Question 2

2) What should be done nationally, regionally and locally and how should they join up?

The engagement responses indicated that more clarity is needed on what should be done where with greater coordination across the piece.

There needs to be agreement on where and when it is best to act e.g. locally, regionally or nationally. (Public health forums and networks, 14)

Many organisations input to public health in Scotland. This fragmentation can lead to a lack of coordination. (Research / academic, 100)

There is sometimes a disconnect between national agencies and the local public health workforce, creating some confusion amongst partners and a sense of lack of co-ordination across Scotland. (Partnership, 47)

Dundee Engagement Discussions/Answers to question 2

Name of facilitator	Question 2. What should be done nationally, regionally and locally and how should they join up?
Jim Cannon	• Public health pivotal to discussion taking place at community planning partnerships and IJBs • Opportunities versus capacity • Partnership agreements of what can be delivered together • Cascading specialist knowledge and skills • Training of the workforce – national strategy, local delivery • Challenging to split PH functions into local/regional/national. • Diminishing resource Develop relationship and trust with local community to improve outcomes. Difficult to split PH functions into local/regional and national. Health Intelligence is required regionally but also available locally for joint planning <u>Local</u> • Health improvement – locality planning, community planning, IJBs, DPH (council/joint? Both?) • Training/support to build capacity <u>Regional</u> • Training/support to build capacity • Planning in specialist resource • On-call 'hub' • Leadership at high level (Director, regional or national) <u>Regional/Local</u> Strengthen public health role. • Proactive approach to co-production • Training and education – skilling up NHS and local authority workforce • Networks <u>National</u> • Health intelligence analysis – national with local interpretation • Training (National standardisation) • Policy/Strategy (clear role and how implemented) • Youth health advisory panel (bottom up approach) • Registration – career progression Bringing it together – leadership, networks and health intelligence (form follows function) Need to bring Health Scotland and national agencies together in terms of a future model of delivering for PH – mapped – functions. How to achieve with no additional funds.

	• PHI – NSS: Health Scotland: NES • National data – need to break down locally – source? Need analysis resource – is that available locally in all areas? Should this be national? • Youth advisory panel – child health commissioner - young scot <u>Leadership</u> Distributed leadership model? Regional DPHMs supported by local teams or National supported by regional expertise. Importance of social media – national, regional and local. • Promoting health • NHS Scotland apprentice scheme Use of digital technology to engage and consult
Andrew Strong	1. What do we mean by different levels? Need to define • National – Scotland or UK? • Regional – HBs? Local authorities? Vast difference in specific HB populations' i.e. Glasgow compared to Orkney. Do we need to create this? • Local – how local? 2. Mixture of vertical approaches and operational level approaches needed. 3. Devolving to third sector requires adequately resourced e.g. welfare reform 4. Button up approach required – letting go and working with communities. • Activists/communities • Community Empowerment Bill • Control over resources at a local level – participatory budgeting – neighbourhood levels in some cases • Engagement process needs to be thought through well • Need to see some political examples of this – barriers… 5. Views from what kind of services people want, at what level and what process. 6. Need to match intent with policy • Resources • CHPs – varied role with PH • HSCPs and CPP - need aligned, resource flow, understanding why that does or doesn't happen. 7. Political process and priorities define a lot of this type of work • Resources • Power • Seeing particular issues are important • Persuasion of service manager

	8. PH needs to be attached to a structure – glue at local level 9. PH needs a strong voice to represent the issues that are being found at local levels to feed them up the chain for national decision makers i.e. welfare reform 10. Local structures around CPPs are weakly empowered • How we scale pilots up to show evidence of this • Community projects not funding path to sustainable support 11. Integration structures • National – SG • Regional – HSCP • Local – locality levels Centralist agenda – prevention/mitigation frameworks – out of crisis. 12. RCOP change fund. • Third sector • Localism – contributions • Big agencies …. – strong knowledge – RCOP/Health Improvement Funding/ Fairer Scotland Funding • Economies of scale – where are we learning from – these new HSPC pilots 13. Prevention needed but many already working at crisis point. 14. GPs • High community footprint • Only operate within terms of contract • Power of local health facilities but little power over them • Lerites programme/Healthy Living Centres 15. Lots of local action – but things need to be done at a local level. PH – means making sense at all levels 16. National/Local or Regional – depends on talk where decision/solution is.
Margaret Hannah	• PH is about the whole nation, not a specific thing • How do we consider everybody? How can we play a role? • Lots of areas of good practice but not systemic across Scotland • Need some over-arching goals that we can all play into e.g. ageing and inequalities • Taking good care of my health now has a long term benefit to society. Could this be incentivised? • Living longer costs society more – being healthier won't necessarily save money • Quality of life has intrinsic value; we're not changing our way of working to save money. This has a second order

