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Public Health Review: Analysis of responses to the engagement paper

HEALTH AND SOCIAL CARE

social research

PUBLIC HEALTH REVIEW: AN ANALYSIS OF RESPONSES TO THE ENGAGEMENT PAPER

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July 2015

Scottish Government Social Research
2016

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EXECUTIVE SUMMARY

1. In November 2014, Michael Matheson, then Minister for Public Health, announced that the Scottish Government would be undertaking a review of public health. An expert group, chaired by Dr Hamish Wilson, was established to take this forward.

2. The review was given the task of examining: public health leadership and influence both within the health sector and more widely; workforce planning and development, succession planning and resourcing; and opportunities for greater joined-up working and successful implementation of public health measures within the context of community planning, single outcome agreements, and health and social care integration.

3. An engagement paper was published to seek input on five questions:

   - How can public health in Scotland best contribute to current challenges? What is your view and evidence of the Strengths, Weaknesses, Opportunities and Threats (SWOT) to the contribution of the public health function in improving Scotland's health and reducing inequalities?
   - How can public health leadership in Scotland be developed to deliver maximum impact?
   - How do we strengthen and support partnerships to tackle the challenges and add greater value? How do we support the wider public health workforce within those partnerships to continue to develop and sustain their public health roles?
   - What would help to maintain a core/specialist public health resource that works effectively, is well co-ordinated and resilient?
   - How can we provide opportunities for professional development and workforce succession planning for the core public health workforce?

4. Responses to the engagement paper were received from 117 respondents – 6 from individuals and 111 from organisations. Organisational respondents included NHS Boards (23), community planning or health and social care partnerships (17), third sector organisations (17), royal colleges or other professional groups (15) and local authorities (11), among others.

5. Responses to the engagement paper were highly diverse, and represented a wide range of understandings and perspectives about the nature of the public health endeavour, the domains of public health and the organisational structures which would best support a strong public health function. Many responses were lengthy and complex and there was a lack of consistency in the use of key terms in relation to the public health function.

Strengths and weaknesses (Question 1)

6. Respondents saw the local positioning of public health as a strength. Other strengths included: the skills and qualities of the public health workforce; partnership working at a local level (although it was also thought this could be improved); and the availability of good-quality data, information and evidence. However, respondents also thought there was insufficient co-ordination of public health functions at national, regional and local levels. Respondents highlighted the large number or organisations involved in public health; a lack of agreement about when it is best to act locally, regionally or nationally; and a lack of coherence between what is happening at the 'grassroots level' and what is happening nationally. Moreover, the public health function was perceived to be not particularly 'visible', and this was seen as a weakness.

Opportunities and threats (Question 1)

7. A range of national policies were seen to provide opportunities for taking more of an 'upstream' approach to addressing inequalities. The integration of health and social care was also seen as an opportunity in some respects, but as a threat in others. Concerns were expressed specifically about the potential for fragmentation of the public health workforce. The main threat to the public health function identified was funding constraints and austerity

Leadership in public health (Question 2)

8. Current public health leadership was described as 'patchy', 'disparate' and 'not cohesive' at national and local levels. There was a view that, in some areas, public health leaders do not always have the skills required for leadership – in particular, the skills of influencing, lobbying and advocating for local populations. Respondents highlighted the importance of developing a clear, shared vision – or national strategy – for public health in Scotland, which would provide a coherent focus and agreed set of priorities for public health.

9. The role of the Director of Public Health was seen, particularly by health organisations, to be very important for providing leadership at a local level, and it was suggested that this role could be strengthened in relation to its contribution to national policy. However, respondents also emphasised the importance of developing public health leaders across a wide range of policy areas and topics (not just in health), for example in employment, education, welfare and economic development.

Strengthening partnerships (Question 3)

10. Respondents thought that good partnerships were vital to the public health endeavour. Thus, a focus on strengthening and supporting partnerships was thought to be essential. This could be done by clarifying roles and remits (i.e. who is involved in the public health endeavour and what outcomes should be achieved), and by finding ways to improve communication between partners.

Respondents spoke of the need to develop a 'shared language' and for public health documents to be more accessible.

11. Community Planning Partnerships were seen to be the main mechanism by which improvements in public health can be achieved at a local level, and some respondents commented that the public health function should be better aligned with and more accountable to local community planning arrangements. Respondents also thought that Health and Social Care Partnerships offered new opportunities for partnership development, and there was an emphasis on strengthening asset-based approaches to working with communities, and developing stronger partnerships with the third sector.

Maintaining a core public health resource (Question 4)

12. Respondents' views in relation to maintaining a core public health resource were wide ranging. While some suggested the creation of a national public health resource unit – or a centre for public health – it was more common for respondents to discuss workforce issues. The diversity of the public health workforce was seen to be a strength, enabling flexibility and resilience in responding to public health needs. However, there was also a view that the public health workforce needs to be properly identified and developed. Concerns were particularly raised regarding the need for better career progression and pathways, and the registration of public health practitioners.

Opportunities for professional development and workforce succession planning (Question 5)

13. Respondents highlighted the challenges of workforce succession planning; the point was made that the small number of public health specialists across Scotland makes it difficult to plan for the number of trainees required each year. There were calls for a national workforce development plan, and respondents specifically thought the review should take into account work currently being undertaken by the Scottish Public Health Workforce Development Group.

14. The importance of developing the wider workforce was emphasised, together with the need for greater flexibility in training opportunities and programmes.

Concluding remarks

15. A consistent theme across all responses to the engagement paper related to the importance of focusing on reducing (health) inequalities. There was almost unanimous support for directing the public health endeavour towards this aim, with some respondents explicitly arguing that this focus on health inequalities should form part of the formal definition of public health in Scotland. There was agreement that reducing health inequalities would require action far beyond the reach of NHS Boards and that community planning partnerships were key to this. However, there were differing views about what the consequences of this should be in organisational terms. Local authorities, in particular, thought the

health improvement domain of public health should be more co-ordinated and driven from within local authorities. Among health organisations, there was a recognition that some organisational change may be necessary, but there was no clear consensus about what that change should be. Health organisations requested that any future reorganisation of the public health function should: i) be clear about what public health is intended to achieve; ii) be undertaken in a staged way rather than attempting to change everything at once; iii) ensure that a 'critical mass' continues to be available within the workforce to be able to respond quickly to unforeseen events / pressures; and iv) take into account the particular challenges of delivering public health in remote and rural areas.

16. The advent of health and social care integration was important in setting the policy context for responses, and it was suggested that different local areas were at different stages in developing their integration arrangements. This 'work in progress' aspect meant that there was no clear sense (yet) emerging of the impacts of integration on public health. However, there were calls to ensure that public health objectives (including reducing inequalities) should be set for the new Integration Joint Boards.

1 INTRODUCTION

1.1 In November 2014, Michael Matheson, then Minister for Public Health, announced that the Scottish Government would be undertaking a review of public health. An expert group, chaired by Dr Hamish Wilson, was established to take this forward, with a requirement to report back in 2015.

1.2 The terms of reference for the group are:

> *To undertake a review of public health systems and the delivery of all public health functions in Scotland with a strong focus on how public health contributes to improving health and wellbeing across the life-course, and reducing health inequalities for the future.*

1.3 The review was given the task of examining:

- Public health leadership and influence both within the health sector and more widely
- Workforce planning and development, succession planning and resourcing for the multi-disciplinary core public health workforce
- Opportunities for greater joined-up working and successful implementation of public health measures within the context of community planning, single outcome agreements, and health and social care integration.

