Scottish Health Promotion Managers Group

Local Health Improvement Teams: Current Landscape

December 2018

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Preface

The Scottish Health Promotion Managers group is committed to providing strategic and operational leadership and visibility for health improvement activity across Scotland and recognises the important contribution that the dedicated health improvement workforce makes to the wider public health effort. The health improvement function is uniquely placed to occupy the 'strategic middle ground' within public health; actively informing policy formulation whilst equally facilitating policy implementation. Aspiring to focus health improvement activity on wider socio-economic factors that affect people's health, SHPM's are grounded in ensuring resources fit with local priorities and there is a professional health improvement workforce that is fit for practice as well as for the future.

For the first time, we have a collective picture of the current landscape that local health improvement staff operate in across each of the health board areas in Scotland. To gather this picture, an initial survey was undertaken to develop a description of the health improvement services in each health board area. Individual telephone interviews were then held with SHPMs in each area. This report highlights

that local health improvement staff operate in various structural arrangements as well as across numerous structures with community planning partners. Whilst such structures can provide a unique vehicle for connection and engagement across sectors in the pursuit of improving the population's health and reducing inequalities, there are real challenges described to realising our collective aspirations and efforts. These include funding, policy drivers, availability and deployment of necessary capacity and skills and holding onto a critical mass for professional recognition, registration and strategic oversight.

The SHPM Group commends this report to the Scottish Directors of Public Health, the Public Health Reform programme in Scotland along with its commissions and the Whole System Steering Group. We invite partners to reflect on the themes and challenges the report highlights. We will also consider how to enrich our understanding of the landscape of local health improvement staff in health and social care partnerships. Overall, it is hoped this report will assist in strengthening the efforts of local health improvement teams across different parts of our local systems as well as supporting relationships between local teams and the new national public health body.

We are grateful for the time committed by Elspeth Molony at NHS Health Scotland to undertake the interviews and produce a high quality report.

Linda Smith
Chair of the Scottish Health Promotion Managers group

Background

The Improving Health Commission is a programme of work being led by NHS Health Scotland and the Integrated Joint Boards Chief Executive Group on behalf of the Scottish Government and COSLA. It is one of a number of pieces of work being undertaken to inform the reform of public health in Scotland. One of the tasks of the Improving Health Commission was to set out the current and proposed future state for the health improvement function. The SHPM group agreed to support this work by providing details of the work of local health improvement[1] teams.

This report is based on written submissions and oral interviews with members of the Scottish Health Promotion Managers Group. With the exception of NHS Grampian, a single submission and interview was conducted for each health board area. This approach was necessary on grounds of pragmatism. However the Project Team recognises that direct contact has not been made with all Health and Social Care Partnerships (HSCPs).

It should also be noted that this is not a report of all local health improvement activities. The scope of the report is the work of health improvement teams within health boards and, where relevant, HSCPs. For information about the health improvement work of other local agencies and partnerships, please refer to the Improving Health Commission's *Current Health Improvement Landscape* report.[2]

[1] This is being used as a catch-all term to refer to local teams within health boards and HSCPs with a remit for health improvement/promotion.
[2] Current Health Improvement Landscape

Executive summary

1. Operating context

There is significant variation in the operating context of local health improvement teams. Every area operates differently to a certain extent, but broadly speaking there are five models for the position and management of local health improvement teams: the health board model, the mixed model, the Health and Social Care Partnership (HSCP) model, the Highland model and the Joint DPH model. Understanding this local variation is key to understanding the health improvement function at a local level.

2. Role and remit

Broadly speaking, the role of the health improvement team is to be the main route through which the health board discharges its duty to improve the population's health. However, there is extensive variation in the remit of the teams as a result of a number of factors including the operating context of the team and extent to which the team works with local partnerships.

3. Strategic plans and strategic priorities

Health improvement teams contribute to a vast array of strategic plans, some local to their governance structure and some jointly owned by a local partnership. CPP Local Outcomes Improvement Plans (LOIPs) and Locality Plans are of particular relevance to the strategic work of the health improvement teams and to whole system working. Depending on the area, teams can be working with up to six HSCPs and CPPs in their area, each with strategic plans and action plans. This requires a considerable investment of time in order to effectively influence their development and play an appropriate role in their implementation.

4. Alignment with the Public Health Priorities

In June 2018 the Scottish Government and COSLA jointly launched Scotland's new Public Health Priorities (PHPs).[3] SHPMs were asked about the extent to which local work aligned with the six priorities. All areas are carrying out work that aligns to each of the priorities, although the perception of how aligned the local teams are with the PHPs varies between areas. The greatest level of alignment is with the healthy weight and physical activity priority, with all areas reporting full alignment. The lowest level of alignment is with the sustainable, inclusive economy priority, with five of the 14 areas reporting full alignment.

5. Balance between prevention and mitigation

SHPMs talked passionately about the aspiration and intention to work upstream around the social determinants of health. While community planning is seen as a key enabler for upstream work, SHPMs reported significant barriers and challenges to realising their aspiration to work upstream. These include national drivers, local politics, lack of capacity, and short term funding.

[3] Public Health Priorities for Scotland

6. Budget and funding

Local health improvement teams receive the majority of their funding from Scottish Government through the NHS Board's annual allocation (core budget) and the Outcomes Framework, including the Prevention Bundle Funding. This is true regardless of the operating model. In models other than the health board model, the funding is delegated to the relevant body and is subject to local finance strategies.

Most of the challenges around budget and funding are shared across the SHPM Group, such as reductions in funding and the non-recurring nature of the Effective Prevention Bundle. The latter was described as a barrier to long-term planning and investment in prevention and gives rise to risks relating to the employment of staff.

7. Staffing

The teams vary in size as a result of a number of factors including the different operating models, their role and remit and the difference in local population served. Common themes discussed include the registration of the health improvement workforce, the reduction in capacity due to cost savings, the move to generic rather than topic specific job descriptions and the need for advocacy and influencing skills to work effectively in partnerships.

8. Engagement with local government

Links with local government are evident in all areas, with health improvement teams working within local partnership arrangements including Community Planning Partnerships, Alcohol and Drugs Partnerships, and Children's Partnerships, as well as directly with local authority teams. This is recognised as key to working on the social determinants of health.

9. Engagement with national agencies

The national agency engaged with most frequently by the local health improvement teams is NHS Health Scotland. In most cases this is through topic leads and the quality of the engagement was said to vary depending on the topic. It was common for SHPMs to report that the links were not so strong outwith that topic-focused relationship.

10. Engagement with the third sector

There is good third sector engagement taking place in all health board areas, either at a strategic level and/or in the delivery of services. It is common for engagement to be through local partnership structures but there are also many cases of teams engaging directly with specific third sector bodies who share a common interest (strategically and/or in the delivery of services). All but two health board areas are funding third sector organisations to deliver services this year.

1. Operating context

There is significant variation in the operating context of local health improvement teams. This leads to differences in the other areas covered by this report, most notably engagement with local government, role and remit, and strategic plans and priorities.