	issue • Change is done locally, but actions need to be taken at all levels. All has to be in equal relationships, national level has potential to facilitate or obstruct this • Physical and mental health go together, changes won't happen without relationships working • People know what would be good for them but lack hope and motivation to change • Co-production is having professionals on tap not on top • No single solutions for PH, different skills and strategies for different 'waves' of PH • Whilst some aspects of structural determinants lie beyond local agencies, others aren't and we could be doing much more in this regard e.g. genuine co-production should be the default position • Engaging with communities is a long term task – relationships build over time, cost involved • How does a co-production work with our screening programmes? Inadvertently widened inequalities through them? If inequality had been default we would have designed them very differently • Start with what is important for communities and build from there • How acceptable is local variation? Will this create greater inequalities? Or is it celebrating diversity? • How can economic and social value co-exist? • Problems with communication and engagement can exclude others • A PH collective can be the outcome from dialogue with communities • People want to be useful – public sector can enable this • National, Regional and Local – dynamic system – walk in each other's shoes, look for commonalities, accept diversity and have empathy <u>National Level</u> • Set direction, not targets • Numbers need to be meaningful • Qualitative and quantitative • Set principles – lay the groundwork • Set standards Default for service design it has to work for those who find is hardest to access care

Edinburgh Engagement Discussions/Answers to question 2

Name of facilitator	Question 2. What should be done nationally, regionally and locally and how should they join up?
A Paterson	What should be done where? Multi-disciplinary teams • Issue might be cross purposes • Licencing boards example of differences in local areas Tactics/knowledge of pol, systems skills we need and whether better local or national. Think strategically about using resources. * Act at right time with regards to poling. Long term relationships between different skills/levels to influence. • Nutrition demonstrates issue of local/national co-ordination Scottish 'brands' of whiskey and Irn Bru e.g. com groups get power from national policy – drink pricing. Full write of local and nationally. Need lobbying expertise, now taught PH. • Political realism – power of GPs/ Drs etc. • Prioritising resources e.g. integration • Too many structures – need to get this message across • Things don't just happen because of laws • People talk to each other Difficulty of attributing efforts of PH. What do we do at local level? • Who is local focus? CPPs? Whole work force locally? (from nutritionists to community projects) • Sharing of info, have to have local buy in • Difficulties of accessing and navigating CPPs Needs to be CPP? Where everyone is, links to communities.
Sally Egan	1. National – Strategy, Leadership 2. Local – PH (Board Level) Delivery Board – chairman + CPPs + SUB Localities 3. Regional – What do we mean? Define. Could some PH functions be delivered at regional level? Less structure change – better integration and partnerships throughout networking. 1. Specifics – Dona to feed back and record 2. Resources at various levels – outputs/outcomes • Define function • No appetite for structural change • Less silo working at all levels • Will create resilience
Phil White	

	• Proposals need to recognise Scotland's relative size (what does 'regional' mean in this context?) • Definitions of national, regional, local? • Definite need to use skills more efficiently (if a literature review needs done – do it once!) • Need to support not just the titular Public Health workforce but the much wider sets of players that carry out the work • Question of – where does the specific public health workforce add most value o Recognition of strengths in: ▯ Developing evidence ▯ Designing interventions ▯ Evaluation o Not particularly skilled in implementation • For example, whilst a range of community planning anti-poverty work might affect wider determinants of health, you don't necessarily need PH skills to implement anti-poverty activity • Need for more 'agile' and flexible approaches at all levels • What about 'accompaniment' model as used by Joint Improvement Team with the 32 local partnerships so that you get the best of national and local combined through networks • There was reflection on the impact in England of the re-location of PH. In some areas this was working well but in others, there were still challenges • A range of dialogue also took place in relation to Health Protection and the arrangements that need to be in place to respond, for example, to an outbreak