1.4 It will make recommendations in relation to:

- Strengthening the contribution of Public Health in Scotland in light of current and future population health challenges and the emerging policy and organisational contexts
- Maximising the effectiveness and efficiency of the public health resource in Scotland
- Achieving consistency where this will enhance quality and impact
- Ensuring the responsiveness and resilience of the public health function for the future.

1.5 At its inaugural meeting in December 2014, the expert group agreed that the views of a wide range of stakeholders should inform the review. An engagement paper was drafted to seek input on five questions:

- How can public health in Scotland best contribute to the challenges discussed [in the engagement paper]? Specifically, what is your view and evidence of the Strengths, Weaknesses, Opportunities and Threats (SWOT) to the contribution of the public health function in improving Scotland's health and reducing inequalities?
- How can public health leadership in Scotland be developed to deliver maximum impact?

- How do we strengthen and support partnerships to tackle the challenges and add greater value? How do we support the wider public health workforce within those partnerships to continue to develop and sustain their public health roles?
- What would help to maintain a core/specialist public health resource that works effectively, is well co-ordinated and resilient?
- How can we provide opportunities for professional development and workforce succession planning for the core public health workforce?

1.6 This report presents an analysis of stakeholders' comments submitted in response to these questions.

2 THE RESPONDENTS AND THE ANALYSIS

The respondents

2.1 The engagement paper received 117 responses in total – 6 from individuals and 111 from organisations. Ten of the respondents (mostly professional associations or third sector agencies) had a UK-wide remit. The rest were based in Scotland. A breakdown of the number of respondents, by respondent type is shown in Table 2.1 below. These respondent type categories will be used throughout this report in quotations, and when making comparisons between different groups.

2.2 Annex 1 contains a complete list of the respondents.

Table 2.1: Number of respondents, by respondent type

Respondent type	n	%
NHS Boards	23	20%
Third sector organisations	17	15%
Partnerships	17	15%
Royal colleges or other professional grouping	15	13%
Local authorities	11	9%
Public health forums and networks	7	6%
Senior public health staff groups	6	5%
National NHS organisations	6	5%
Research / academic organisations	4	3%
Other organisations	5	4%
Individual respondents	6	5%
Total	**117**	**100%**

2.3 In some cases, different departments or sections within a single NHS Board or local authority submitted separate responses.

Analysis of the responses

2.4 The responses received in this consultation were very diverse, and some were lengthy and detailed. Most, but by no means all, respondents addressed the engagement questions; however, they also often had other points they wanted to make.

2.5 Some respondents, reflecting the perspective of their organisation, focused their response on a particular topic (e.g. substance misuse, child health, asthma, cancer, sustainable food production, optometry, dentistry, pharmacy, etc.). These responses generally highlighted the contribution made to the health of the population by work in this area and / or they identified priority needs in relation to the topic. Chapter 9 provides further information about the topic-focused responses.

2.6 The reporting of the analysis cannot fully reflect the level of detail in the wide range of comments received. Rather, this report presents the *main themes* identified in the analysis, and its focus is primarily on the points made in relation to each of the engagement questions. A separate comparative analysis was also undertaken in relation to the comments from health, local government, partnership and third sector respondents, and the results of this comparison are presented in Chapter 10.

2.7 Note that the engagement paper referred to the three domains of public health as: (i) health improvement, (ii) improving health services and (iii) health protection (with a fourth area comprising public health intelligence and evidence). However, it was clear that, in many of the responses, 'public health' and the task of reducing health inequalities was largely equated with the 'health improvement' domain. Thus, an attempt has been made in this report to draw out where respondents made specific comments about the other domains of public health – namely, improving health services and health protection.

3 SWOT ANALYSIS – STRENGTHS AND WEAKNESSES (Q1)

3.1 The first question in the Engagement Paper was, 'How can public health in Scotland best contribute to the challenges discussed [in the engagement paper]? Specifically, what is your view and evidence of the Strengths, Weaknesses, Opportunities and Threats (SWOT) to the contribution of the public health function in improving Scotland's health and reducing inequalities?'

3.2 Seventy-three (73) respondents submitted comments in relation to one or more of the SWOT headings. It should be noted that there was considerable overlap in the themes identified for all four headings. So, for example, comments in relation to 'opportunities', were often expressed as future actions that could be taken to address identified 'weaknesses' or 'threats'. Similarly, some respondents identified 'strengths' which other respondents considered to be 'weaknesses', and issues identified as 'weaknesses' by some respondents were seen as 'threats' by others.

3.3 Thus, to provide a clear structure and to avoid undue repetition in discussing the themes identified, we have used the framework below as our approach to analysing the full range of material submitted across all four headings. This section presents an analysis of those that related specifically to strengths and weaknesses.

	Helpful to the public health function	**Harmful** to the public health function
Internal (within the public health function)	**Strengths** • Advantages • Capabilities • Resources available • Assets	**Weaknesses** • Vulnerabilities • Lack of resources • Pressures • Failures
External (external circumstances and the context in which public health sits)	**Opportunities** • External developments and factors which can support or benefit the public health function in the future	**Threats** • Obstacles • Pressures from outside public health which may put the public health function at risk in the future

3.4 The rest of this chapter addresses the material raised in relation to strengths and weaknesses. As noted above, topics / issues were often raised as strengths by some respondents, and as weaknesses by others.

3.5 The main (9) themes are set out below. These are: the locating / embedding of public health at a local level; the coordination of (and relationship between) the public health function at national, regional and local levels; public health networks; public health approach to improving health services; the public health workforce; partnership working; data, information, intelligence and evidence; the poor visibility of public health; and examples of successful programmes and initiatives.

The locating / embedding of public health at a local level

3.6 The advantages and strengths of the public health function being embedded in local structures was referred to repeatedly. In some cases, respondents talked about the public health function being positioned locally within NHS Boards whilst in other cases they talked about it being positioned within wider local partnership organisations (particularly Community Planning Partnerships).

3.7 This local positioning was thought to be vital in bringing public health close to decision making structures at local level. The other advantages of this local positioning included: being able to influence local partners, building strong partnerships, having direct access to data and information which were required to understand local population health issues, being 'on the inside', being an integral part of the planning and delivery of local services, being able to provide 'surge capacity' (for a health protection issue, for example), being well placed to understand local needs, and developing the local understanding of national issues.

> *There are number of advantages to being locally based (management could be centralised) – this facilitates a proximity to decision making both within NHS Boards and wider partner organisations. The internal Board position of Public Health enables direct access to local population health systems and data vital in improving health services. The inherent local positioning enables the sharing of knowledge and data between partner organisations and the local intelligence gained by such positioning strengthens the application and contextualisation of national policy, evidence base, etc., to reflect local needs and priorities. An additional advantage to being based locally is the ability to influence, through being part of a local organisation, rather than working remotely from outside an organisation. Change happens most effectively through working relationships and partnerships and the importance of the local dimension cannot be underestimated [sic]. (Senior public health staff groups, 63)*

3.8 However, there was also discussion about the weaknesses of the delivery of public health at the local level. Two main issues were raised. These were the possibility of *duplication* of function and / or effort across localities, and *variation* in capacity, structures and the quality of the public health function at local level. The issue of duplication will be addressed below in relation to the co-ordination of the public health function at national, regional and local levels, and in relation to public health networks. The following comment illustrates the kinds of points made in relation to the variation in capacity, structures and the quality of the public health function across localities.