Every area operates differently to a certain extent, but broadly speaking there are five models for the position and management of local health improvement teams:

a. The health board model
This covers teams that are located and managed wholly within the health board. The team is part of the Public Health Directorate and works in partnership with external stakeholders including HSCPs and CPPs.

b. The mixed model
This covers areas where there is a team in the health board (sometimes called a 'corporate team') and teams in the HSCP/s (sometimes called 'locality teams').

c. The HSCP model
This describes areas in which the health improvement team/s are located and managed wholly within the HSCP and responsibility for health improvement has been fully devolved to the HSCP/s.

d. The Joint DPH model
This is a model unique to the Borders where the team is located in the health board but governance is shared between NHS Borders and Borders Council. The Borders model is a result of the joint employment of the Director of Public Health in the Borders between the health board and the council. This is a well-established arrangement dating from 2010 and therefore predates current national integration initiatives.

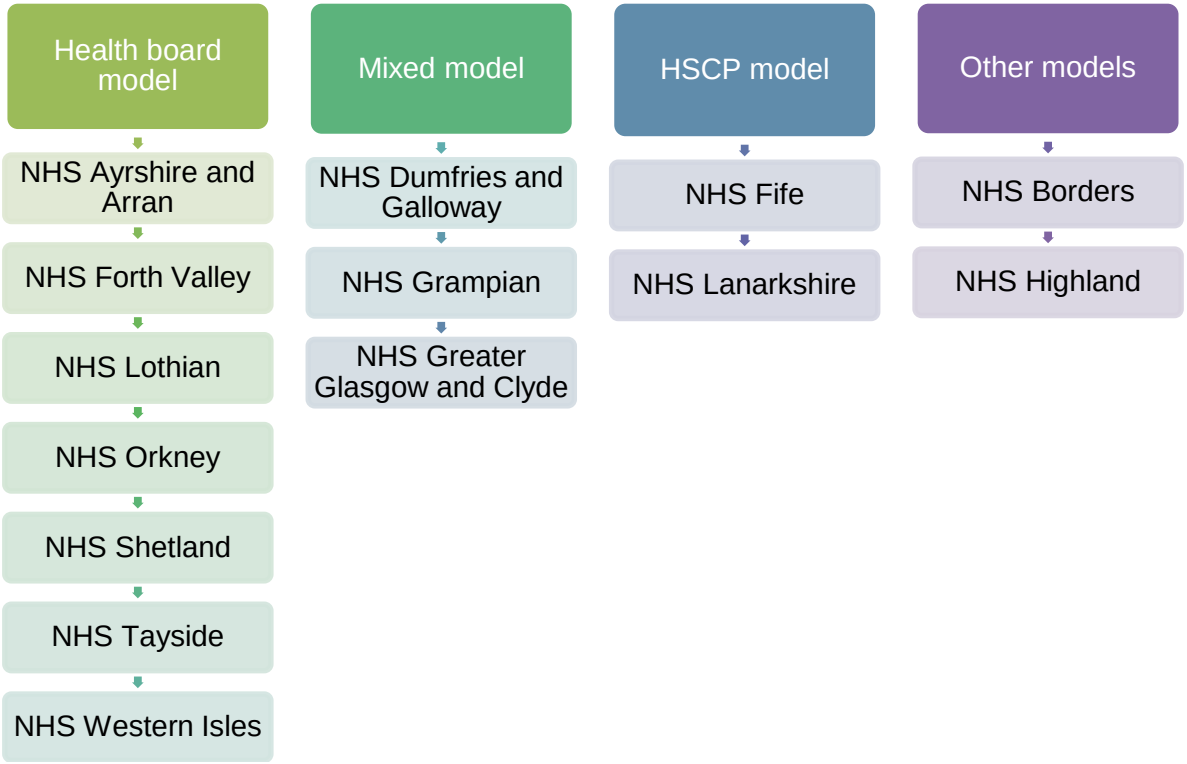
e. The Highland model
This is a model unique to the Highlands (where NHS Highlands covers the Highlands and also Argyll and Bute[4]). In this model the team is split four ways between NHS Highlands, the Highlands operational unit (the Highland equivalent of a HSCP), Argyll and Bute HSCP and Highland Council.

The Highland model is a result of the different approach to integration taken in the Highlands. They operate the 'lead agency' model rather than the 'body corporate' model employed elsewhere in the country. They are also working to a different timeframe as a result of integrating health and social care services many years before it was a requirement of the Public Bodies (Joint Working) (Scotland) Act 2014.

These models do not operate the same way in each area as a result of factors including which elements are delegated to the HSCP/retained by the health board and how the teams are involved in local partnership arrangements.

[4] The boundary of NHS Highland was changed to include the area of Argyll and Bute Council when NHS Argyll and Clyde was dissolved in 2006.

Figure 1: Position and management of local Health Improvement Teams



The model in operation is generally a result of historical factors. The earliest influencing factor is the creation in 1999 of Local Health Care Cooperatives (LHCCs). This was the first attempt to increase partnership working between the NHS, social work and the voluntary sector. Then in 2004 the NHS Reform (Scotland) Act replaced LHCCs with Community Health Partnerships (CHPs) in a further attempt to increase partnership working. Teams that are partly or fully located within the HSCP are in most cases there as a result of health improvement being delegated to the LHCC and/or to the CHP in the past.

There are however some notable examples of what happened at the time of LHCCs and/or CHPs leading to the health improvement team returning to the health board in its totality as a result of challenges faced by moving out of the health board. These include losing public health critical mass by the team being divided into two or more and losing specialist supervision by moving out of the public health directorate.

"When staff were put in LHCCs they weren't used properly. They were highly experienced staff but they weren't being professionally managed. They got drawn into non-health improvement work like secondary care of diabetes. Our DoPH said this would not happen again and made sure that the critical mass of specialist service was maintained. So now there are no health improvement staff in the HSCP but we work in partnership with them."

The most common reason given for the health board model was retaining critical mass:

"We're not delegated to the HSCP for reasons of capacity and protection. The team is not huge so dividing us would divide our effectiveness. We don't want division of labour or people. We are stronger together and able to offer services to the IJB. We are also safer – we don't want to go into the same budget lines as delayed discharge and adult care. Also, there was no great appetite from the IJB to have us. There is enough going on for the IJB to worry about".

"The core team is small team. If you divided that by four it would leave very few in each area. So what everyone decided was that the sum of the parts is better than dividing us up."

"Pros and cons" were reported in relation to each model. For example one SHPM working in the mixed model who recognised the positives and negatives said:

"NHS Boards are public health bodies in the legislation. HSCPs were never going to be public health bodies. Getting into HSCPs through the mixed model is like being a Trojan horse. The delegated teams help the HSCP recognise their role in public health. They get public health directly into partnership management meetings. This means as a public health system we have an 'in'. The downside is that expectations are placed on the teams by the IJBs, who aren't public health people. There are lots of asks around epidemiology, service improvements and service planning activity. They're put under pressure to deliver on priorities that aren't public health priorities."

Within mixed model areas, SHPMs reported that it is common for the health board corporate team to focus on strategic work and for the locality teams to focus more on the delivery of services.

"We have the mixed model and it doesn't really work as there's a division with us at the strategic end and them at the delivery end. We are trying to enhance the links and trying to develop a supervision model for PH practitioners who run locality groups. But it's difficult with different management."