Glasgow Engagement Discussions/Answers to question 2

Name of facilitator	Question 2. What should be done nationally, regionally and locally and how should they join up?
Jacqueline Lamb	Example: EYC – When will we not need a national role? Needed for leadership, direction, prompt, different levels of intensity. Enhance profile of PH nationally and locally. Including clarity of roles and responsibilities. • How do we best describe to others? • The broader the remit of PH – not just those in PH important • National priorities influencing resource at local level • Recognition of different evidence bases and credibility of these. Flow their evidence through national regs and local levels • Health and social care provides hope – not to take away resource from local level • Need to strengthen capacity of key engagement in third sector to feed through knowledge and evidence, perhaps partnership with those in PH who have that already • Mixed experiences of collaborative working with PH • Informed partnership working at regional level not being risked by formulating and moving resources away from local level Multi layered, leadership at all levels. Culture – courage • Not all afraid of letting go • Leadership at all levels – not being afraid of getting it wrong • Are service/s structures set up for engagement? How does your service need to change? • Involve local communities by engaging something that interests them, that may not be your interest. Use of language • Manage expectation, pick some easy problems to help people see the value • Common understanding of community engagement and partnership • Reaching those who aren't usual influencers • Read across with existing legislation and policy. National standards for community engagement • In environment of reduces funds how do we involve community in solutions with reduced resources • Focus on what can change • Combining data/lived experience/leadership to decide on difficult allocations • Challenge of elected members versus local wider community • Protect the partnerships that already work well
Michelle Gillies	<u>National</u> • Screening – perhaps not delivering implementation immunisation * evidence for structural change • HPS/Lab/Surveillance/Networks

	• ISD – data collection/Epi/Knowledge services – fixed programme? Responsive to local need. • Standards. • All of the above could reduce duplication, increase efficiency and resilience/capacity. • Cost savings – role? Leadership? Reactivity? How relevant is some data to the end user? <u>Regional</u> • On call – governance issues • Commissioning services e.g. needle exchange, condom distribution • Screening *acute services • Emergency planning • Audit • All of the above at board level <u>Local (definition?)</u> Delivery of services • Community development • Third sector • Health improvement • 1 degree care • HSC partnerships (acute) • CPP/IJB • All of the above is reactive to local population, risk loss of critical mass, risk inconsistent delivery and inequality Networks • Sharing information and practice i.e. teeth • Governance and accountability • Added value?
Fiona MacKay	<u>National Initiative</u> • 'SG 'thing that happened at local level – unclear where Health Scotland sat – What does 'national' mean? – national not joined up – Where does GCPH sit? • Language – collaborative • How do national priorities layer on top of pre-existing local priorities Early Years • Local – also multiple levels to this • Regional lacking? – distraction? – threat to the local – risk of takeover – no structure – geographic or networks? Influence local; • Efficiency in delivery (financial pressure) • Strategy delivery and formation national • Data collection, analysis and translation of knowledge, evidence reviews from national resource banks Buy in – evidence says 'this way is most expensive'.

	National – consistency Immunisation – national and local No structure – but clear statements of what needs to happen. Health Improvement • Less clear at national level • Too much room for interpretation • Tension with local empowerment (Analogy "Curriculum for Excellence", schools deliver in many different ways Question of resilience locally – what part of the chain could be done elsewhere? Opportunity to influence lots of different services. Role of influencing policy development – aggregate. Local links to education – needs to be stronger from national. Don't have national partnerships – co-ordination role. National – Local • Understanding – dialogue (learn from Health Protection Network) • Accountability • Mixed roles High level national outcomes – focus. CPP – SOAs more geared to national outcomes. Health protection review – network and oversight group – lessons – obligate, 5 topics, co-chair (HPS, Board). Healthy working lives – learning from what didn't work here.
Katherine McKay	<u>National</u> Directive and rigid political intervention is not helpful. • Set the vision and framework • Co-ordinate collection of KPIs 'measures' across all agencies and focus on tasks • Be consistent with funding streams and integrate across justice, health, LAs. Policy to demonstrate 'health' outcomes • i.e. PH economics <u>Regional</u> • Join up boards/LAs learning especially after 'SG reviews e.g. Mental Health Board reviews' <u>Local</u> • Want to respond flexibly to emerging issues in an co-production between local NHS/LA and SG outwith • Standard policy timescales • Emerging populations of need e.g. adults with CP…problems with definitions across LAs/Boards
Karen McGuigan	Common vision across all 3 levels which is used by all 3 'levels' Focus on outcomes – tasks Routed back to communities Screening programmes are a good example – national – set direction and tasks and goals / KPIs

