Public Health and Health and Social Care Partnerships:
learning from the past and utilising current capacity

Response to consultation on Health and Social Care Integration

Responders

This response is a collective effort from a professional network of Public Health Specialists in Scotland. The Network comprises 27 non-medical public health specialists, 22 of whom are registered by portfolio route with the UKPHR as generalist specialists and one as a defined specialist. All registered members achieved registration as employees of Scottish public sector organisations with only one exception who was employed in Wales while completing her portfolio. Around half of the Network members are currently employed in territorial health boards, with some employed in public health departments, and five or six working in consultant equivalent posts. The remainder are in national NHS organisations, local partnership structures or local councils. Most NHS Board areas are covered by the Network.

Introduction

Outcomes for older people could be maximised if service commissioning and planning included population profiling, improving equality and preventing illness. The new health and social care partnerships offer an opportunity for strengthening prevention through partnership action on anticipating need and acting on social determinants of health. Public health consultants, specialists and practitioners already provide information and leadership within local, multi-agency partnerships for joint service planning and for prevention. This paper provides an overview of three arguments for public health to be included as an integral element of the new health and social care partnerships, from the perspective of non-medical public health specialists in Scotland. The three arguments are as follows:

1. To build on learning from actions to improve health and reduce health inequalities in LHCCs and CHPs.

New public health practitioner posts were developed in Scotland 10 years ago for all Local Health Care Cooperatives (LHCCs) in Scotland to establish a population approach to improving health in primary care. The posts complemented the work of health promotion structures in implementing health improvement programmes and contributed to and built on the emergence of population profiling for prioritising and planning preventative actions. Evaluation of the posts found that the most productive were those that had strategic influence on LHCC planning and delivery, bringing population health and well being closer to community based service planning. Some posts are still in place at the time of writing, others have further developed into public health specialist posts, and the remainder were incorporated into Community Health Partnership (CHP) health improvement structures. Similar posts were established in local authorities soon after the LHCC public health practitioners to lead the improving health agenda across Council departments.

The 2005 CHP statutory guidance gave an advisory and networking role to public health in the new structures, and proposed partnership approaches to needs assessment and health improvement some of which have been taken through community planning partnerships. The document gave little guidance on health inequalities, proposing only that the needs of different groups should be taken into account. The study of CHPs commissioned by the

Scottish Government (2009), and the Audit Scotland review of CHPs (2011) both found that much still remained to be done to establish effective preventative actions for improving health and reducing health inequalities. The Audit Scotland review also suggested that a different way of thinking about the ways in which services are planned and delivered was necessary for CHPs to develop roles in addressing health inequalities.

2. To strengthen new health and social care partnerships' contributions to reducing health inequalities.

A study carried out by Glasgow Centre for Population Health in 2010 identified that application of knowledge of patterns of health and health inequalities in Scottish communities was patchy in CHPs and often depended on interested individuals rather than a systematic use of the evidence base. Recent conclusions from the *Better Together* patient survey data analyses (2011, 2012) and research from general practice in Scotland (various dates and including *Deep End* reports) demonstrated that health services in Scotland have some way to go to achieve equality of access and outcomes and of patient experience. A systematic gathering and application of evidence relating to social determinants of health and of service use should be central to decision making for health and social services based on need and the basis for improving well being in the population. Capacity for gathering, analysing and applying these data exists in Scotland but will remain patchy and underutilised while sitting remote from locality service planning.

3. Capitalising on public health workforce capacity

Twenty two non-medical public health specialists in Scotland at the time of writing have completed their skill set for registration on the voluntary UK Public Health Register as specialists, equivalent to consultant level. In addition, there are currently around 28 specialist public health trainees in the system in Scotland (including 3 non-medics). More than 40 Scottish public health practitioners registered interest in 2010 in developing their public health skills to specialist level, some of whom have already been partially assessed. Specialists and practitioners are engaged in a wide range of roles within local and national health boards, research organisations, CHPs and councils with few in consultant posts but a willingness for development, to date supported only through peer support and pilot projects. This suggests an unrealised capacity within the Scottish public health function some of which could be galvanised around prevention of ill health, service development and delivery for older people and adults. The health and social care partnerships and more importantly, older people, could therefore benefit from the experience of the public health workforce across all domains of public health, including community development, building healthy communities, applying an understanding the impact of socioeconomic factors on health to planning, protecting health, service improvement through identifying and planning around patterns of use of resources, and leading partnership working.

Conclusion

Health is not improving as fast in Scotland as it is in other European countries and health inequalities are increasing for some conditions, particularly for young and middle aged adults. Learning from reviews of previous and existing structures suggests that more could be done to improve health and reduce health inequalities through health and social care service provision. There is a pool of public health resource in Scotland that could be brought together

and utilised better within the new partnerships to strengthen their impact on improving health and reducing health inequalities.

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