> *Fragmentation and variation in local public health structures compounded by different accountability models in health and local authorities (National NHS organisation, 25)*

3.9 It was also suggested, less often, that a further weakness was the lack of local integrated service delivery models within neighbourhoods.

The coordination of public health at national, regional, and local level

3.10 On the whole, when respondents discussed the coordination (and relationship between) public health at national, regional and local level, it was in the context that there was insufficient coordination and leadership across these various spatial levels. However, an exception to this overall picture was the discussion of the positive coordination and leadership offered within specific networks, which was seen as a key strength. The discussion of the networks follows at paragraph 3.16 below.

3.11 There were a number of different aspects raised in relation to the (lack of) coordination and leadership across the various levels. These covered:

- The large number of organisations involved in public health (described as 'a cluttered landscape') which could lead to confusion, a lack of clarity about roles and responsibilities, and inadequate coordination
- A lack of agreement about when it is best to act locally, regionally, or nationally
- A lack of coherence between what is happening at the 'grassroots level' and what is happening at national (Scottish Government) level.

3.12 The following quotes illustrate some of the points made in relation to this theme.

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

> *There is confusion, even amongst the Public Health family, as to who [and] which organisations are leading on particular elements of Public*

Health – organisations which play into this are NHS Health Scotland, ScotPHN, Health Protection Scotland, NES, etc., etc. (Royal colleges or other professional groupings, 65)

3.13 There was considerable discussion by respondents about the best ways to address the problem of poor co-ordination. There were three suggestions:

- Improve co-ordination of different ministerial portfolios at Scottish Government level: While respondents largely saw the commitment by the Scottish Government to tackling health inequalities as a strength, there was also a view that various policy initiatives were not always joined up well.
- Develop a national public health strategy: There was a common view that a national strategy for public health (one respondent suggested a Scottish Health and Wellbeing Plan) is necessary to bring about a more cohesive and coherent approach across Scotland, both at a national and local level. This could also provide the basis for better integration with community planning partners at a local level.
- Consider the potential for more regional (and national) approaches: Although respondents clearly valued the local positioning of public health, some also saw merit in developing a more regional (cross-NHS Board boundaries) 'shared service' approach for certain aspects of the public health function. For example, this type of approach was seen to be appropriate for the health protection function, and in remote / rural areas, and respondents referred in positive terms to the Health Protection Network and North of Scotland Public Health Network. Those who offered this suggestion commented that this type of approach would improve efficiency, resilience and sustainability and avoid duplication.

3.14 While a "once for Scotland" approach was seen by some respondents to offer greater efficiencies, the importance of balancing such an approach with the need to engage with local communities and act at a local level was also emphasised.

There are clear opportunities to strengthen resilience by regional networking and development of shared services. There are 14 Boards but not everything has to be done 14 times for Scotland but this must be balanced by the need to engage with local populations and to have strong local knowledge and commitment to local needs. (NHS Board, 66)

3.15 Furthermore, other respondents were concerned about a move towards greater 'centralisation' of the public health function, and this will be discussed below in relation to 'opportunities and threats'.

Public health networks

3.16 Comment about public health networks was often made in the context of a wider discussion about the national, regional and local co-ordination of the public health function. However, the topic of public health networks also appeared to be a separate and significant theme in its own right. Comments on this topic were generally made by respondents representing public health networks and forums.

3.17 Respondents thought that the networks which had been developed were highly effective. The fact that Scotland was a relatively small country was thought to be helpful in developing close networks and good links which could operate at national and regional levels and could support the development of best practice and minimise duplication of effort.

3.18 The networks were sometimes specialism specific, and sometimes more broadly based. The Scottish Public Health Network, the Scottish Public Health Observatory, the Regional Dental Health Network, the Pharmaceutical Network / Community Pharmacy Network and the Health Protection Network were all mentioned specifically as providing examples of good and effective collaboration, and partnership working which could offer models for further development. Academic input into the networks was also mentioned as a strength.

> *The size of Scotland and systems in place such as networks for some specialisms allows for a national approach to issues where there is benefit in working towards a single solution. (Public health forums and networks, 14)*

> *The links with the academic institutions further strengthen the network, bringing independent research and expertise to investigate and analyse current service delivery and support the adoption of best practice. (Public health forums / networks, 55)*

Public health approach to improving health services

3.19 Respondents across a range of sectors discussed the ways in which they 'took a public health approach' to improving services. The point was made that the Scottish Government had identified the importance of aiming to deliver health services which were equitable in terms of access, patient experience and outcomes in the Healthcare Quality Strategy.[1]

3.20 Organisations with a remit for providing pharmacy services commented in detail on the integration of public health perspectives within their clinical work and confirmed that public health is a core part of the provision of pharmacy

[1] http://www.gov.scot/Resource/0039/00398712.pdf

services, especially by practice nurses and community pharmacists. For example:

> *… a wide range of healthcare staff [are] aware of public health in their role and committed to delivering health improvement and protection messages and functions (NHS Board, 19)*

3.21 Other aspects of a public health approach to improving health services were also highlighted including: designing services that are easy to access; encouraging recognition that many public health work strands are undertaken by health and social care staff whose main role is not defined as public health; delivering opportunistic lifestyle interventions from within health services; taking action to address the 'inverse care law'[2]; working to reduce variations across different settings; and monitoring access, use of services and equity of outcomes.

3.22 Much of this type of work was described as not very visible because it primarily involved public health in an influencing and advising role.

> *By its very nature much good public health practice entails influencing and advising others and enabling change. For example, in the area of health services public health such change is more sustainable where owned by services themselves, even when public health is the key catalyst and facilitator. This is successful public health practice that can have the effect of reducing the visibility of the public health activities though the public health contribution will be clearly recognised and valued by the services involved. (Royal college or other professional grouping, 80)*

3.23 While the public health approach to improving health services was often seen as a strength, and something that should be developed further, it was also noted that passing public health responsibility to frontline healthcare staff is problematic without proper training on the health improvement role.

3.24 Most of the comments made in relation to the improving health services domain were raised by local organisations, public health networks or other professional groups. Among national organisations, there appeared to be consensus that there is no clear ownership of the improving healthcare service domain at a national level, as Healthcare Improvement Scotland do not currently have a strong public health role. It was also acknowledged that public health had not made a clear contribution to the quality improvement work of Healthcare Improvement Scotland.

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[2] The inverse care law is the principle that the availability of good medical or social care tends to vary inversely with the need of the population served.

[Healthcare Improvement Scotland] do not view themselves primarily as a public health organisation. The work that HIS undertake is important and has certainly not been without success, but there are unquestionably differences of approach when compared with a public health view of improving services. (National NHS organisation, 25)

... the contribution [of public health] to improvements in service quality and safety, effective care, and care that is person-centred is less clear (National NHS organisation, 46)

Public health workforce

3.25 Respondents often highlighted the (skills and qualities of the) public health workforce as a key strength. The workforce was described as highly skilled, professional, knowledgeable, committed and enthusiastic. It is also multidisciplinary, with staff from a wide range of backgrounds and this was seen as a key strength. Much was made of the workforce's ability to work collaboratively across issues and boundaries.

