ScotPHN report

Scottish Public Health Network (ScotPHN)

Public Health Review – Engagement Events - Report

ScotPHN

25 June 2015

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1. Background

A review of the public health function was announced at the UK Faculty of Public Health's annual Scottish conference in November 2014 by the then Minister of Public Health, Michael Matheson.

The Public Health Review Group (PHRG), chaired by Hamish Wilson, vice Chair, HIS, and facilitated by Heather Cowan, Policy Lead, Scottish Government was established to progress the review. The PHRG sought contribution from the public health community through an engagement paper which included five questions on public health related issues in January 2015. Hamish Wilson and Heather Cowan have undertaken an on-going process of engagement, inviting presentations to the PHRG and meeting with various groups etc. to increase their understanding of the views of stakeholders. Early in this process it was decided that the PHRG should also engage through regional events.

The Scottish Public Health Network (ScotPHN) was invited to organise a series of events before the summer of 2015 which would include a broad range of those working or interested in public health in Scotland.

2. Events

Three events were originally arranged by ScotPHN with a fourth being added at a later stage to accommodate the demand for places:

- Dundee 6 May
- Edinburgh 14 May
- Glasgow 19 May
- Inverness 21 May. This event included video conferencing.

Each event included a mix of attendees from the public, public health, the wider NHS, local authorities and the third sector. Members of the PHRG were also in attendance and participated in discussions.

The format of each event was the same: an introduction by the PHRG; a presentation providing a local perspective; and then facilitated group discussions. The Presentations are available on the ScotPHN website here.

At each event, groups were asked to discuss two of four questions. The questions were:

1. More of an upstream focus – what does that mean to you and how is it best achieved?
2. What should be done nationally, regionally and locally and how should they join up?
3. What public health outcomes would be meaningful and over what timescales?
4. How do we really involve communities in partnerships and enable community empowerment?

These questions were posed in order to find out more about some of the issues that had come to light through the responses received to the five engagement questions and reflected a desire of the PHRG to understand these issues better.

3. Summary of discussions

A thematic analysis of the main points brought out in discussions is provided below. These are organised by question.

Question 1 More of an upstream focus – what does that mean to you and how is it best achieved?

'Upstream'

It was clear from all the events that 'upstream' is understood differently by the public health community with perspectives differing depending on an attendee's role and/or organisation. The following terms were provided by way of response: 'Prevention'; 'Intervention'; 'Early Years'; 'Fundamental Causes'; and 'Social Determinants of Health'. Some described examples of work that were 'upstream': 'early years collaborative'; 'mitigation of the impact of welfare reform'; 'immunisation'; 'screening' etc.

Attendees understood the concept of 'upstream' but were placed at different positions along the 'stream'. One group spoke of the tributaries leading into the stream.

It was generally understood that much upstream activity is not within the gift of the NHS but is delivered by partner organisations with significant input of the local authorities, the third sector, and communities of interest or location.

'How is it best achieved?'

Creating a common understanding of how 'upstream' actions were to be best achieved was felt to be critical; not only across the entire public health (and wider) workforce, but also for the public too. However, given the varying understanding of the meaning of 'upstream', there was equally a range of opinions on what this meant practically.

On possibility suggested was to use an alternative terminology that might help instil a shared understanding of the ethos of what is trying to be achieved. One proposal at the Glasgow event was: 'prevent, undo, mitigate'. On another point about terminology, it was noted that actions taken 'upstream' should be framed in terms of 'inequalities' rather than 'health inequalities'.

From the first event in Dundee where there was a strong focus on co-production, there was clear recognition through all the discussions of the person-centred approach and the empowerment of local communities being fundamental to achieving upstream aims. Listening to local priorities, involving communities in planning and providing feedback would create ownership, build resilience, and develop local assets for sustainable change. This would entail a move beyond current boundaries and structures. This would be supported by a shift from 'process driven', 'top down' to 'bottom up' policy. The role of specialist and wider public health would be to support, educate and encourage communities.