Challenges reported include:

- In mixed model areas, the HSCP teams within the health board area working very differently to one another:

"It's different in the different HSCP areas. In one area, the team is focussed around the CPP and LOIP. In another the focus is on primary care clusters and what's happening in primary care in those localities. In another, the focus is on place."

"The HSCPs in this area are of very different sizes. One is big and very well linked in to community planning substructures. They take a thriving places approach and focus on communities of need. It's very place-based. It is a very deprived area and whether its tobacco or sexual health work, it's all rooted in inequality. But in another area, which is smaller, they are working more at a policy level, e.g. looking at licencing, rather than working with communities."

- The exclusive focus of some HSCPs on older people:

"Some of the HSCPs in our area are focussed on older people as that's the emphasis of the legislation. This leaves a gap in children's work in some areas."

"[In the HSCP model] Children are covered in different ways in the different areas. In one area children are in for both health and social care, but in the other they are in for health but not for social care. This causes complications around strategy and resource and management of staff. Social care tends to be more of a partner with education. Health's responsibility is universal though."

- Competing priorities between health boards and IJBs:

"For HSCPs, tackling bed-blocking is the day job. The prevention aspect is difficult for people at the coal face dealing with care issues."

2. Role and remit

Health boards are responsible for the protection and the improvement of their population's health.[5] In all models except the health board model, this responsibility is partly or fully delegated to HSCPs.

Broadly speaking therefore, the role of a health improvement team is to be the main route through which the health board discharges its duty to improve the population's health, including being the credible and authoritative source of evidence of what works to improve health and reduce health inequalities. There is, however, extensive variation in the remit of the teams. The main factors contributing to variation in remit are:

- The operating context (see section 1)
- The extent to which the team works on the social determinants of health (see section 5)
- The amount of service delivery work undertaken (see section 5)
- The extent to which the team works with local partnerships (see section 8)
- The remits of other teams within the health board and/or HSCP.

On this last point, there is variation in what the health improvement teams lead on and what is within the remit of other teams. For example, most health improvement teams work with employers and within workplaces to deliver Healthy Working Lives services. However in other areas this work is conducted by the occupational health team. Other examples relevant here are maternal and infant nutrition work and Childsmile, both of which are not always within the remit of the health improvement team.

[5] The National Health Service (Scotland) Act 1978 Section 2A (1) states:
"It is the duty of every Health Board and Special Health Board and of [HIS and] the Agency to promote the improvement of the physical and mental health of the people of Scotland."

Alcohol and drugs work is another example – in some areas the local health improvement team leads on alcohol and drugs work, while in others it is delivered through the local Alcohol and Drugs Partnership with varying degrees of input from the health improvement team.

It was reported that in the mixed model, the role and remit of the team in the health board is often different to the role and remit of the teams in the HSCP/s.

"The corporate team has an upstream inequality focus. But the locality teams have an overriding focus downstream on behaviour change."

3. Strategic plans and priorities

Health improvement teams contribute to a vast array of strategic plans, some of which are local to the parent body and some of which are jointly owned by local partnerships that the team is either a part of, or seeking to influence. In addition to plans specific to the health improvement team and wider Public Health Directorate, SHPMs referred to:

- The health board's Local Delivery Plan
- The health board's Clinical Strategy
- CPP Local Outcomes Improvement Plans (LOIPs)
- CPP Locality Plans
- HSCP Strategic Plans
- Integrated Children and Young People's Plans
- Alcohol and Drugs Partnership (ADP) strategies
- Community Justice Partnership (CJP) strategies
- Tobacco Control Plans
- Sexual Health Strategic Plans

CPP Local Outcomes Improvement Plans (LOIPs) and Locality Plans are of particular relevance to the strategic work of the health improvement teams and to whole system working. LOIPs are required to set out clear and agreed priorities for improving local outcomes and reducing inequalities. LOIPs and Locality Plans were a common theme in discussions with SHPMs around upstream working and tackling the social determinants of health (see section 5).

Depending on the area, teams can be working with up to six HSCPs and CPPs in their area (see Appendix B), each with strategic plans and action plans. This requires a considerable investment of time in order to effectively influence their development and play an appropriate role in their implementation.

"We are drowning in plans and strategies both from a national and a local perspective, with some plans trumping others."

This also represents a lot of committees, boards, subgroups and working groups to either link into or be represented on (see section 8: Engagement with local government).

SHPMs also highlighted the national drivers. There has been a significant refresh of national health improvement strategies this year, including:

- A Healthier Future: Scotland's Diet and Healthy Weight Delivery Plan (2018)
- Suicide prevention action plan: every life matters (2018)
- Active Scotland Delivery Plan (2018)
- Prevention, Early Detection and Early Intervention of Type 2 Diabetes framework (2018)
- Raising Scotland's tobacco-free generation: our tobacco control action plan (2018)
- Scotland's National Public Health Priorities (see section 4).

4. Alignment with the Public Health Priorities

In June 2018 the Scottish Government and COSLA jointly launched Scotland's new Public Health Priorities (PHPs).[6] The priorities "reflect a consensus on the most important things Scotland as a whole must focus on over the next decade if we are to improve the health of the population."

The priorities are:

- A Scotland where we live in vibrant, healthy and safe places and communities
- A Scotland where we flourish in our early years
- A Scotland where we have good mental wellbeing
- A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs
- A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all
- A Scotland where we eat well, have a healthy weight and are physically active.

These priorities reflect the public health challenges that the whole system must work towards, including public services, the third sector, and community organisations. They are not priorities for any one part of the system alone. However both Public Health Scotland and local health improvement teams will have an important role in supporting the realising of the priorities. In recognition of this, SHPMs were asked about the extent to which their work aligns with the priorities. This is a question that many were already asking locally – a number of SHPMs talked about developing papers for their Boards about how their work aligns with the PHPs and referred to undertaking significant work locally to establish where there may be gaps.

For the purpose of this paper, SHPMs were asked to consider if the team's work was fully aligned or partially aligned ("not aligned" was also an option but none of the SHPMs answered to that effect). This is by no means a robust analysis. SHPMs were put on the spot during the telephone interviews to give their opinion. Parameters for "fully aligned" and "partially aligned" were not provided so the results are quite subjective. Some SHPMs made reference to it always being possible to do more and so were inclined to say that they were only partially aligned. Others opted