3.26 Other qualities of the workforce were also highlighted. These included their objectivity, their ability to offer an independent view and voice, their qualities as advocates for the public health function, their flexibility, adaptability, and responsiveness.

3.27 The following quotes illustrate the positive comments made about the public health workforce and its strengths.

Key strengths include multi-disciplinary professional practice, well educated workforce, adaptable workforce, responsive workforce (Local authority, 97)

The Public Health workforce is multi-disciplinary and as such provides expertise from a range of backgrounds. They are highly skilled and have an expert knowledge base. In addition they are able to offer an independent and objective voice. (NHS Board, 31)

A committed, enthusiastic workforce that is knowledgeable about local needs and priorities whilst maintaining the flexibility and resilience to direct public health activity according to need and to maximise the efforts of the workforce (Partnership, 47)

3.28 Whilst the skills of the public health workforce were identified as a key strength, there was also substantial focus on the weaknesses of the career structure and career pathways for the public health workforce, especially for those who were not in the core or specialist workforce, but who were part of the wider public health workforce.

3.29 These workforce issues are discussed in greater detail in Chapters 7 and 8 in the analysis of the material offered in response to Questions 4 and 5 of the engagement paper. However, some of the main points raised are briefly mentioned here.

> *There is a need and an opportunity to further develop and strengthen career pathways for the PH practitioner workforce both in NHS and Joint Settings and Environmental Health workforce employed in Local Authorities. The value of professionalisms such as health psychology, social anthropology and health geographers to the broader PH workforce is yet to be fully realized. (NHS Board, 92)*

> *Developing defined specialist accreditation and accreditation for public health practitioners (especially in health improvement areas) is lacking and out of step with the rest of the UK. This can lead to different standards of professional practice becoming normalised locally and- in the long run – undermine the professional development and career aspirations of public health practitioners and the wider workforce. (Senior public health staff groups, 89)*

Partnership working

3.30 Partnership working (particularly in relation to working at a local level within Community Planning Partnerships or Health and Social Care Partnerships) was often identified by respondents as a strength. However, partnership working was also mentioned frequently as a weakness, and something which needed to be further developed and / or strengthened.

3.31 Those who identified partnership working as a strength highlighted the ways in which partnership working operated effectively, both in relation to topic specific areas (e.g. tobacco, food and health, physical activity, mental health, etc.) and in wider (whole population) approaches. Partnership working was thought to offer advantages in terms of 'economies of skills and scale' by sharing resources in terms of both staff and equipment within and across local authority boundaries. It was built on the development of skills and expertise which facilitated multi-disciplinary working.

> *Successes in local collaboration, championing and delivering on cross-sectoral programmes, e.g. in healthy weight and physical activity, engagement with local communities, and using board members and other community leaders as local champions. Historical successes on tobacco, alcohol, both good examples of action across the whole system from national public policy and legislation through range of public sector and partnership programme development and delivery, right down to working with local communities at locality and neighbourhood level. (NHS Board, 81)*

3.32 However, other respondents identified weaknesses in partnership working, and suggested that there was scope for public health to become more embedded in the work of Community Planning Partnerships. Respondents called for public health to be 'a strong voice at the table' to ensure that partnership priorities and outcomes are more focused on reducing inequalities. Respondents also saw a need for public health to engage more, and more effectively, with non-public sector partners in the third / community sector.

3.33 There were also practical concerns in relation to performance management systems and accountabilities across partners which made it difficult to work effectively in partnership.

> *Cross-sectoral engagement including the private and third sector could be strengthened in some areas. (Royal colleges or other professional grouping, 17)*

> *The NHS and Local Government have different performance management systems and accountabilities. Collaborative approaches to improved performance are therefore difficult to achieve. (National NHS organisation, 79)*

3.34 Chapter 6 will explore in further detail respondents' views on the ways that public health can be involved in strengthening and supporting partnerships.

Data, information, intelligence and evidence

3.35 The availability of data, information and evidence was perceived as a strength. Substantial resources had been, and continued to be, devoted to developing high quality datasets. This had been undertaken at national level, (for example through the Scottish Government's 'big data' initiatives), at local level, (for example the development of the KnowFife Dataset) and within specialisms (for example the development of child health dental data).

3.36 Moreover, through high quality analysis (often involving academic partners) these datasets had become important strategic assets.

> *Data sets are good to very good, and are amongst the important strategic assets on which to improve a public health system (National NHS organisation, 79)*

3.37 However, alongside these positive views of the data and intelligence functions, there were some more critical views, particularly in relation to gaps in the evidence base, and poor translation of evidence into practice. It was thought that one of the greatest weaknesses of public health was the lack of a robust evidence base as to what works.

Lack of coordinated approach to health needs assessment and translating evidence into policy (National NHS organisation, 25)

Data is not yet sufficiently robust to assist in evaluating progress and identifying next steps. (Partnership, 32)

3.38 This was partly due to the intrinsic difficulties of evaluating the public health endeavour and attributing causation within complex systems; but it was also mentioned as a (political) failure to implement evidence where it was available.

Failure to implement water fluoridation to effectively narrow dental health inequalities. … Ineffectiveness of educational approach still not recognised by policy makers; especially when trying to address health inequalities. (Royal colleges or other professional grouping, 65)

Making sense of the huge body of evidence, data and research to avoid duplication, share learning and respond appropriately. This is a function both of the volume of material and learning available, and of the challenge of translation into service change, including the ongoing challenge of diverting resources to preventative approaches. (Research / academic organisation, 99)

3.39 However, respondents believed there was scope to do more. Suggestions included:

- Conducting natural experiments between Scotland and the rest of the UK where different public health policies are being pursued
- Developing more partnerships with academic researchers in universities and think tanks
- Improving cross-sectoral record linkage (linking data between health and other sectors) and strengthening surveillance (for example, in the areas of environmental hazards, communicable diseases, health improvement activities)
- Setting out a stronger conceptual understanding of public health challenges and evidence.

Lack of visibility of public health

3.40 Respondents commented on the perception that the public health function was not particularly 'visible' or well understood, and that insufficient effort had been directed at making a clear case for investment in public health. This was seen as a potential weakness (or threat) when resources were under pressure.

Public Health has a wide scope and consequently experiences pressure from a wide range of sources. There is a lack of appreciation

of the breadth of the work and consequently public health teams are rarely seen to excel in any particular area. This leads to lack of priority for investment and further challenges the workforce. (NHS Board, 66)

3.41 The visibility of public health was thought to be particularly poor in the improving health services domain of public health. The explanation for this was that the role of public health in improving health services is largely an influencing and advisory role.

3.42 Respondents often commented that the Public Health Review provided an opportunity to re-energise and raise the profile of public health. There was also a view that the success in developing progressive public health policies (i.e. the smoking ban, minimum pricing for alcohol, the multi-buy ban for alcohol products, etc.) provided a platform for public health to advocate for further progressive policies.

Examples of successful programmes and initiatives

3.43 A number of successful programmes and initiatives were highlighted by respondents as strengths, and they were offered as examples which demonstrated what could be achieved with political will and commitment, combined with effective implementation.

