ScotPHN report

Scottish Public Health Network (ScotPHN)

New Ways of Working for Public Health: Providing Specialist Public Health Input to Integrated Joint Boards for Health and Social Care and Community Planning Partnerships: An Update

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Contents

1 Introduction

In 2015 the Scottish Public Health Network published the key findings from its surveys in 2010 and 2014 which explored the ways in which local public health directorates were responding to the need for greater integration in the planning and provision of public services.[1] These surveys explored the ways in which support and collaboration with Community Planning Partnerships (CPPs) were operating and how early approaches to supporting the "Integration Agenda" through the Integration Joint Boards (IJBs) for adult health and social care delivery were being developed.

The publication by the Scottish Government of the 2015 Public Health Review for Scotland[2] and the Health and Social Care Delivery Plan[3] signalled developments in the organisation and delivery of specialist public health within the wider context of public sector reform in Scotland. These reforms will see the creation of a new national public health agency for Scotland and see local public health teams support both regional NHS planning systems and provide local public health leadership and input to local IJBs and to CPPs, especially in the context of the new statutory arrangements for community planning set out in the Community Empowerment (Scotland) Act 2015.[4]

In the light of these changes it seemed timely to:

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[1] ScotPHN (2017). New Ways of Working for Public Health: Providing Specialist Public Health input to Community Planning Partnerships and Integrated Health and Social Care Arrangements. (Available at: https://www.scotphn.net/wp-content/uploads/2015/09/2015_01_16_CPPs_Consolidated_Report_Final.pdf Last accessed 12/7/2017)

[2] Scottish Government (2016). 2015 Review of the Public health Function in Scotland. (Available at: http://www.gov.scot/Topics/Health/Healthy-Living/Public-Health-Review Last accessed 12/7/2017)

[3] Scottish Government (2016). Health and Social Care delivery Plan. (Available at: http://www.gov.scot/Publications/2016/12/4275 Last accessed 12/7/2017)

[4] Scottish Government (2015). Community Empowerment (Scotland) Act 2015. (See: http://www.gov.scot/Topics/People/engage/CommEmpowerBill Last accessed 12/7/2017)

1 update the 2014 survey in regards of the specialist public health input to IJBs and CPPs; and

2 take early soundings of the degree to which public health colleagues locally were becoming involved in activities associated with the new duties to empower local communities as co-producers of local outcome plans and owners of community assets.

2 Methods

This 2017 survey followed the methods used for the earlier 2014 survey. The DPH (or their nominated responder) for each NHS Board completed an online questionnaire during December 2016 and January 2017. The purpose of this was to establish the 'local landscape' in relation to inputs to IJBs, CPPs and locality planning. In all 11 of the 14 NHS Board public health directorates responded to the online survey. This was then followed up with a structured telephone survey during January and March 2017. This explored in more detail public health inputs to IJB/CPP planning arrangements and the emerging roles of public health in response to the community empowerment arrangements locally. 12 of the NHS Boards participated in the telephone survey.

The data from both these collection exercises have been subjected to thematic analysis, highlighting where possible consistent themes and those where divergence was clear. Where appropriate these themes are considered in the light of the key findings from the earlier surveys. A summary of this thematic analysis is presented in this report.

3 Public Health Support to IJBs and CPPs

In 2014 the specialist public health teams within NHS Boards in Scotland were working with thirty-two CPPs, each focussing on a Local Authority (LA) area. At that time it was clear that each operated in a different way and at a range of different organisational levels to suit local circumstances. Co-terminosity between NHS Boards and CPPs was an issue with eight NHS Boards working with between two and six CPPs each. In supporting these CPPs, two models were emerging: firstly, inputs provided by a devolved community health and care partnership based public

health team; or the inputs were provided by public health 'experts' providing topic or issue based input to the CPPs.

The 2017 survey suggests that this analysis still holds true, with all Directors of Public Health (DsPH) reporting that the local arrangements for their IJBs generally mirror the CPP landscape. NHS Forth Valley was an exception to this as it reported working with three LAs that each had a CPP, but two of the LAs were operating within a single, shared IJB. NHS Highland is also an exception in that whilst it works within Argyll and Bute Council's CPP and IJB, there is no IJB for adult health and social care in the Highland Council area as the NHS Board and Highland Council having opted for a "lead agency" arrangement alongside the existing CPP. In addition to these statutory arrangements, seven DsPH reported working within significant local integrated planning arrangements. One of the DsPH within an Island NHS Board noted the further developments signalled by the Scottish Government's Islands Bill that responded to the Our Islands, Our Future campaign.[5] Overall, the responders to the survey felt that whilst the CPPs were now well established, the IJBs were still be evolving.