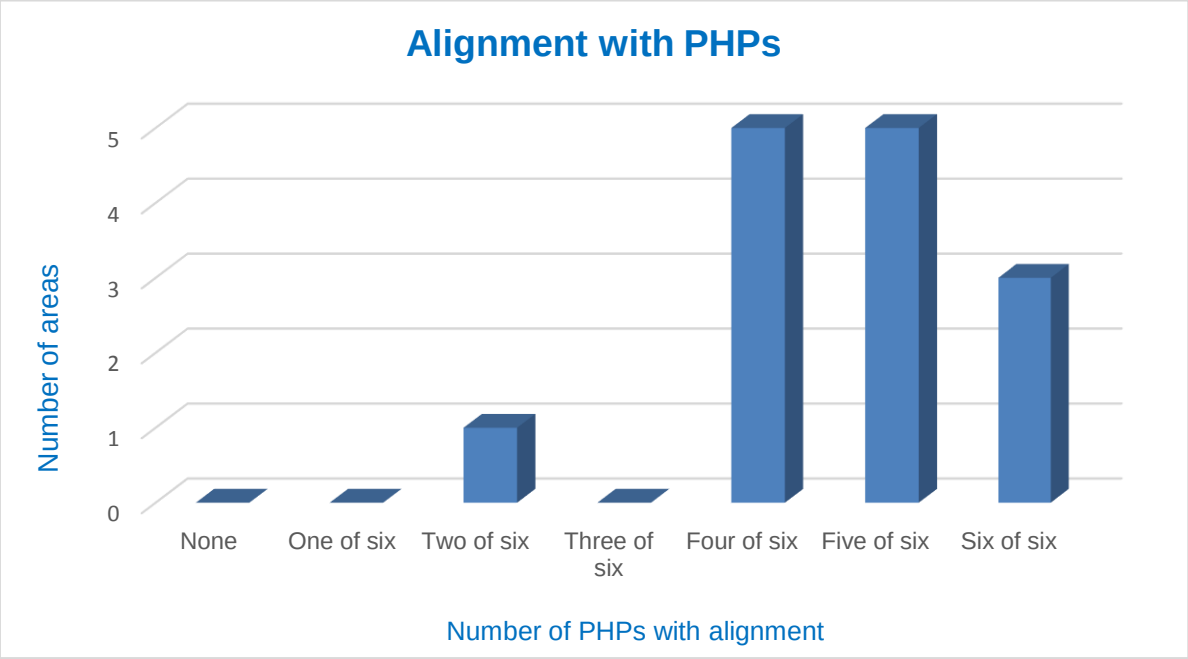
[6] Public Health Priorities for Scotland

for “fully aligned” if they were able to demonstrate that at least some work was being undertaken in the relevant area.

As can be seen in the chart overleaf:

- Three areas reported full alignment to all six PHPs
- Five areas reported full alignment to five of the six PHPs
- Five areas reported full alignment to four of the six PHPs
- No areas reported full alignment to three of the six PHPs
- One area reported full alignment to two of the six PHPs
- No areas reported full alignment to fewer than two PHPs.

Figure 2: Alignment by overall level of alignment



This non-scientific analysis therefore suggests that local health improvement teams are in a reasonably positive position with regard to alignment with the PHPs. However, as was pointed out by one SHPM, further work would be needed to establish:

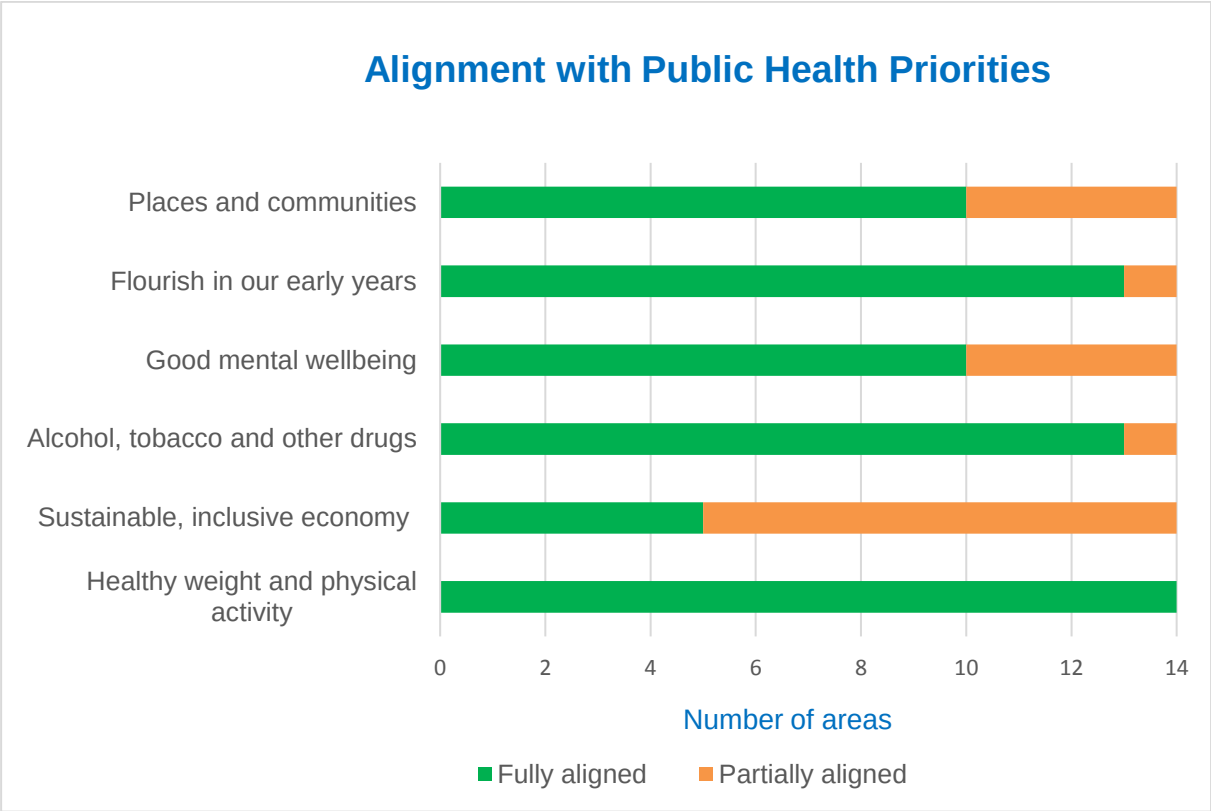
“... the extent and efficacy of that alignment and the sustainability of it on fragile funds.”

The rank order of PHPs with alignment reported is shown in the table below:

Rank	Public Health Priority	Quote from SHPM
1st	Healthy weight and physical activity (All areas reporting full alignment)	*“We could do with dedicated staff in physical activity. Leisure colleagues are effectively the delivery arm of healthy weight and physical activity interventions. We could do with strategic leads.”*

Joint 2nd	Flourish in our early years (13/14 areas = 93% reporting full alignment)	*"We've got lots going on here and dedicated capacity."* *"Yes, we have a Children's Commissioner."*
Joint 2nd	Alcohol, tobacco and other drugs (13/14 areas = 93% reporting full alignment)	*"There used to be an industry around alcohol, drugs and tobacco. Now we're thinking more about what it means for society."* *"We're not as engaged in alcohol and drugs as we should be. It's historical – nine years ago we had to give up posts. The three officers and the financial resources went to the ADP to do operational work and strategic work. One by one these three posts have been taken out to make savings. So now the ADP is just doing strategic work and they don't do operational work at all."*
Joint 3rd	Places and communities (10/14 areas = 71% reporting full alignment)	*"We could definitely do better around places and communities. It's a capacity issue. We had to lose so many staff. We lost the skills and time to do community engagement."*
Joint 3rd	Good mental wellbeing (10/14 areas = 71% reporting full alignment)	*"We've done a power of work on mental health in the past, especially around training. But it's not a very coordinated area – it feels disjointed and needs more focus. It was service level but is now shifting to a population level. We need to get it to a more strategic place. It's dominated by national strategy and the focus is on adults."*
Last place	Sustainable, inclusive economy (5/14 areas = 36% reporting full alignment)	*"We could do a lot more with the CPP around economic regeneration, especially now there's a pilot for basic income in our area. The employment side is covered though, including working with the DWP around work coaching."* *"Partly aligned might be generous for the inclusive economy priority – not at all is more likely. We try to input into the conversation that Economic Development teams have in community planning. But community planning owns it and drives it. The health improvement team feeds into the conversation."* *"We could definitely do better around inclusive economy but we'd need to know what to do."*

Figure 3: Alignment by priority



5. Balance between prevention and mitigation

In the follow up interviews SHPMs were asked two questions about the balance between upstream and downstream work: overall, the extent to which capacity and resource is deployed around the social determinants of health as opposed to individual experiences, and within topics, the extent to which capacity and resource is deployed around prevention as opposed to working with people experiencing negative health outcomes.