3.44 The main programmes discussed in this context were: nursery toothbrushing and fluoride toothpaste distribution schemes, the national health screening programmes, the immunisation programmes (for children), and the coordinated efforts (in terms of national policy and legislation, partnership development and local implementation and action) in relation to smoking, alcohol and drug use. Other, less developed programmes were also mentioned as success stories including: early years strategies, long term conditions strategy, the 'Deep End' initiative for GP practices in Glasgow, and the 'Glasgow Council for Voluntary Sector Connectors Project'.

3.45 However, even in these widely praised population health programmes, cautionary notes were sounded as to whether the aim of reducing health inequalities was actually being delivered. For example:

Population wide health improvement initiatives are likely to have exacerbated this with higher take up amongst more affluent communities. (Research / academic organisation, 99)

4 SWOT ANALYSIS – OPPORTUNITIES AND THREATS (Q1)

4.1 This chapter presents an analysis of respondents' comments related to opportunities and threats. There are two points to make about these comments. First, opportunities were often described as actions which could be taken to address weaknesses or mitigate the risk created by threats. Second, issues seen by some respondents as 'threats' might better be described as potential outcomes *resulting* from threats.

4.2 Again, we have applied the framework presented on page 9 to impose some coherence and structure on this material. Six (6) main themes were identified and these are set out below. The themes are: Scottish vs UK Government policies; the wider policy context; integration of health and social care; reorganisation; austerity and lack of funding; and vested interests.

Scottish vs UK Government policies

4.3 Respondents saw Scottish Government policy as providing a favourable context for public health, while UK Government policy was generally seen as a threat.

4.4 Respondents commented that the current Scottish Government has a 'strategic focus on inequalities' and an explicit focus on the wider determinants of health. The was a recurring view that the Scottish Government's commitment to public health had been demonstrated in relation to both policy and legislation, and the reach across multiple policy areas beyond health was clear. This 'receptive political environment' was seen as presenting an opportunity for public health to provide greater leadership and advice, and to take a more active role as an 'agent of change' in bringing about policies focused on the wider determinants of health.

> *The current focus of the Scottish Government on the need to address the wider determinants is seen as a particular strength as is political willingness to address controversial issues to improve public health for example and alcohol and smoking restrictions. Public health can give both leadership on and advice to these agendas. (Public health forums and networks, 14 and NHS Board, 88)*
>
> *Opportunity for public health to be agents of change, drivers of political and fiscal policy (NHS Board, 28)*

4.5 However, alongside this positive comment, and the identification of political engagement and willingness to act on a wide agenda, there was also substantial comment that there was *insufficient* focus on the wider determinants of health at Government level, and that policy initiatives were not always joined up. In particular, respondents thought the current balance of activity was too focused on short term targets and individual behaviour, and did not sufficiently take into account the wider 'upstream' issues.

A focus on behaviour change activity at the expense of time devoted to wider determinants of health, e.g. housing and employment. (NHS Board, 85)

The public health agenda has been significantly determined by political focus such as that applied by HEAT targets and as such a focus on individual lifestyle outcomes has prevailed. This has created very much a service output focus rather than a community/population outcome which emphasises the risk of health improvement being seen solely as an NHS agenda. (Partnership, 21)

4.6 It was also thought that there was *insufficient* leadership at national level. This was needed in order to join up and co-ordinate the effort in relation to the public health endeavour across ministerial portfolios. As mentioned above at paragraph 3.13, it was suggested that a (national) public health strategy would help to achieve this.

There can appear to be disconnect between Scottish Government departments in relation to joined up public health outcomes. (NHS Board, 18)

4.7 Respondents saw UK Government policy as posing a threat to the public health endeavour, specifically in relation to austerity and welfare reform and their effects on the most vulnerable individuals and families.

The wider policy context

4.8 Respondents commented that a range of national policies provided greater opportunities for more of an 'upstream' approach to addressing inequalities. These included:

- The refreshed Economic Strategy
- The Health and Sport Committee report on inequalities
- The 2020 Vision
- The Early Years Collaborative
- The Community Empowerment Bill (along with recently published reports on the national audit of community planning[3] and from the Commission on Strengthening Local Democracy[4]).

4.9 The Community Empowerment Bill was specifically highlighted as presenting an opportunity to put empowered communities at the centre of planning. Respondents saw the potential for this agenda to have enormous benefits to

[3] Audit Scotland (2014) *Community Planning: Turning Ambition into Action*.
[4] Commission on Strengthening Local Democracy (2014) *Effective Democracy: Reconnecting with Communities.*

the health of populations, but cautioned that political will and strong leadership at a local level would be required to achieve this. Respondents commented that public health is in a good position to capitalise on the changes being introduced as a result of this new legislation.

Integration of health and social care

4.10 The integration of health and social care was seen as both an opportunity and a threat. On the one hand, respondents highlighted opportunities for:

- Building better links with the wider public sector to address the wider determinants of health at a locality level
- Better integrating NHS with third and private sector service providers and engaging the wider workforce in the public health effort
- Strengthening existing links that support prevention and health improvement initiatives (e.g. access to screening and vaccination programmes; alcohol licensing; reducing drug-related deaths; etc.)
- Working together towards jointly agreed shared outcomes
- Adopting different / new, more effective ways of working
- Delivering multi-agency training
- Raising the profile of public health in primary care (via GP and pharmacy contracts) and facilitating a population approach to care planning
- Combining resources and reducing duplication in policy development, procurement and management.

4.11 There was also a view that public health had important skills to offer health and social care partnerships in terms of needs assessment, coproduction and evaluation. In a few cases where shadow boards had already been established, it was noted that the health improvement activity had already come under the umbrella of the health and social care partnership.

4.12 However, among some respondents, health and social care integration was seen as a possible threat, with the potential for fragmentation of the public health focus and workforce. Concerns were also expressed about loss of capacity and resilience; loss of clarity about the focus for prevention initiatives; and reduction in quality and breadth of health data. It was also suggested that integration could provide an impetus for further cuts to staffing budgets in a misguided attempt to demonstrate ‘efficiency’.

> *Integration of Health and Social Care is both an opportunity and a threat. A key challenge is that an already fragmented and confused workforce will become increasingly ineffective as key staff are pulled into the new Integrated Health and Social Care Partnerships. There is a risk that the Integrated Joint Boards (IJBs) interpret prevention as being about individual well being and anticipatory care. There needs to be clarity that the IJB’s are about adult health and social care and the CPPs are about health inequalities and health improvement.*

Health improvement teams should be empowered to focus on populations and inequalities. (NHS Board, 66)

4.13 Respondents noted that different areas may adopt different integration models; however, regardless of the structures put in place, it was thought that Directors of Public Health (or their deputies) should be represented in Integration Joint Boards.

Reorganisation of the public health function

4.14 It was evident within respondents' comments that the announcement of the review had prompted debate about the configuration of the public health function, and about what is best to deliver at a national, regional and local level. (See Chapter 3, paragraphs 3.10-3.15 regarding the discussion on co-ordination.) Within this debate, there was recognition that the policy landscape is changing and therefore, the delivery of the public health function may also need to change. Specifically, it was acknowledged that community planning partnerships (rather than NHS organisations alone) have a key role in addressing health inequalities and the wider determinants of health. However, some respondents saw threats in the possible reorganisation of the public health function. In particular, there were concerns about the possible centralisation of the public health resource which could have an impact on the responsiveness to local needs. At the same time, there was also a concern that the drive towards localism may make it harder to deliver change on a national basis.