Involvement by public health teams in IJB based planning was taking place. However, one DPH reported no involvement in their single IJB and two NHS Board areas with multiple IJBs noted that participation was not happening in all of their IJBs. In contrast, all areas reported that there was public health input to CPP planning. Generally, where public health involvement in IJBs, this was being provided by with the DPH (5/10 NHS Boards) or by a Consultant in Public Health (2/10). In one area, public health input was at request for specific agenda items. With the CPPs, eight of the NHS Boards reported that involvement was mainly provided by staff from the Health Improvement teams, in two areas this was shared with CPH input. DsPH were directly noted as being involved in four areas. Generally, it was identified that public health was involved in providing input to the new Local Outcome Improvement Plans (LOIPs) at the IJB/CPP levels. In two areas, however, this

[5] Our Islands Our Future. Joint Position Statement by Shetland Islands Council, Orkney Islands Council and Comhairle nan Eilean Siar. (Available at: http://www.cne-siar.gov.uk/oiof/documents/JointPositionStatement.pdf Last accessed 12/7/2017)

involvement was seen as minimal. Public health involvement planning which involved community groups, supporting local outcome planning within communities, was reported in only four areas.

Public health input into the governance of the IJBs/CPPs was seen as being limited to either involvement in performance monitoring of health improvement activities (4/11 NHS Boards) or taking place through other mechanisms directly within the IJB/CPP (6/11). In only two areas were public health fully involved in IJB/CPP governance and in one area, the DPH noted no involvement in governance.

Of those responding, seven felt that maintaining public health input to IJBs and CPPs was sustainable *at present*. However, this must be treated with a high degree of caution. Five of the DsPH suggesting current levels of input were sustainable, three specifically made comments about the relatively modest inputs currently and two commented on the need to prioritise CPP work over other demands. In addition, four DsPH reported uncertainty that public health inputs to their IJB/CPP inputs were sustainable.

Overall the DsPH were asked to comment on whether the IJBs and CPPS were working well prior to the changes brought about by the Community Empowerment (Scotland) Act 2015. Of those responding, five said “yes” pointing to factors such as the focus on public health and health improvement issues afforded by CPPs and that they have supported a natural evolution towards local integration. Of the three who said “no”, one noted that the area had already been operating in an integrated manner and the other two noted that the changes had changed the nature of local relationships. Finally, the four who described themselves as being “uncertain” about whether integration was beneficial, highlighted the fact that financial limitations, differences in the local operation of the bodies, and the focus on governance in some cases made it difficult to make an assessment. As was noted in one area which was uncertain that the changes had been beneficial, the new arrangements had actually resulted in delaying the implementation of recently agreed developments.

4 Public Health Contributions to Community Engagement

The major focus for the telephone survey was on the ways in which public health directorates were making contributions to the development of community engagement within their CPP areas and ways in which they were involved in supporting community groups in locality planning.

4.1 Contributions and Gaps

The first area considered looked at existing contributions to developing community engagement and tried to consider any emerging gaps that were being identified.

Most DsPH noted that it was very “early days” in this agenda. Most described their involvement either in terms of helping develop local community engagement policies or as parts of strategic planning arrangements, particularly within specific geographical areas. More than one DPH commented on specific planning to improve health within city-based development partnerships to reduce poverty or health inequalities. In some areas, community engagement was seen as having had a positive impact in sharpening the focus on communities themselves, especially as Elected Council Members were linked into IJBs. In others, it was helping to focus on exploring approaches to individual health behaviour change as a tool for local empowerment. However, others noted that the existing ways in which local IJBs/CPPs had developed their initial Local Outcome Improvement Planning remained as a limiting factor. A focus on topic based planning was noted by more than one DPH, though at least one area noted that this was seeing an increased interest in positive ageing as part of the local “preventative agenda”. The challenge facing local teams was neatly summarised by one DPH who commented that they were having to take opportunities when they occurred.

One area where community engagement was seen as creating new opportunities was in developing healthy and sustainable communities. In one area, the NHS

Health Scotland Place Standard[6] had been specifically used to help develop a local focus on health improvement. The local public health team reported now moving forward with in developing work with two communities to improve local health outcomes.