Without exception, the SHPMs talked about the aspiration and intention to work upstream. There are common themes in relation to both enablers and barriers.

Common themes in relation to enablers include:

- Community planning

"We are very involved in community planning. This tends to be the forum through which we do the upstream work. A reasonable chunk (c. 30%) relates to the wider determinants e.g. poverty, employment, housing."

"Overall we are too skewed to downstream work like health walks and smoking cessation work. Though we do also do a lot with health service staff and health professionals. We're trying to do more with CPPs. We're in the early stages of consultant level input going into the poverty strategy, housing strategy and local authority planning department. Within the topics, we're getting better at recognising

that upstream work needs to happen. We're deliberately trying to get upstream and the CPP definitely helps."

"Community planning may be an enabler to working upstream in some areas, but not necessarily a generalised picture in reality."

- Fairness Commissions

"The fairness commission we had here has really helped. Many of the recommendations were about poverty. It's been a very powerful tool in engaging in other work and taking different approaches. It's helped us get more into the social determinants of health."

Common themes in relation to barriers to upstream working include:

- The focus of national drivers

"The direction of travel is upstream. We know it's where we should be working but policy pulls us downstream. We take up opportunities to be involved in community planning and DWP colleagues want to work with us more. But then things like HPHS pulls us into hospital."

"In the HSCPs their sole focus is on delayed discharge and reducing admissions. That's their boss. The agenda is set nationally for IJBs. So health improvement staff get pulled towards people with long term conditions. It's still health improvement but it's through services. Even in the health board corporate team, a big part of the team supports the acute services. They support people in and beyond hospital. They try to influence the acute division around health improvement but they get pulled downstream. They are pulled downstream by SG targets – older people, people with long term conditions, older vulnerable people. HPHS takes up a significant number of staff. But what's come out is good."

- Funding (see section 6: Budget and funding)

"We talk about it a lot but a lot of funding comes through specific topics so we have posts tied to topics. It's probably 50/50. People will always want to talk about health behaviour. It's really important to deal with the people who have the problems. But there aren't people working on stopping people getting the problems in the first place."

"The SG Prevention Bundle funding is very topic based. It means that the function ends up being very delivery-focussed in these areas. They try to maintain a strong inequality dimension by being universal but targeted. But there's still topic drift."

- Local priorities and politics

"This is a constant tension and a significant drain on capacity. Despite our best efforts in justifying why we don't want to invest downstream, there are tensions due to government policy and local drivers, including local government politics. It just takes

a phone call from a local councillor to derail our best intentions. It can be difficult politically to go upstream."

"There's a rhetoric around inequality but not much action. The reality is that inequality is mitigation at best. So much energy goes into how awful it is, they are not thinking about how the health service can respond differently and work with the right people and partnerships to influence. They need to turn it from "that's terrible" to "this is what we can do to influence". They need training and workforce development in policy advocacy and influencing skills."

"We've suffered from cuts in local authority funding. It's affected our partnership work. The council has lost loads of staff, including a lot of posts in the softer stuff. There a fewer people to work with on the social determinants of health. We need to build partnerships and relationships and use hooks. We might start downstream as a hook to then get upstream."

"We don't get to focus on the social determinants. There's been lots of organisational change in the council. The scale of efficiencies being made across the public sector is unprecedented. This makes it very challenging to do upstream work at a local level. I couldn't tell you what upstream work was being done in the CPP. Downstream there is a lot about dealing with people with issues. It's firefighting. We're just trying to just deal with the demand coming through the door."

- Capacity

"Capacity is a massive issue. The aspiration is there but there's no capacity. The band 6s are doing strategic work as well as delivery work. You become very good at juggling."

- Specific challenges for smaller boards

"We're very heavily focused on traditional topics. There isn't the same inequality focus as in bigger boards. We don't have massive areas of need. We do a fair bit of prevention work in the topics though – it's enforced around community planning structures and plans."

6. Budget and funding

The work of local health improvement teams is funded either directly or indirectly by the Scottish Government. The main sources of funding are:

- The NHS Board's annual allocation (core budget)
- Scottish Government Outcomes Framework funding:
  - Effective Prevention Bundle (Child and Adult Healthy Weight, Tobacco control, and Sexual health and blood borne virus)
  - Maternal and Infant Nutrition
  - Childsmile
- Healthy Working Lives (only relevant for some teams – see section 2: Role and remit)

- Early adopter/pilot funding such as *A Healthier Future: type 2 Diabetes prevention, early detection and intervention framework*

This is true regardless of the operating model. In models other than the health board model, the funding is delegated to the relevant body and will be subject to local finance strategies. A number of SHPMs based in health boards reported frustration at having no knowledge of what the funding was used for once it was delegated.

"Budgets for the teams in HSCPs are determined by the HSCP. Once a function is delegated you cannot influence how the budget is spent."

Core budget

Each health board receives an annual allocation from the Scottish Government. The Audit Scotland report NHS in Scotland 2018 states that of the £13.1bn total Scottish Government health budget in 2017/18, £11.2bn was allocated to the 14 territorial boards, of which £5.8bn was delegated to HSCPs.

The amount of funding each health board receives is worked out using the NRAC formula developed by the NHSScotland Resource Allocation Committee. This is based on a number of factors including population size, age and gender profiles, and deprivation.

Boards have discretion as to how they use the funding, with the exception of ring-fenced funding. The proportion received by the local health improvement teams therefore varies between areas.

A common theme in discussions around the core budget for the health improvement team is that it has been decreasing year on year and that savings are having to be made.

"It is the worst possible time I remember in the NHS".

Outcomes Framework funding

The Outcomes Framework is the means by which the Scottish Government Health Finance Directorate funds and performance manages specific elements of NHS work. The framework covers outcomes spanning a number of directorates, namely:

- Population Health directorate (Effective Prevention Bundle)
- Chief Nursing Officer directorate (MRSA screening programme)
- Children and Families directorate (infant nutrition, IVF and maternity and neonatal services)
- Quality and Strategy directorate (general dental services)

As stated in the 1 June 2018 letter from the Director of Health Finance and Infrastructure to all Chief Executives of NHS Boards:

"The Framework is a single source of funding to NHS Boards which provides greater local flexibility regarding decisions on how to maximise the value from this resource

against clearly defined outcomes. The Framework has a strong focus on delivering strategic priorities such as prevention and reducing health inequalities…"

The element of the Outcomes Framework Funding mentioned most frequently by the SHPMs was the Effective Prevention Bundle. This includes:

- Child and adult healthy weight
- Tobacco control
- Sexual health and blood borne virus

Maternal and infant nutrition (MIN) and Childsmile, which are part of the wider Outcomes Framework, were mentioned in some areas but not others. This is an example of where the teams' remits differ as in a number of areas it is not the health improvement team that delivers dental or MIN services (see section 2: Role and remit).