It was acknowledged that not all Community Planning Partnerships (CPPs) were functioning as they should but they were seen as essential to the future empowerment of local communities with some suggesting that the requirement for CPPs to deliver upstream activity be included in the Community Empowerment Bill (Ref). In addition, the third sector has an important role to play in reaching, working with, and empowering local communities.

More generally, it was felt that Public Health needs to be better integrated within health and social care partnerships and Integrated Joint Boards (IJB).

With the potential for contributions from many organisations, attendees spoke of how this could be achieved to best effect. There was a consistent request for a clear vision of what Public Health should achieve, set within a clear articulation of national / shared priorities and (possibly) a national strategy to ensure that everybody was working towards the same end. It was also suggested that without knowing public health outcomes, you cannot fully understand what 'upstream' activity is required; Public Health outcomes should influence and inform the upstream action for a range of organisations. This approach would need to be supported by appropriate funding

cycles, data gathering, evaluation, shared governance and accountability, and performance management.

The tension between local priorities and national policy was acknowledged but the potential for each to inform the other was seen as a positive prospect for the future. It was acknowledged that not all Public Health functions can be achieved at the local level.

A fundamental problem to achieving 'upstream' working was considered to be short term funding and goals. There should be a shift to long term goals. There was a consistent message to the Scottish Government to truly recognise that improvement to health and well-being and reduction in health inequalities may take a generation or more to achieve. Therefore there is a need to create policy that addresses upstream issues (e.g. welfare, licencing/gambling), as well as what works across government (i.e. 'silo' working should be eliminated as far as possible). There was an equally strong message to Government to focus less on targets; upstream activity is required at population level, whereas much Public Health activity is currently focussed on individual behaviour driven targets. The Scottish Government is hugely important to achieving 'upstream' activity through support, leadership, creating political will and encouraging local action.

There was recognition that 'upstream' should not be achieved at the sacrifice of 'downstream'. There will continue to be a need for 'downstream' activity, but it is about achieving a shift and a balance.

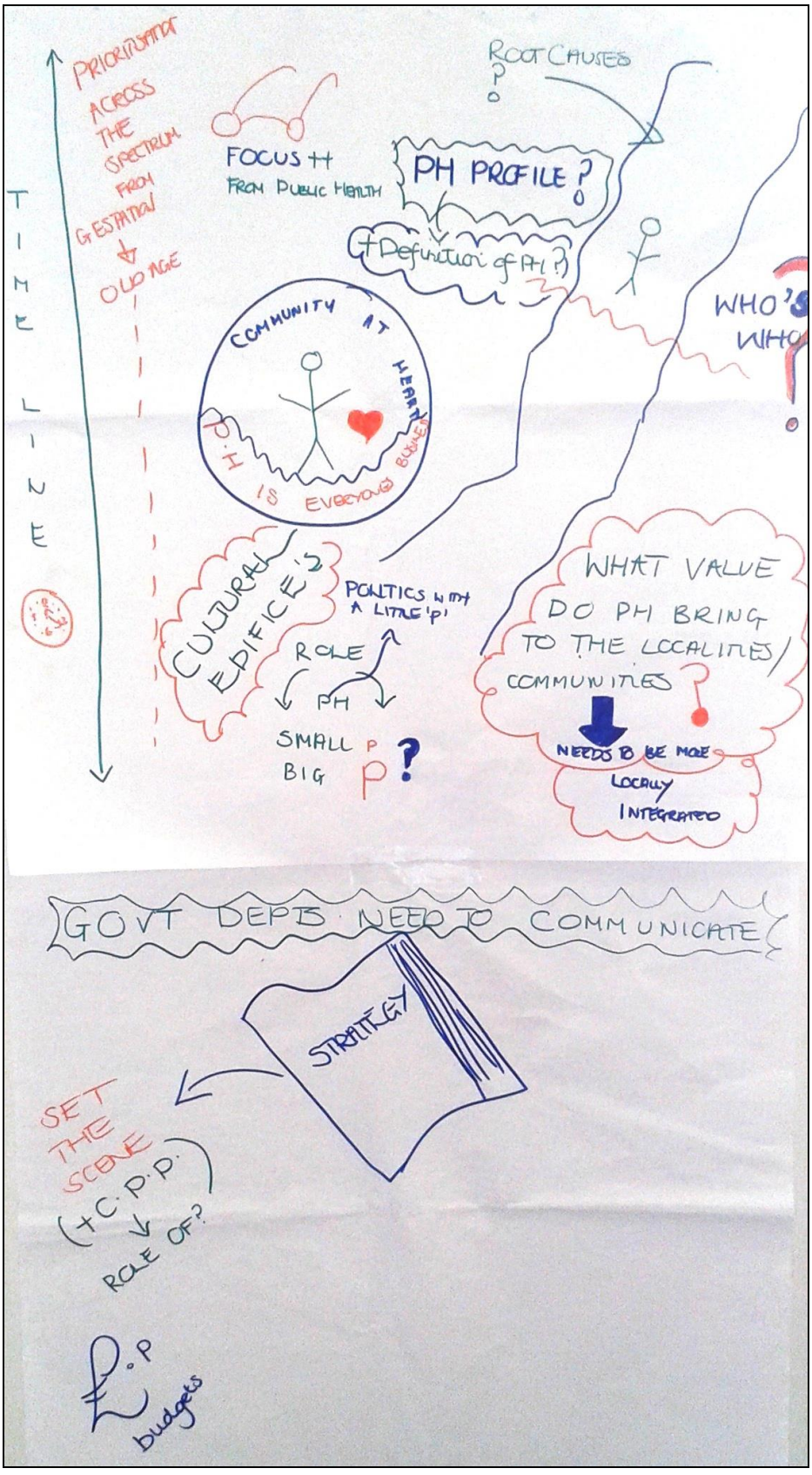
Additional comments included:

- There needs to be better leadership at all levels including local government. Public Health should have a strong independent voice;
- Public Health needs to be involved at early stages of planning. It needs to be at the 'right' meetings. SOAs need to be improved;
- Such planning needs become more used to dealing with complexity. For example: dealing with proportionate universalism; matching appropriate

responses to evidenced need; learning when to target intervention and when to intervene at a population level;

- Workforce:
    - The specialist public health workforce needs to be used to better effect. It should not be spread so thin that it loses all efficacy;
    - The wider workforce needs to have a better understanding of 'upstream' and its role in achieving it;
    - In rural and remote areas the workforce input to public health should be maximised through diversification eg fire brigade as first responders;
    - The workforce needs to be skilled, regulated and competent;
- Data requirements should be better understood. It should be relevant to all including local communities; and
- Better evidence is required at local and population levels. Evaluation should be undertaken over the long term.

Question 1 Pictorial Response (Dundee)



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

As in Question 1 the differing perspectives on what was meant by 'local, regional and national' and what function should be undertaken at what level were of interest. How local is local? Local authority or local community? Does national mean Scotland or the UK and so forth.

Although some discussion groups were quite prescriptive in allocating functions at different levels, others spoke in more general terms and there was a degree of variance in what should be undertaken at the different levels ie how the public health function could be split. It seemed that the two extremes of a continuum were perhaps easier to conceptualise; for example, what should be undertaken at national and local levels.

National

It was commented that it is hard to envisage a time when a national role would not be required. Foremost, leadership at national level is vital from Scottish Government, national organisations, groups (e.g. Scottish Directors of Public Health etc.) to provide an overall vision, inform and set policy 'direction', and so forth. It needs to be more visible and the vision more clear.

However, leadership was thought necessary at all levels. The right type of leadership is required and various models – distributed leadership, for example – were suggested.

There was a feeling that there could be more 'done once' for Scotland to limit unnecessary duplication. Some functions could be undertaken centrally (e.g. health intelligence).

Local

The desire to 'do things with, not to' local communities identified in discussions on Question 1, was reflected in the Question 2 discussion on 'local' activity. The activity

therefore should be to support and develop co-production. There was comment that structures should support local level activity and that the control of resources should be held at local level (e.g. participatory budgets). It was noted that local expectations need to be managed.

Activity requires a national and a local component. These need to influence and inform each other. Good policy needs to be informed by local experience, grass roots and multi-agency input.