Most DsPH reported positive engagement in community work, especially given what was seen as the "welcome" extended to public health involvement. When specifically asked about "gaps", three issues were identified:

1 some concerns about the impact a very local focus was having on maintaining work on wider public health issues, especially in developing broader approaches to disease prevention and population based initiatives;
2 the interpretation of community empowerment as simply a locality planning issue, rather than developing approaches to creating participatory/co-productive approaches to assets-based community involvement; and
3 public health capacity to support this work.

As might be anticipated, the limitations associated with capacity varied across NHS Board areas. Some related simply to a general lack of capacity in specialist public health teams or health improvement teams and how they worked. However, as one DPH noted, even if extra capacity was available, would it actually help? This point was further illustrated in comments from others who noted even within NHS Board areas, local differences between IJBs and CPPs meant that the capacity requirement was different in different areas. Another area had responded to similar constraints by moving to more generic working; whilst this increased flexibility, it did mean that overall community coverage was reduced. As a general comment, when working with communities, there was a feeling that demand was already outstripping supply.

[6] NHS Health Scotland. The Place Standard Tool. (Available at: http://www.healthscotland.scot/tools-and-resources/the-place-standard-tool Last accessed 12/7/2017)

4.2 Limiting Factors for Public Health Contribution

The largest group of limiting factors focussed on structural issues within IJBs and the refocussed CPPs. In reality, most DsPH acknowledged that few of these were new, but the integration agenda was an added factor. As one DPH noted, integration will take five years. Not least because whilst there is clear willingness to become more integrated, there are limitations associated with organisational capacity to deliver change sufficiently quickly, especially when the changes could themselves result in a loss of the type of organisational memory of how things worked and why. A further limiting factor was seen as the degree to which public health issues were likely to be prioritised, given the current financial challenges facing the NHS and LA. One DPH noted that there might be a benefit in waiting for IJBs to "shake-down" first, though another stated that as they locally had a voice on the local strategic group, it was an opportunity to exert influence. It is clear one of the consequences of the community engagement legislation has been to create new complexity for integration. More than one DPH noted that whilst there may be a single, joint agency plan in their areas, there can be more than a single LOIP. How well communities learn how to influence plans which meet their expectations is likely to be a future consideration.

A second set of limitations considered wider alignments with other integration mechanisms requiring public health involvement. Comments were made concerning the lack of clear local alignment between IJBs and early years collaborations, housing and homelessness planning, the Community Justice Authority for Scotland, and the 3rd Sector interface.

A number of limiting factors specifically associated with local public health and health improvement teams were reported. Some of these were technical (How can we agree what is a locality? How do we avoid problems associated with misleading small area statistics?), the majority of comments focussed on two factors:

- the loss of local alignment between public health teams and the health improvement teams; and
- the consequences of prioritising community engagement work within public health.

In many areas the local health improvement teams are now managed within locality health and social care arrangements or are closely aligned to them. As a result, the potential for the overall public health workforce to support both health and social care integration and community empowerment is restricted. From a public health stand point, we have direct experience that engaging with community groups and developing their potential is very time consuming. One DPH considered that developing such engagement will mean they have to consider what areas of existing work will need to be subject to disinvestment and stopped.

The DsPH were asked to identify any early lessons in working within or around these limitations. Approaches mentioned included being more flexible in ways of working, developing local prioritisation, and seeking to develop collaborative approaches. The comment that it was "*too early yet*" is perhaps the most to the point.

4.3 Issues in planning

The telephone survey asked what issues were being raised, either generally or for public health, as a result of a greater focus on local planning. In analysing the responses it was difficult to tease out a difference between general issues and those specific to public health, save for the view that there was a need to become more adept at getting public health onto the planning agenda, especially around health inequalities and their social, economic, cultural and environmental determinants.

Many of the structural problems identified above were seen as directly feeding into local issues in planning: focussing on financial concerns; meeting unrealistic community expectations; resourcing community engagement; creating coherent plans across IJBs and CCPs; and moving the agenda beyond the inherited focus on access to health and social care. In several areas the IJBs themselves were still in development thus affecting planning. In one NHS Board area, the IJB had agreed its arrangements for prioritising services and establishing service review groups, though its process for the LOIP was being established. In another the IJB was still identifying its localities. Most DsPH reported that despite such issues, local planning was being progressed, though more than one queried if it was being effective. Some noted that planning for multiple localities created a duplication of effort and, in some

circumstances, a loss of a joined up focus. There was also a concern expressed that communities would always want their own needs to be met and not simply accept a generic LA plan that had been localised.