4.15 Some respondents commented that reorganisation is a threat simply because of the disruption it causes (to staffing, to capacity, and to the effective delivery of successful initiatives). The point was also made that a 'fixation' with finding 'the perfect organisational structure for public health' was itself a significant threat.

4.16 However, some respondents saw the possibility of reorganisation in a more positive light. There appeared to be some differences in views between respondents from different sectors and this issue will be discussed further in Chapter 10.

Austerity and lack of funding

4.17 Austerity was seen almost unanimously as a threat. A few respondents considered that financial pressures on public services provided an opportunity to review resourcing and to target resources more effectively, and there was a suggestion that public health needed to respond innovatively to financial constraints, rather than continuing to try to do more with less.

4.18 However, respondents were more far likely to identify the potential risks of continued public sector budget cuts. Austerity was seen as a threat because of its impacts on:

- Reducing the capacity of the workforce
- Shifting priorities and resources towards the provision of critical services and away from prevention
- An over-emphasis on short-term initiatives which undermine the widely held view that improving public health is a long-term endeavour
- The move towards increasing centralisation
- Making it impossible to mainstream successful short-term projects.

4.19 The focus on short term initiatives, at the expense of longer term commitment was mentioned frequently. Respondents wished to see the balance redressed in favour of a longer term approach which focused more on the 'most important outcomes' including 'upstream' activity rather than on 'immediate priorities' which were often related to acute services.

4.20 Respondents were concerned that, at a time of austerity, the public health function would lose resources, both in terms of funding for specific (long term) programmes, initiatives or projects, but also in terms of developing the capacity and skills of the (wider) workforce.

> *Current austerity measures and reduced employment opportunities risk increasing inequalities. Evidence suggests that young adults, disabled people, ethnic minorities and less skilled workers experience increases in unemployment during economic downturns. As well as the obvious financial consequences, unemployment can result in poorer mental health, such as anxiety and depression (Third sector, 60)*

4.21 One respondent put forward an argument for the ring-fencing of funding for public health:

> *Currently the emphasis of funds being skewed towards the acute sector will not enable Public Health to undertake the necessary work to make the big impacts needed. Ideally, funding for Public Health should [be] ring-fenced given the known effectiveness and cost-effectiveness of prevention relative to treatment of ill health, including in the reduction of health inequalities. (Royal college and other professional groupings, 70)*

Vested interests

4.22 Respondents saw serious threats to the public health endeavour from powerful multi-national business interests. Those mentioned specifically were:

- The powerful and influential alcohol industry in Scotland, and its associated well-organised, well-funded lobby group

- The tobacco (and e-cigarette) industry – it was noted that the popularity of e-cigarettes had had an effect on the number of people entering NHS smoking cessation services, and that policy responses and the evidence base had not kept pace with the speed of change in this area
- Soft drinks manufacturers, processed food manufacturers (including confectionery).

4.23 Concerns were expressed about the 'disproportionate and undemocratic power of big business relative to that of the electorate', and about global trade and finance agreements (i.e. the Transatlantic Trade and Investment Partnership (TTIP)) which could result in the increasing privatisation of the NHS and allow investors of multi-national businesses to sue governments whose policies cause a loss of profits.

5 LEADERSHIP IN PUBLIC HEALTH (Q2)

5.1 One of the objectives of the Public Health Review in Scotland is to examine public health leadership and influence both within the health sector and more widely. In relation to this, the engagement paper asked: 'How can public health leadership in Scotland be developed to deliver maximum impact?'

5.2 Ninety-eight (98) of the total 117 respondents addressed this question, and in general, comments suggested that there was a need for, and scope to, strengthen public health leadership to make it more effective.

5.3 Respondents returned to the issue of leadership in public health in their responses to other questions in the engagement paper. Leadership was a theme raised in relation to strengthening and supporting partnerships (Question 3), helping maintain a core public health resource (Question 4) and providing opportunities for professional development and workforce succession planning (Question 5). The comments on leadership in the responses to these other questions have been integrated into the text in this chapter.

Perceived weaknesses of current public health leadership in Scotland

5.4 Current public health leadership was described as 'patchy', 'disparate', 'not cohesive' and 'fragmented' at both national and local levels. There was a perception that public health leadership was not very visible, and that (at least in some areas) public health was seen as more of a support service, rather than making a key contribution to the development of local services. There was also a view (again, in some areas) that public health leaders do not necessarily have the skills required for leadership – in particular, the skills of influencing, lobbying and advocating for local populations.

5.5 Respondents often commented on the plethora of individuals and organisations with some type of remit for public health, and expressed a desire for greater clarity about the roles of these individuals and organisations.

5.6 The lack of clarity and uncertainty about roles, both at national and local level, was seen as limiting the effectiveness of public health leadership, and there was a suggestion that leadership could be strengthened if local partners were aware of the role and skills of public health leaders.

> *The public health contribution of professional leads at national and local level should be articulated e.g. CMO, CNO, Chief Pharmacist, Chief Dentist, Chief Allied Health Professional, etc. (NHS Board, 88)*

> *Clarity is required on the population health improvement roles within the Scottish Government and how public health structures and bodies relate, e.g. the Directors of Public Health Group. There is confusion at*

practitioner levels of the role of government and agencies such as the Joint Improvement Team and Health Scotland. (NHS Board, 85)

Challenges to public health leadership

5.7 Respondents highlighted the challenges to public health leadership in Scotland. The move towards integrated health and social care services was seen as one of these and respondents highlighted the importance of public health having a strong role in the new Integration Joint Boards (IJBs).

5.8 A further challenge for public health leadership was the need to work within very complex systems, far beyond NHS and health boundaries, to influence wider agendas, policies and programmes. Moreover, the wide range of partners involved in public health and the diversity of partner perspectives, make leadership a very demanding task.

The role of a national public health strategy in strengthening leadership

5.9 Respondents highlighted the importance of developing a clear, shared vision – or a national strategy – for public health in Scotland:

We can strengthen leadership in public health by providing a clear vision and goals for public health, at a national, regional and local level. (NHS Board, 74)

5.10 A public health strategy would provide 'a coherent national policy' and an agreed set of priorities, thus also providing a focus for leadership effort. In particular, a national strategy would provide the basis for a more consistent, and potentially more streamlined leadership structure and leadership arrangements (which were more clearly aligned to national priorities), as well as improving the accountability of leaders.

What should public health leadership look like?

5.11 Respondents frequently identified what they wanted to see from public health leadership in Scotland. This included:

- Being a 'population advocate': This would involve advocating and lobbying on 'upstream' issues that affect public health (e.g. welfare reform, local development planning, etc.).
- Being independent: The independence of the public health voice was emphasised as this would allow public health leaders to challenge policy makers at a national level, to say things that were 'uncomfortable', and to address poor performance at a local level.
- Engaging with local communities: Respondents highlighted the need for greater engagement and better communication between public health leaders and local communities – to give communities greater ownership of health improvement and prevention.