Regional

The 'regional' function varied most in the discussions. In Inverness where attendees are well used to the northern way of regional working there was clear understanding on what can be achieved at this level. Elsewhere, there was perhaps less clarity on what could effectively happen at regional level rather than locally or nationally. Perhaps giving rise to some query that 'regional' is a distraction from 'local' and 'national' function. Perhaps this was reflective of a desire for the Public Health system to be more flexible and dynamic and not too prescriptive in terms of which level it happens. One group in Dundee certainly took this view, suggesting that public health should be viewed in terms of how good health for all can be achieved, instead of considering function at varying levels.

'How should they join up?'

At whatever level activity *should* take place, it was clear that there is a requirement for 'connectedness' through all levels. The following points were made on how to achieve this:

- a common vision across all levels;
- avoid structural change and improve operational connectedness. It is less about structural change but about better integration and partnerships, and through networking. Health & Social Care Partnerships, Community Planning Partnerships, and the third sector should be better aligned;
- the third sector should be supported and resourced so that its skills and expertise can be used to best effect;

- shared governance. Clear accountability at all levels. Shared Key Performance Indictors;
- consistency of delivery;
- less silo working;
- networking. Examples of successful national and regional networks were provided (Health Protection Network, ScotPHN, NoSPHN). However, it was noted that networks need to be well resourced to be effective;
- better resourcing and more consistency of the flow of resource. Does the balance between local boards, national boards etc. need to altered?
- training and skill development at all levels to improve expertise at all level;
- better use of social media;
- better evidence of what works. Evidence should not be solely ‘academic’; and
- pockets of good practice need to be scaled up and better communicated.

Question 3 What public health outcomes would be meaningful and over what timescales?

'Meaningful outcomes'

Across all the events and discussions there was general consensus on what meaningful outcomes would be. Firstly, these would be population not workforce outcomes.

Suggested high level outcomes included:

- protecting and improving the health of the population;
- the 'happy and healthy lives' of the population;
- full employment at a minimum of the living wage;
- eliminating child poverty;
- a reduction in inequality; and / or
- reduction in health inequalities.

Creating indicators for such outcomes needed innovation and imagination, not a recycling of existing indicators as (increasingly loose) proxies for these outcomes.

In light of discussion throughout the events on community empowerment, there was comment that outcomes need to be meaningful to the public.

'Timescales'

It was unanimous that the timescale for achieving these outcomes is significantly longer than current planning cycles. There should be short and medium term outcomes to ensure the policy direction is correct, with such milestones being served by meaningful proxy measures. Logic modelling was cited as a helpful tool in identifying short and medium term milestones and long term outcomes.

It was acknowledged that achieving outcomes would not be straightforward and discussions focused on some of the problems and possible solutions.

Given that many outcomes will need input from non-NHS partners, a shared understanding of what outcomes are and how they can be achieved would be required across all organisations.

There should be a national public health outcomes framework with shared Key Performance Indicators to ensure that all organisations are working to the same ultimate goals. Single Outcome Agreements should be revised to ensure they reflect these national outcomes and reduce variance.

Evaluation over the longer term would be welcomed. Again it was requested in the widest sense and not simply to fulfil purely academic (or political) purposes. It was also noted that it is difficult for the third sector, for whom it can be a costly exercise.

The role of the Scottish Government was seen as fundamental to any move to long term outcomes as it would have to commit to longer term policy and funding, and reducing the potential for policy incoherence.

Question 4 How do we involve communities in partnerships and enable community empowerment?

The importance of involving communities in partnerships and community empowerment was acknowledged throughout all the discussions, notably of Questions 1 and 2. The link between empowerment and well-being was well understood. It was a given that communities should be involved in the design and production from the outset; a successful example from Western Isles of mothers and toddlers work started in the 1990s which continues to exist today was provided. However, it was acknowledged that it is not straightforward, nor simple to do (see above).

It was felt that the (many) existing structures were sufficient but could be better used to facilitate better community involvement. In Inverness, the example of themed groups, similar to those required for community care planning arrangements in place prior to community planning, which allow communities to relate better to issues was given. Health and Social Care integration meetings were seen as a 'way in' to communities for public health. It was felt important to get clinical buy in at local level The involvement of communities in partnerships and ensuring a strong voice for them should be embedded within the Community Empowerment Bill.