Whether it is the local health improvement team or another part of the public health directorate, wider board, HSCP, CPP or CPP sub-group that leads the work around the different areas depends on the operating model, the remit of the team and the engagement with other bodies as detailed elsewhere in this report.

The funding streams (tobacco control, child and adult healthy weight etc) are no longer ring-fenced, meaning that teams have flexibility as to what they use the funding for as long as they meet the required outcomes (set out in Appendix A).

By far the most significant and common issue raised in relation to the Outcomes Framework funding is the non-recurring nature of the funding. The Scottish Government confirms the funding and the level of funding in June each year. SHPMs reported that this means they cannot make long-term plans, which affects how impactful they can be with the funding, which in turn affects their ability to meet the outcomes specified in the framework. SHPMs reported that the non-recurring nature of the funding is a barrier to planning and implementing longer-term preventative work, which leads to downstream drift (see section 5).

"We don't know from one year to the next. It's really frustrating."

"We are not free to take a three or five year view in planning. We can't make investment decisions. Work is disjointed and short term as a result."

"We know by June if we've got it but because it's non-recurring we can't plan anything. There are real challenges in terms of using the funding in any meaningful sense."

SHPMs respond to this challenge in different ways. The majority use the funding for staffing costs despite the non-recurring nature of the funding (see Figure 4 below). They are highly aware of the risks associated with this approach but in most cases felt that it was the only viable option given the issues relating to planning and implementing delivery work between June (when the funding is confirmed) and the end of March.

"It's a fragile situation - 48% of my budget for pay is non-recurring. This means that a disproportionately high proportion of staff are on money which is fixed term. This is high risk."

Figure 4: Use of Outcomes Framework funding for staffing costs

No	Yes
• NHS Highland • NHS Lothian	• NHS Ayrshire and Arran • NHS Borders • NHS Dumfries & Galloway • NHS Fife • NHS Forth Valley • NHS Greater Glasgow & Clyde • NHS Grampian • NHS Lanarkshire • NHS Orkney • NHS Shetland • NHS Tayside • NHS Western Isles

In addition to these shared challenges, there are a number of issues specific to smaller boards:

- Allocation through NRAC (the NHSScotland Resource Allocation Committee formula)

"Very small amounts of funding come here due to the way NRAC works. But we still have to deliver the same core services for the population. They are very small services but they still have to be effectively managed, the people trained and kept up to date etc."

"Obesity is a real issue here. We're getting £42k of seed funding for prevention and type two diabetes work from SG. But it's difficult to do anything with £42k. We get a very small amount of funding for Maternal and Infant Nutation work – only enough for a member of staff to work 6 hours a week."

- Use of Scottish Index of Multiple Deprivation data to allocate funding

"SIMD doesn't work here. We don't have any areas classed as quintile one. We do have quintile two areas but when we did some work on employment and poverty we discovered that 70-80% of our deprived people do not live in deprived areas."

7. Staffing

The combination of the different operating models, the variety in role and remit, and the difference in local population served, makes it difficult to meaningfully compare the size and structure of the teams themselves. However there were some common themes:

- Registration of the health improvement workforce

A number of SHPMs reported challenges with staff becoming registered with UKPHR through the pilot being run in Scotland.

"I know of two boards that are struggling to take part. They've trained some assessors but nobody goes through it."

"We've come together with other island boards to go through practitioner registration for UKPHP. It would have been prohibitively expensive otherwise."

- Cost savings reducing staffing capacity

"Critical mass is beginning to be insufficient."

"Public health capacity is vulnerable to saving measures, though the savings expectations are the same as in other areas. But a 5% saving in some areas of public health can mean the loss of a member of staff or two."

- The move to generic rather than topic specific job descriptions

This was said to provide greater flexibility within the team. Some SHPMs also referred to it as a way of dealing with challenges associated with the non-recurring Outcomes Framework Funding.

- Skills and experience

"It used to be that you worked in a deprived community as a Community Health Worker to get into health improvement. That's what you did. You had a real experience of inequality. But in the recruitment for health improvement now there's more of a focus on academia rather than experience of working in communities. Understanding the theory is one thing but knowing what you can actually do about it is another. They don't have the experience of effective positioning and relationship-building in local areas. It can't just be theoretical. They need to have a people feel – outcomes as they relate to people. They need influencing skills."

"Most health improvement staff have an understanding of inequality but it's not as sophisticated as it needs to be to really work on structural elements."

"We need to adapt to the new world. This requires us to work at pace, be flexible, visible and agile. People want us out there with accessible information, and good advice, not a 100 page document that takes ages to pull together and digest."

- Losing posts and resource through delegation to partnerships

"A fair chunk of funding/posts was transferred to the local authority as part of integration. Most of these posts have now disappeared and there is no way to trace what happened to the funding for these posts."

"It's a problem when there are cuts to posts in partnerships. The savings go towards the partnership's bottom line. Ultimately it's not the Board's shout."

8. Engagement with local government

Local government is seen as a key partner in all local areas. Most commonly, the link is through the community partnership arrangements in place in the area, though in some cases there are links directly with a local authority team, such as children's services, safer communities, and community learning and development.

Figure 5: Local partnership arrangements

The Joint DPH model is important to note here, where the Director of Public Health is jointly employed by the Board and the council. As detailed above, the health improvement team works across both the HB and the Council and enjoys close relationships with relevant teams in the council.

It should be noted that the partnerships above are also a major way in which the teams connect with the third sector (see section 10 below) and the wider system.

Common themes in the discussions include:

- Senior colleagues in the public health directorate and wider board/HSCP being involved in strategic work with partnerships

"We enjoy very good working relationships with all CPPs, we are very much aligned to their structures and priorities and involved at all levels up to CPP Board – which is attended by our NHS CEO, Chairman and a consultant or DPH."

"One of our Consultant in Public Health Medicine is the Public Health Lead on each of the CPP and IJB boards."

- Members of the health improvement team leading on work around early intervention and prevention and specific topic areas

"Health Improvement are a valued contributor to both Community Planning Partnerships and indeed lead on much of the work around early intervention and prevention, some specific topic areas and within some LOIP priorities. Health Improvement staff are part of many multi-agency forms. Senior health improvement staff chair and lead many of these as relevant."

- Engagement with all the various local partnership committee structures being time and resource intensive

"The Integrated Children's Services Boards are of huge importance. But we don't have public health on the ICS partnerships. We fed into the development of the plan but we're not round the table or on the implementation groups. To get in and around prevention in early years you need to be on this group. But we can't get on because the people setting up the group don't want it to be too big. They earmark one place for the NHS and they expect the NHS rep to cover a lot more than public health. The rep is expected to talk about the whole of the NHS – hospitals, ambulances etc. Even if there was a public health seat though we might not have the capacity to fill it. We have to prioritise which of the many groups we sit on – Community Justice, ADPs, children's partnerships, LOIP groups etc. All the groups then have subgroups for implementation work."