Several NHS Boards were involved in developing local need assessments, with a high demand on specialist public health input for data analysis and interpretation reported by many DsPH. A clear desire to support intelligence for locality planning was identified. This was reflected in the observation that at least five IJBs were being supported by the national Public Health and Intelligence: Local Intelligence Support Team. However, at least one DPH noted the problems in a lack of an agreed mapping between LA localities and public health data. Interestingly, most DsPH (7/11) felt that the new arrangements were unlikely to improve local health intelligence and of those who did, one felt it would only occur if the data was developed and interpreted at a national level.

Finally, there were number of observations that focussed on the learning needs of the new integration arrangements. Areas where the IJBs and community empowering CPPs needed to learn included how to: develop community facilitation; become better local advocate; develop wider, more inclusive partnerships; and understand how each of the other organisations with IJBs/CPPs work.

5 Supporting Public Health Teams in Community Engagement

As with the 2014 CPP survey, the 2017 survey asked what sorts of additional supports would be helpful for local public health teams in developing approaches to the community engagement agenda.

As a general response, there was a call to help NHS Boards share ideas and experience, creating the type of cross-fertilisation which would help shape practice quickly. One DPH commented that this was already possible within their region, but both regional and national support was mentioned by two others.

A number of DsPH identified the need for supporting delivering the massive cultural change that is necessary to complete integration properly. It was noted that the legislative changes were important, but it was also highlighted that processing such change needed time: both in terms of learning how to use the integration mechanisms; and in helping to break down organisational barriers to become effective collaborators.

A number of DsPH mentioned the need for developing shared frameworks on key issues. Specific mention was made the ways in which local teams should be responding to community participation and local queries regarding asset transfer requests. However, there was a more generic call for developing a national evidence-base for community engagement, populated with evidence reviews that give sufficient detail to allow local action, even if the evidence was not of the highest quality. Another area for evidential support identified was in identifying the sorts of tools that can support the development of community engagement skills within the specialist and wider public health workforce.

One area mentioned that they had developed local training to raise awareness, suggesting that such an approach may allow for the development of action resources – such as those which were developed to support the sharing of experience in relation to obesity prevention and promoting the health of migrant communities.

National support for health intelligence was mentioned by some DsPH. More specifically, however, were suggestions that national support should be developed to allow local teams to be able to draw up intelligence that would inform health care needs assessments for LOIPs and in developing and undertaking evaluations of community engagement which were meaningful.

The survey asked what, if anything, would be an appropriate role for ScotPHN in such areas. One DPH did question is this was an appropriate use of ScotPHN as a national mechanism. Other highlighted the “new ways of working” strand that had been developed by ScotPHN for the SDsPH as a potential mechanism to support

practice development. Specific areas where there was a suggestion that ScotPHN could facilitate this included:

- leading work on developing Scotland-wide national public health frameworks for community engagement;
- helping to identify those across Scotland with the necessary skills-sets to sustain community engagement work, and facilitate the sharing of such skills;
- working with other agencies (e.g. the International Futures Forum or the Improvement Service) to help local public health partnerships explore new ways of working with key partners and enhance strategic planning approaches;
- developing national “conversations” that would help share emerging knowledge and support professional updating in community engagement;
- co-ordinating the work needed to develop and implement a Scotland-wide evaluation of community engagement;
- helping develop social media approaches to reduce health inequalities; and
- helping to develop a stronger voice public health.

In making these suggestions, two specific cautions were mentioned. The first was a reflection that any ScotPHN work had to be routed through the local SDsPH to add value to the local public health team’s work. The second was that whether local, regional or national, there was limited public health capacity for all work, not just on community engagement.

6 Conclusion

In concluding the 2014 survey, it was observed:

"As structures change, so will the support provided by Public Health Directorates. But this needs to be done in a thoughtful fashion. Whichever structures to which such teams are aligned, there is a need to ensure that the other parts of the overall system – those that also affect and mediate the health of local populations – are not differentially disadvantaged and new health inequalities and social injustices created." [1]

This remains true in 2017.

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