It was suggested that funding of local authorities, the NHS and the third sector should be aligned to improve partnership working. Empowering communities will take time and resource to achieve. It could be at odds with national policy. Specific points raised included:

- the wider workforce was seen as important in achieving community empowerment. For example GPs have access, local profile, trust in the community which could be better harnessed;
- the use of participatory budgets was also commended as a good way of increasing community involvement; and
- the third sector has skills and expertise that should be used more effectively. There was some comment on the need to justify existence through continued evaluation and how that is a strain on resource for third sector.

It was noted that it may be beneficial to develop national standards for engagement. However, there were fundamental activities that the public health should undertake in for successful empowerment of communities:

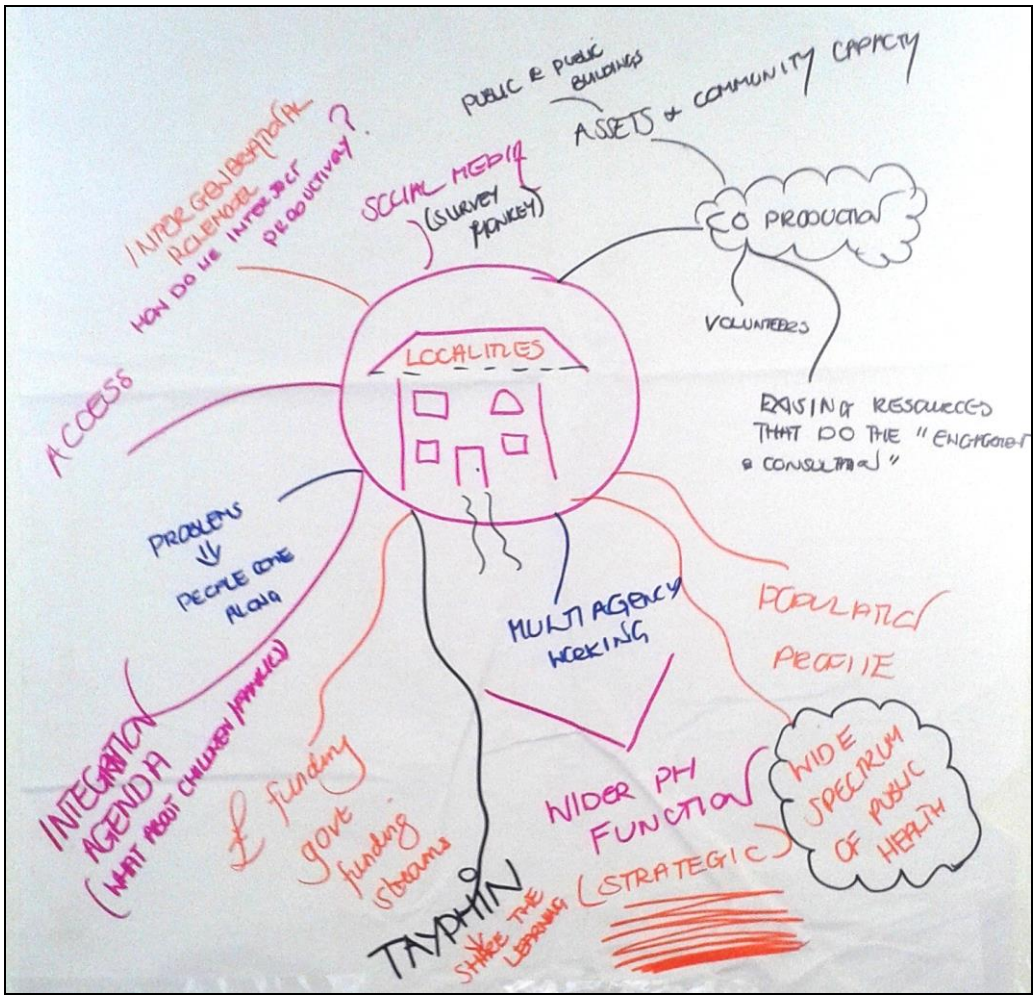
- clear leadership at all levels is required to support this way of working;
- 'Public health' needs to be visible at local level. 'Coproduction is having professionals on tap not on top';
- use a common language. The term 'public health' may not be well understood and an alternative term should be used;
- build relationships and trust. Transparency is paramount;
- two way dialogue is important with active listening. Feedback should always be provided eg do not consult without feeding back;
- manage expectations and communicate what cannot be achieved;
- build confidence;
- act as an equal partner not a leader;.
- make better use of the tools available. The Alaskan Nuka model of care was frequently mentioned at events; a positive example of its adoption in Tayside/Angus was provided;
- better communication of success stories at all levels (local, regional, national);and
- do not be afraid to make mistakes.