9. Engagement with national agencies

The third element of the public health reform programme is around supporting different ways of working to develop a whole system approach to improve health and reduce health inequalities. The way in which local areas and national agencies engage with one another will be key to this. SHPMs were therefore asked about what works well and less well in their engagement with national agencies.

"It is better when there is closer working - two-way learning. It's not just about the local teams learning from the national agencies. The national agenda must be informed by local practice."

"Having one go-to public health body will really help things."

The national agency mentioned most frequently was NHS Health Scotland (HS):

- Topic leads in the local team having links with the national lead in HS

"We have topic-based links but how good those links are depends on the topic and the people involved."

"We've got named link people for each topic and they maintain the relationship with the national lead in NHS Health Scotland and the named lead out in the partnerships."

"We used to work far more with HS across the piste as they had people working on similar things as us like diet and physical activity. Then HS went into the abyss. But it's much better now. Now there is work on topics again and what works and what doesn't. We've used that a lot with CPPs. Over the last three years things have got better. Partnership rather than leadership is what is needed."

- Engagement through the SHPM group

"We work quite closely with HS through the SHPM group but outwith that, we work with HS significantly less than we used to. The connection with the locality teams is pretty limited. Local teams used to be prime stakeholders of HS but then HS changed strategic direction, forgot about local teams and just helicoptered in".

- Membership of networks supported by NHS Health Scotland such as the HPHS leads network

- Support from the Learning and Improvement Team

"We have a really productive and positive relationship with Wilma's team."

- Ordering publications for use with professionals

"It's straightforward and Agnes is always really helpful."

- Support around focussing on inequality – both directly and through national leadership

"It was of great value when HS went public with fundamental causes. A national agency saying in public that health is not just about health behaviours."

- Data and evidence, including through the ScotPHO collaborative

- National groups managed by ScotPHN

"*ScotPHN is very good as the custodian of national groups – we get high quality support."*

Other national bodies mentioned include:

- Scottish Government

"The current situation can be frustrating. Directives go from SG to the board at the same time as they go to HS. The lead in time given to HS should be longer so as to support local intervention. HS needs time to develop resources but in the meantime the boards just need to get on with it – they can't wait. There needs to be a better understanding of the sequence of support for whole system working to really be effective."

"Collaboration opportunities are improving. But we're a small area so we tend to get left out of things. The focus for new SG initiatives tends to be urban."

[In a mixed model area] "SG communicates more with CPPs than with HSCPs. Then with the regulated professions like primary care, nursing, and AHPs, the line of sight into SG is though health boards. But it's loose with health improvement – it's messy. The HB doesn't proactively put information out to the HSCPs. There's a role for PHS here as otherwise we are left hunting around."

- Improvement Service

"It ends to be very local government orientated. It's interesting though as they tend to be parallel initiatives but you don't hear about it directly – you have to go and seek it out as they just talk to local government and CPPs."

- Healthcare Improvement Scotland support around commissioning plans

- Health Protection Scotland

"We have a good relationship there."

- NHS Education for Scotland

"We don't have much to do with NES. It would be good if they helped more explicitly. NES just works with the regulated professions so they don't work with us. Health promotion staff are the only unregulated profession that a DoPH manages. We need that to change. It doesn't matter who does it – NES or Public Health Scotland, it just needs to be done. We need a good, safe, regulated workforce."

- Education Scotland

"It would be good to have links with Education Scotland around our children and young people work, but they link in more with local authority colleagues".

With specific reference to remote and rural areas:

- The North of Scotland Public Health Network (NoSPHN)

"NoSPHN is a fantastic resource."

- There are barriers to face to face engagement

"We have a good relationship with national agencies. But we are isolated so travelling to meetings is a problem for us. On the whole people are good at including us despite us not being there in person. It's not just that there are financial barriers to travelling. Sometimes we decide not to travel even if another organisation offers to fund it. Time is also an issue. It can take three days out of your week just to go to one meeting. We're all generalists – we do a bit of everything. So going to a meeting on a particular aspect of your role takes you away from the rest of it. There's also the work-life balance aspect as it's time away from home."

10. Engagement with the third sector

All SHPMs reported working with the third sector to a greater or lesser extent. This is often but not exclusively through local partnership structures. Themes around third sector engagement include:

- Working with Third Sector Interfaces (TSIs) as partners in CPPs (both collaborating at a strategic level and in the delivery of LOIP actions)

This can vary even within a local areas – there were reports of teams having a good relationship with one TSI but not with another.

- Working with the third sector through ADPs and Children's Partnerships

- Commissioning services from third sector organisations

All but two health board areas are funding third sector organisations to deliver services this year.

Figure 6: Third sector commissioning

No	Yes
• NHS Fife • NHS Orkney	• NHS Ayrshire and Arran • NHS Borders • NHS Dumfries & Galloway • NHS Forth Valley • NHS Greater Glasgow & Clyde • NHS Grampian • NHS Highland • NHS Lanarkshire • NHS Lothian • NHS Shetland • NHS Tayside • NHS Western Isles

In most cases the funding comes from the Outcomes Framework, with Sexual Health and BBV being mentioned most frequently, followed by mental health. SHPMs talked about the added value the third sector brings as being the motivating factor, though a desire not to use the Outcomes Framework funding for staffing was also mentioned (see section 6 above).

"The main deciding factor for us is whether or not they would achieve better outcomes than a statutory body. For example, we fund our local mental health charity to run services – they're the experts, they're in the right place and they have the reach. Distance from the statutory body can be helpful. Credibility and experience are the main drivers."

"We commission out a lot because they can effect change and be more fleet of foot than we can."

"We use 75% of the substance misuse money to commission the third sector."

Many SHPMs talked about not commissioning as much out to the third sector as they used to. Reasons given include a reduction in funding available due to efficiency savings, tightening of procurement rules and not having budget available.

"We used to, but now all the budget is used to deliver the public health plan."

"The public health directorate has no budget to commission anything as the bundle funding goes to the HSCP."

"We've dabbled in it but not much. It's quicker to just do it yourself."

"Our board has recently tightened up its procurement rules. Three years ago, if you could make a convincing case for a single tender exemption you would get it. For example we have a local football club that runs Football Fans in Training, which includes smoking cessation support. So we gave them £10k to help support that element. But we can't do that anymore. An extreme example was last year when we wanted Year of Care to come up from down south and do training in House of Care. They are the only people that do the training and it's a requirement of the Clinical Strategy that we do it. They're the only provider but we still had to go through the procurement process and go out to tender. It took months and then Year of Care didn't even tender because the amount was so low that it wasn't worth their time to go through the process. No-one else tendered to do it because no one else can do it. Only then did we get a single provider exemption."

- Commissioning services from the third sector through partnership arrangements

"We've persuaded the IJB to fund stuff. The IJB is very up for this and have said "you come up with the ideas and we'll find the money".

- Engaging directly with specific third sector bodies who share a common interest (strategically and/or in the delivery of services)

"We work closely with the Health and Social Care Alliance Scotland on the Self-Management Agenda."