	Boards& NSD coordinate what needs to be done Some topics do not have clear views of delivery eg sexual health / suicide prevention – need more 'multiagency' focus Policy may be only for NHS actions; need to engage CPPs and articulate their actions Measurement of impact on communities and their involvement in solutions. Should there be a framework at national level and allow regions/local flexibility BUT need measures which can be collected – KPIs- in locality to send up to 'national' observatory. More SG support to locality eg mental health. NHS review visits from SG feel punitive! Missing opportunities for collaboration across local , regional levels and lack of understanding by SG Note the PH aspects retreated into a NHS action plan Need consistency from SG esp If they work focus on funding Long term not short termism Funding streams should be integrated across SG policy ie PH economics must be able to be used to show that all sorts of policies/intrventions by health/justice/LA can improve health outcomes 27-30 month assessment has uncovered 'unmet' needs – is this an unforeseen consequence Directive political intervention is not helpful! "Best evidence" is often not able to be implemented because of their 'interference' Rigidity is not helpful! Eg impact of welfare reform Can we and our partners respond more flexibly to emerging issues in a coproduction between NHS/LA/SG outwith the standard 'policy' timescales. Emerging populations of need eg adults with CP are not being 'properly' defined by LA/NHS therefore their needs are not being met and are hidden – can't access services therefore increasing inequalities Person centred approach

Inverness Engagement Discussions/Answers to question 2

Name of facilitator	Question 2. What should be done nationally, regionally and locally and how should they join up?
Joanne Larson	• Is there a need for uniformity across Scotland? • A good policy is informed by local experience, grass roots & multi-agency • Support structures to help local level activity feed into national group and vice versa • National policy (single voice) to set priorities – how do we decide what priorities are? • Stats & data (multi-agency) required to help inform activities relevant to community • Joint resources (financial staff) – to help consistency & action • Local level – being on ground to help understanding, negotiation and raise awareness. Being visible in communities → help community buy-in, involvement and strengthen → building community assets • Sharing practice, skills across boards, sectors, communities ↑ Networks → help capture activities • Significant role for GP practice → at practice level
Alan Yates	Key issues: • Local/regional – good examples of CPP where PH and DoPH have key roles – gives focussed joined up working • Does appear to be disconnect between national/local – need early communication and strong PH leadership at all levels to address • NoSPHN is good example of supportive network with joined up approach • Data collection may be one area where national approach useful e.g. in Environmental Health some specific national, internet based databases to allow consistent data input and review. • Review must emphasise national approach on workforce planning/professional development for PH. Must cover medical/non-medical workforce in all agencies. • Note key and important role for generalist in rural and remote areas. Must be appropriate support and recognition of value of this approach General discussion • Recognised appropriate national role of providing policy, strategy with flexiblilty for local application. National role useful for publicity/standard material/consistency • Regional networks useful e.g. PHN, Health Protection, environmental health networks • Question on how to get local priorities fed back up to national level

	• Effective leadership may be logistically easier in smaller areas • Could there be cross-agency work on PH leadership at local level • Noted variation across Scotland in population/rural/remote – must have flexibility to work locally • Noted support for networks is important e.g. Scottish Health Protection Network, especially as ever greater pressure on time/travel/finance to support professional networks • To address disconnect must emphasise communication but must be care not to just increase amount of information being circulated – must be smarter – less is more • Disconnect – problems with local data collection/consistency – must make information gathering easier • Useful for more clarity on key focus e.g. top 3 PH issues but need local buy-in • Workforce development – pilot in Highland and 2 other Councils must be taken forward and rolled out • National funding crucial to support workforce development • Noted Shetland good scheme of local training for health improvement – diverse background and utilising general skills • Need to consider how to access academic routes – Highland/Isles issues