Finally, the need for the public health practitioners to 'let go' of power was recognised. It was acknowledged it is difficult to do but must happen if true empowerment is to be achieved.

Other difficulties that were noted but not completely resolved:

- how do you reach the hardest to reach and not just usual voices?
- how do you account for funding in this way of working when it is harder to show clear outcomes?

Question 4 Pictorial Response (Dundee)



4. Themes

'More radical, more brave, more in your face'

There were clear themes that threaded through the discussions at all the events.

Visibility

Public Health needs to be more visible at all level: in local authorities, in CPPs, in IJBs, in communities, in the media. Its message/vision should be clear and consistent.

Influence

Public Health should be able to influence at all levels. In order to influence to greater effect it needs to understand different systems eg if you want to reduce alcohol consumption you need to know how licencing boards work.

Leadership

There is great potential and overwhelming desire for Public Health to provide leadership at all levels and advocate on public health issues.

It was noted that Public Health should not spread itself so thin that it loses critical mass. How it maintains its core function whilst developing greater presence in all these areas, without losing efficacy, given that resource will continue to reduce, is a key consideration.

Shared language and understanding

All organisations have their own 'language', understanding and approach to public health issues. This hinders the progression of a shared vision. How can Public Health communicate with different sectors and organisations?

Multidisciplinary Workforce

The four questions posed deliberately did not focus on workforce issues as this has been covered extensively within other contributions to the work of the PHRG.

However, given its integrity to all that was being discussed, there was recurring mention of workforce requirements. In essence, the workforce should have the appropriate skill set and competencies to implement the shared vision. This would apply to the wider workforce.

Performance

There should be shared performance measures and joint accountability across all organisations involved in the delivery of public health. Financial performance is complex, but should be included..

National v Local

Throughout discussions there were calls for the future direction of public health to be set nationally at the same time as calls for meaningful community empowerment to be achieved through 'bottom up' policy. The tension between national policy and what communities want was recognised.

Connectedness

How do you ensure the various levels (local, regional, national) and the various partners are connected? Is a single model of delivery possible? Structural change is not the answer!

Remote and Rural

It was recognised that the way in which public health is tackled in remote and rural areas often needs to be different; the issues may be the same as for other parts of Scotland but factors such as distance, lack of dedicated resource etc come into play. The issue of 'urban isolation' was also raised.

Funding

Attendees were realistic and understood the constraints of funding and the need to use diminishing resource to best effect. The challenge of ensuring that "upsteam" activity / intervention was appropriately funded was noted on several occasions. In particular, the need to ensure that funding was appropriately aligned to explicit public health outcomes and the wider organisational outcomes, and sustained over a sufficient period of time to allow the benefits of preventative interventions to accrue.

Local control over funding for public health was also raised as an issue, as was the potential to link this to encouraging greater local, community participation and organisational partnerships. Ensuring accountability for the use of such funding approaches was noted to be an unresolved issue.

5. Conclusion

It was clear through all the discussions over all four engagement events, that there is a broad vision and understanding for what Public Health should be and consistent messages on how this could be achieved.

Feedback from attendees would suggest that the events have been a welcome part of the engagement process and have provided additional information for the PHRG to consider.

There is a wealth of material from the discussions; the notes from each discussion have been typed up and are available here on the ScotPHN website.

ScotPHN report

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