- Being more visible: This would involve building relationships with key partners in health, social care and third sector agencies, being able to influence their agendas effectively. It would also involve building and maintaining the profile of public health at all levels.
- Making the case for public health: This would involve making an effective case for increased priority and resources for public health.
- Understanding the evidence: In order to ensure that organisations which distribute resources for public health and public health interventions do this in an effective – and cost effective – manner, leaders in public health should have a good understanding of the evidence base
- Working in partnership: Respondents highlighted the importance of good leadership in strengthening partnerships.

5.12 Respondents reflected, more generally, on the very broad range of skills, qualities, and shared approaches required for public health leadership. These included:

- The ability to work strategically within complex systems
- The ability to work across organisational boundaries with a wide range of stakeholders to influence and facilitate system-wide change
- The ability to look beyond current pressures to understand future challenges and opportunities to do things better
- Evidence synthesis skills and the ability to communicate evidence succinctly, and translate it into effective practical action
- Good people and management skills, including team building, networking, building trust, negotiation and facilitation skills
- The ability to consult and work with communities using asset-based approaches to co-produce local solutions to public health problems.

5.13 Respondents wanted to see greater opportunities for the development of public health leaders from a wide range of backgrounds (not just medical and clinical backgrounds). The point was made that there are numerous leadership roles across a range of disciplines in the wider realm of public health, Respondents believed that leadership is not necessarily about a particular skill set, rather that it requires certain qualities, including the ability to adopt shared approaches and work in partnership.

5.14 Some respondents also highlighted the need for public health leaders to build strong relationships with academic or other research organisations. More important, however (as noted above), was the need to be able to develop effective action (i.e. in terms of interventions, programmes, policies and strategies) based on evidence.

5.15 While respondents expressed some confusion about the roles of particular individuals and organisations (as discussed above), they were clear that the boundaries of public health should be drawn very widely. Respondents emphasised that public health leaders should not only be found in health and

NHS services. Rather, public health leadership needed to be demonstrated in areas as diverse as employment, education and skills development, poverty and welfare reform, planning, housing, children's services, climate change, etc. Some respondents (including NHS respondents) specifically argued for the importance of non-NHS staff, including third sector and community champions, taking on leadership roles in these areas.

> *Leadership also applies beyond the public sector, particularly in relation to the third sector and community champions. Place based change is reliant on community champions and 'anchor' organisations. It is time to acknowledge this more within public health. (Partnership, 42)*

Developing leadership at different levels

5.16 Respondents discussed the importance of having – or developing – public health leadership at all levels (both within organisational structures and within geographical areas). The levels at which public health leadership is required to operate and be effective included: governmental, national, NHS Board, Local Authority, Community Health Partnership, Health and Social Care Partnership, Joint Strategic Board, regional, local, community and neighbourhood. One respondent commented that the question about leadership has to be answered in the context of the 'public health **system** we are designing'. Moreover, respondents argued that public health (and public health leadership) was everyone's responsibility and noted that the leadership for public health at (Scottish Government) ministerial level lies not only within the Public Health and Health spheres, but also more broadly within employment, education, welfare, and finance portfolios.

5.17 The importance of better linkages and better coordination between leadership at different levels of organisational and geographical hierarchies and structures was emphasised. These comments reinforced the earlier discussion (paragraphs 5.9-5.10 above) about the benefits of having a national strategy for public health in Scotland. However, it was also recognised that leadership arrangements would vary according to the local context. There was a suggestion that local leadership capacity in particular needed to be strengthened.

Different 'models' of leadership

5.18 Respondents highlighted a range of different 'models' that could provide insight or learning in relation to how leadership in public health might operate at different levels. Some of these 'models' were very general, and covered leadership at all levels; others were more specific and related only to one type of leadership post or one set of relationships. The first example below was described by a wide range of respondents; the other models were described by just one (or occasionally two or three) respondents.

'Peloton' leadership / 'Distributed leadership' / Network leadership

5.19 The model which was most often referred to as offering the potential to strengthen leadership within public health was the 'peloton' model.[5] This model was referred to variously as a 'distributed', 'distributive', 'dispersed' or 'diffuse' model of leadership. This model recognises that leadership is not restricted to public health specialists, but is also exercised by individuals in partner organisations who lead and advocate for the public health agenda from a wide range of disciplines and perspectives. The work of the national and regional public health networks and the more informal groups within public health that share knowledge and expertise across Scotland were thought to be good examples of peloton leadership in practice.

> *Distributive or peleton (sic) leadership is the most effective to meet the scale of this challenge as it maximises the use of the workforce. (Royal colleges or other professional grouping, 86)*

5.20 One specific example of a network which was thought to offer a useful way to maximise learning and minimise duplication, was the (newly established) Scottish Health Protection Network. However, it was recognised that it was still too early to consider this a proven model which might work across the wider domain of public health. For example:

> *The Scottish Health Protection Network is a good opportunity for leadership and communication to emerge and tackle the challenges ahead, utilising all resources available from the various participants involved. (Local authority, 115)*

Other leadership models

5.21 Other leadership 'models' discussed, sometimes by just one or two respondents, included:

- Public Health England 'model': There were differing views about whether the recent creation by Public Health England of a single leadership agency for public health was a positive step. Some organisations saw the advantages, whilst others focused on the disadvantages. In any case, it was thought important to monitor how this model develops.

  A move to having one single leadership Scottish agency, taking responsibility for improving health and tackling health inequalities would be a good way forward. This could be similar to that as Public Health England. (Partnership, 21)

[5] This model suggests that leadership is a symbiotic relationship between those who choose to lead and those who decide to follow – the 'peloton' style describes how leadership emerges from a group.

- Public Health 'Tsar': A research / academic respondent suggested the appointment of a public health 'Tsar', supported by expert advisory group (a Scottish public health advisory committee), which would have representation from NHS, academic and voluntary sector organisations.

  Its role would include advising government on actions needed, commenting on policy proposals (a NICE for public health), ensuring policies are implemented in a way that will maximise benefit and that they are properly evaluated. (Research / academic organisations, 8)

- Joint appointment (between NHS and local authority) of Director of Public Health: A fourth leadership 'model' highlighted by respondents was that of the 'joint appointment' for the Director of Public Health, whose contract was shared between the NHS and the local authority. Such an arrangement was in place between NHS Borders / Scottish Borders Council and between NHS Greater Glasgow & Clyde / Glasgow City Council. Some the many advantages of such an arrangement were that it: provided a 'check and counterbalance against short-termism'; prevented the prioritisation of acute services from compromising the longer term prevention agenda; acted as a mechanism to support collaborative leadership; and provided better links to political decision making at a local level because of the closer links to local elected representatives.
- Senior health improvement manager: This model was highlighted as successful in NHS Greater Glasgow & Clyde. This senior-level post was considered to provide an effective means of bringing about a strategic health improvement influence upon health and social care partnerships.

Role of Directors of Public Health

5.22 The role of the Director of Public Health (DPH) was thought to be very important. However, respondents commented that, in some cases, this role had become diluted over time. It was thought that the DPH role could be strengthened through fuller implementation of the responsibilities set down in the *Public Health etc. (Scotland) Act 2008*. However, it was also noted that the specific role of a 'Director of Public Health' was not itself set out in the legislation.