"Engagement with third sector is extensive at both a corporate level and local level. Corporately engagement is largely direct with individual third sector agencies many of whom have a specific health remit or with organisations who provide services within the community who 'connect' with hospital settings. In some instances the third sector may be commissioned to deliver services on our behalf."

- Fewer opportunities to engage with third sector organisations in some rural areas compared to urban areas

11. Conclusion

The Improving Health Commission's *Current Health Improvement Landscape* report identified the Scottish Health Promotion Managers as a core national health improvement group and local health boards and Integration Joint Boards (IJBs) as core local health improvement bodies. This report sets out the contribution made by local health improvement teams in health boards and IJBs for the first time. It also highlights a number of shared challenges, together with opportunities for the future.

This report is designed to set out the current landscape rather than make recommendations. The intention is that the information contained in this report will help the Improving Health Commission in the development of their recommendations for the future state of the improving health function in Scotland. Longer-term, consideration may also be given to further work in this area, including:

- The addition of material from Health Improvement Managers working in Health and Social Care Partnerships.
- Conducting the same exercise with Community Planning Partnership managers.
- More robust analysis around alignment with the Public Health Priorities, incorporating the activities of all local partners.

Themes emerging from this report include:

- Significant variation in the way in which local health improvement teams operate.
- The personal and strategic intent to work upstream is hampered by a number of factors outwith the control of the SHPMs including national drivers such as funding models and strategies, as well as local priorities and team capacity.
- Local teams are operating within a challenging financial climate, with a reduction in core allocation, the main Scottish Government funding being non-recurring, and the loss of control over budgets and workload resulting from delegation to HSCPs.
- Health improvement is a shared goal across a number of agendas and bodies, which is positive but does lead to a fragmented landscape and makes it difficult to gain an accurate picture of the totality of health improvement activities being undertaken, and outcomes achieved, in local areas and in Scotland as a whole.

It was clear through the written submissions and the interviews that SHPMs share a real passion and commitment for their work and have great pride in their specialism. They are supportive of public health reform and committed to helping to design a health improvement function that is equipped to meet the challenge of improving the health of the people of Scotland.

Appendix A: Scottish Government Outcomes Framework funding

Funding stream	Outcomes
Effective Prevention Bundle: Child and Adult Healthy Weight	• Sustained improvements to weight and diet through weight management interventions to at risk adults, children and families focusing on those from deprived communities. • Support for national work on minimum standards that aim to improve the consistency and quality of healthy weight interventions. Progress towards referral pathways between healthy weight interventions and other services (e.g. type 2 diabetes) to healthy weight interventions.
Effective Prevention Bundle: Tobacco control	• NHS Boards to tackle health inequalities by significantly reducing smoking rates within local communities, in line with the national target to reduce smoking prevalence to 5% or less by 2034. • Tobacco control through: - Cessation: supporting smokers to quit - Prevention: supporting young people to choose not to take up smoking - Protection: supporting action to reduce exposure to SHS (e.g. protect children from second-hand smoke in homes and vehicles, introduce smoke-free prisons, supporting smoke-free hospital grounds and banning smoking near hospital buildings).
Effective Prevention Bundle: Sexual health and blood borne virus	• Fewer newly acquired blood borne virus and sexually transmitted infections; fewer unintended pregnancies. • A reduction in the health inequalities gap in sexual health and blood borne viruses. • People affected by blood borne viruses lead longer, healthier lives, with a good quality of life. • Sexual relationships are free from coercion and harm. • A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and blood borne viruses are positive, non-stigmatising and supportive.
Maternal and Infant Nutrition	• All Stakeholders should understand the Public Health imperative of making Maternal and Infant Nutrition a priority and having a clear vision of our aspirations. The key aim to prevent ill health by: • Tackling the unsustainable burden of poorly planned preconception nutrition including: folic acid uptake and achieving a healthy weight prior to the first pregnancy. Then by ensuring that pregnant women continue to make good

	nutritional choices, including Vitamin D supplementation. • Preventing childhood obesity, nutritional deficiency or stunting by ensuring that parents have the ability to make good choices about weaning, toddler diets and family mealtime behaviours. • Keeping breastfeeding maintenance as a priority: ensure that the UNICEF best practice standards for supporting infant nutrition are in place; core staff have the necessary support, tools, capacity and capability to deliver this care and that the additional specialist support for mothers with feeding challenges in maternity, neonatal and community services is in place.
Childsmile	• Improve the oral health of Scotland's children, specifically the achievement of the national outcomes: - 75% of P1 children with no signs of dental disease by 2022 (this requires a ten percentage point increase on each NHS Boards last NDIP result) - 80% of P7 children with no signs of dental disease by 2022 (this requires a ten percentage point increase on each NHS Boards last NDIP result)

Appendix B: Local partnership arrangements

NHS Board	Health and Social Care Partnership[7]	Community Planning Partnership[8]
NHS Ayrshire and Arran	- East Ayrshire - North Ayrshire - South Ayrshire	- East Ayrshire Community Planning - North Ayrshire Community Planning Partnership - South Ayrshire Community Planning Partnership
NHS Borders	- Scottish Borders	- Scottish Borders Community Planning Partnership
NHS Dumfries and Galloway	- Dumfries and Galloway	- Dumfries & Galloway Community Planning Partnership
NHS Fife	- Fife	- Fife Community Planning
NHS Forth Valley	- Clackmannanshire and Stirling - Falkirk	- Clackmannanshire Alliance - Falkirk Community Planning Partnership - Stirling Community Planning Partnership
NHS Grampian	- Aberdeen City - Aberdeenshire - Moray	- Community Planning Aberdeen - Aberdeenshire Community Planning Partnership - Moray Community Planning Partnership
NHS Greater Glasgow and Clyde	- East Dunbartonshire - East Renfrewshire - Glasgow City - Inverclyde - Renfrewshire - West Dunbartonshire	- East Dunbartonshire Community Planning Partnership - East Renfrewshire Community Planning - Glasgow Community Planning Partnership - Inverclyde Alliance - Renfrewshire Community Planning - West Dunbartonshire Community Planning
NHS Highland	- Argyll and Bute - Highland	- Argyll and Bute Community Planning Partnership - Highland Public Services Partnership

[7] Source: https://www.gov.scot/Resource/0048/00485238.pdf
[8] Source: http://www.improvementservice.org.uk/scottish-councils-and-cpps.html

NHS Lanarkshire	- North Lanarkshire - South Lanarkshire	- North Lanarkshire Partnership - South Lanarkshire Community Planning Partnership
NHS Lothian	- City of Edinburgh - East Lothian - Midlothian - West Lothian	- East Lothian Partnership - The Edinburgh Partnership - Midlothian Community Planning Partnership - West Lothian Community Planning Partnership
NHS Orkney	- Orkney Islands	- Orkney Community Planning Partnership
NHS Shetland	- Shetland Islands	- Shetland Partnership
NHS Tayside	- Angus - Dundee City - Perth and Kinross	- Angus Community Planning Partnership - Dundee Partnership - Perth & Kinross Community Planning
NHS Western Isles	- Na h-Eileanan an Iar	- Outer Hebrides Community Planning Partnership