral system change locally and nationally. There should a check and challenge for representativeness of leaders for the functions and programmes they lead.

Role clarity is essential – for levels of the function – to ensure quality, efficiency, sustainability. Health & Social Care Partnerships, Community Planning Partnerships and allied partnerships need to know what to expect from public health practitioners and specialists. There should be more formal continuous improvement processes, and resolution to the debate over registration of practitioners in public health roles.

‘Independence’ is a position of autonomy prized by health professionals – there should be clarity to its scope and implications – whether the main focus is on thought and advice within NHS agencies, within the context of services we need and can apply, but grounded in reality. The element of support and challenge needs to be finely and carefully balanced.

**Well co-ordinated** - Future arrangements may be of several shapes, as has been set out in outline in Section 3 – a strengthened national role within the NHS, encompassing all of the domains of public health and relating to local delivery within an agreed framework; another shape might be aligning Health Scotland with social justice-orientated organisations to establish a national unit to play its part through focus on health inequalities, recognising the social and economic determinants of health creation. This alignment would shift the balance from a health body that looks outwards to other sectors, to a specialist resource within a multi-sectoral body that has health-orientated capability. Whatever arrangement evolves, there is a need, for professional coherence and standards as well as the need for continued influence over effective NHS strategy and practice, for strong NHS links.

Building on existing collaborative and network systems to improve links within the specialist/core resource – including programme delivery by practitioners, such as with health improvement, nursing, AHPs, resources and groups with specialist skills such as intelligence.

There should be improved links and mutual respect between local with national – the health protection stocktake has been a difficult area that bears lessons, but there is a need also to examine the case for stronger and more consistent approaches on Inequalities, HTA, new medicines and service design that follows the evidence.

**Resilient** - Efficiency and consistency suggests that, for several functions, efforts should tend toward national, or certainly larger PH core resources with knowledge management links (academic, intelligence, knowledge into action capability). Resilience for public health incidents and sustained programmes requires critical mass and connectedness, with local resource that has clear purpose, sufficient profile and acceptance, and sufficient capacity for influence and change. At each level, there needs to be thought to sustaining delivery of a service on a planned and strategic pathway, and the ability to respond to incidents competently and over a sustained period.

While the focus of this engagement may be on the ‘core/specialist’ workforce, it must recognise and encourage the potential of the wider PH and public community.

The academic public community is, in our perception, a substantial resource with great potential. There are several units that demonstrate the utility of engagement of the academic community with service and other stakeholders – they include the Scottish Collaboration for Public Health Research and Policy (SCPHRP), the MRC Social and Public Health Sciences Unit hosted in the University of Glasgow, and the Glasgow Centre for Population Health (GCPH). There are many opportunities for engagement from several quarters, and much academic activity that exists to study and apply relevant topics - indeed, the knowledge into policy and practice chain. Newer universities with public policy, social policy and health interests are contributing to capacity and knowledge in the field of public health. Yet, the academic community relates only loosely within its own groups, and patchy in its relationships with the service community. This distance remains an area for early action. The benefits in education, training, evaluation and research, higher and post-specialist training and challenge would be important to underpin the effectiveness of the core resource – whilst it is instructive to reflect that the academic community are not perceived as part of that resource.

Finally, we note the very recent emergence of a programme of shared services that lists Public Health. In principle, we welcome the NHS Chairs’ and Chief Executives’ resolve to address this matter through a programme management approach, and will look forward to further developments with interest.

6. How can we provide opportunities for professional development and workforce succession planning for the core public health workforce?

There are several elements to answering this question. NHS Health Scotland hosts several leaders from a range of disciplines including education, devoting important resource to support and develop the public health workforce. It wishes to continue to do so, within a supportive framework and in partnership, with the following actions:

1. We should reaffirm established UK Faculty of Public Health and People in Public Health work on, and refreshment of, core competencies, at different levels. Part of this work would implicitly promote, recognise and respect the wider workforce, and contributions to public health from many sources. This endeavour still needs continual monitoring and updating.
2. In line with good practice, and health protection colleagues are already active in this area – we should reassess and refresh expectations, ambitions, training and opportunities – for individuals and functions, balancing the aspirations of people working in public health who come from all disciplines including established clinical backgrounds.
3. There should be more fluid movement of people wanting to develop careers outwith formal programmes, to become defined, general specialists, academics, and post-specialists for leadership positions – possibly in combined roles.
4. Development programmes need to take a wider approach to leadership across disciplines – more open to potential and less to conventions about background.
5. In line with trends in public service workforces, programmes should be shaped to encourage people who are part-time working, or have other work commitments that complement public health practice.
6. There should be more opportunity in association with Government – local and national – to grow, broaden careers and prepare to lead.
7. Public health needs NES support to develop people from diverse backgrounds in many respects, in partnership. Academic centres have a key role to play in developing the public health workforce, in education, training and research.
8. Any programme should be aligned with a broader and agreed strategy, for public health overall and with an integrated professional development plan, and with milestones that record and ensure progress. The health protection workforce has the best developed arrangements in this regard.