5.23 The role of DPH was seen to be essential to provide leadership at local level, to challenge policy, to link the domains of public health, and to work with the Chief Medical Officer and Scottish Government in relation to the development of policy. On this latter point, it was suggested that the DPH leadership role could be strengthened in relation to the bridge it provided to national policy.

5.24 It was specifically suggested that the DPH should have a role in relation to the new Integration Joint Boards, local authority committees, and community planning partnerships, as well as having an executive role in the Health

Board. Indeed the DPH role in relation to strengthening partnerships of all kinds was thought to be vital.

5.25 The annual reports provided by the DPHs were thought to be a significant contribution in highlighting effective action and practice. However, there was comment that greater consistency between these reports might be helpful.

5.26 It was not clear how the DPH role would translate into the new policy / organisational context, as it was not thought realistic for each IJB to have its own DPH. It was suggested however, that leadership capacity in public health could be increased by providing greater opportunities for non-medics to take on public health leadership roles.

Leadership training

5.27 Paragraph 5.12 (above) sets out the skills which respondents thought were required by public health leaders. The final theme discussed by respondents was in relation to the training and professional development of public health leaders. The subject of training and professional development for the wider public health workforce will be discussed in detail in Chapter 8, in relation to Question 5.[6] This section, therefore, focuses *mainly* on leadership training.

5.28 There was a general view among respondents that 'more' and 'better' leadership training opportunities were needed, both for the core public health workforce and for the wider public health workforce. It was noted that the development of leadership and management capabilities across the NHS is a key priority of the 2020 Workforce Vision.

5.29 In relation to training for the core (specialist) public health workforce, there were comments that the leadership aspect of post-graduate public health training could be developed further – although the point was also made that 'creating effective leaders in public health requires a lot more than just training'. Respondents suggested that the inclusion of leadership skills in postgraduate courses and continuing professional development should be more systematic and consistent.

5.30 While respondents believed there was some value in the 'generic' leadership programmes currently provided within the NHS in Scotland, there was a view that a specific public health leadership training programme could be better. One respondent pointed to Durham University's 'Leading Health and Wellbeing' programme as an example. There was also a suggestion that it may be necessary to review the leadership training currently delivered by NHS Education for Scotland (NES) to ensure that this programme addresses the challenges of providing leadership across organisations.

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[6] Question 5 asked: 'How can we provide opportunities for professional development and workforce succession planning for the core public health workforce?'

5.31 More generally, respondents suggested that providing opportunities for ‘peer challenge’ and ‘shared learning’ could be beneficial.

6 STRENGTHENING PUBLIC HEALTH PARTNERSHIPS (Q3)

6.1 Question 3 of the engagement paper asked: 'How do we strengthen and support partnerships to tackle the challenges and add greater value? How do we support the wider public health workforce within those partnerships to continue to develop and sustain their public health roles?'

6.2 One hundred and four (104) respondents made comments at Question 3. It is noted that Question 3 is a two-part question. This chapter considers the first part of the question about the strengthening and supporting of partnerships. The issue of supporting the wider workforce is covered in the discussion of wider workforce development in Chapter 8.

6.3 Respondents confirmed that good partnerships were the key to the public health endeavour and that 'public health is a partnership issue'. Without effective partnership arrangements the aspiration for improved public health could not be achieved. Thus, a focus on strengthening and supporting partnerships was thought to be vital.

6.4 A wide range of themes were raised in response to this question. In their comments, respondents discussed both *what* they thought should be done to strengthen and support partnerships, and *how* it should be done. These aspects (the how and the what) are discussed together in relation to nine (9) key themes. Themes which relate to *what* needs to be done are: clarify roles and remits; improve understanding of public health; improve data, intelligence and research; and increase resources. The remaining themes relate to *how* this should be done: by adopting an inclusive approach; building on existing partnership structures; strengthening asset based approaches; developing stronger partnerships with the third sector; and enhancing sharing across boundaries;.

6.5 In addition, respondents commented on the importance of good leadership to support partnerships. These comments have been addressed in the analysis of the material on leadership (see Chapter 5). Finally, respondents provided suggestions in relation to practical steps which could be taken, as well as highlighting examples of good partnership models. These are presented at the end of this chapter.

Clarify roles and remits

6.6 Respondents identified a need to clarify roles and remits. The clarification which respondents wished to see included:

- Who is involved in the public health endeavour and how
- Who the stakeholders are
- The goals which have been set and the outcomes which it is hoped to achieve

- Accountability structures.

6.7 Respondents thought that greater clarity of roles, remits and responsibilities would help in achieving the desired public health outcomes. For example:

> *If the review clarified roles and responsibilities of IJBs, CPPs, NHS Boards, LAs and Scottish Government with regard to public health it would be helpful. (NHS Board, 73)*

6.8 This request for greater clarification was sometimes linked to the preference (see again Chapter 5, paragraphs 5.9-5.10) for a national strategy which would map out the various contributions to the overall public health endeavour.

> *Irrespective of the final configurations of the public health workforce, such partnerships also require a single, shared vision of what is to be achieved. The creation of a Scottish Public Health Strategy, setting out the outcomes required and recognizing the need for local and regional collaborations and partnerships, may be helpful in creating such a vision. (Public health forums and networks, 62)*

Improve understanding of public health

6.9 Respondents thought that, overall, there was a lack of understanding both about the scope of public health and the activities which comprise it. Therefore, respondents thought efforts should be directed towards increasing understanding of public health (and partnerships concerned with improving public health).

6.10 The lack of understanding covers a range of scenarios including:

- The lack of understanding that the specialist public health workforce has about the work of other healthcare professionals
- The lack of understanding between partners within a partnership concerned with public health issues
- The lack of understanding between sectors (e.g. public, third and private sectors)
- The lack of understanding of the different 'levels' at which public health operates (national, regional, local)
- The lack of understanding of the issues which impact on public health (including wider social determinants of health)
- The lack of understanding of public health within communities.

6.11 Part of the response to this lack of understanding, is to find ways to improve communication, develop a 'shared language', make communications more accessible, and heighten public awareness of public health through education and other channels. For example:

One of the key areas that needs to be developed further is a common understanding of each partner's role of contributing to tackling improvements in health and reduction in health inequalities. Quite often partners use different language and terminology, but are actually working towards similar outcomes. We need to find a shared vision and objectives in order to get 'buy-in' with partners effectively. (NHS Board, 28)

Public health can be seen as distant from local communities and the reports produced are often weighty documents which are difficult for the general public to interpret and understand. (Other organisational respondent, 11)

Improve data and intelligence

6.12 Data, information, intelligence and evidence were all thought to be crucial in supporting partnerships. While some respondents perceived that there were already very good information resources available, others made suggestions about how these could be enhanced and some national organisations set out the programmes that they were currently engaged in to improve the public health intelligence function.

6.13 Respondents commented that having a good understanding of the local context and being able to 'translate' complex data and information for local partners were key.

6.14 It was suggested that the Joint Strategic Needs Assessments currently being undertaken by health and social care partnerships provided an opportunity for public health professionals to work closely with local partners.

Increase resources

6.15 Respondents frequently identified a need for increased resources for partnerships. The additional resources which would strengthen partnerships were in the form of: i) increased funding for partnership programmes and initiatives, ii) increased capacity in terms of the public health workforce, and iii) increased time to nurture, build and sustain partnerships (including time to build trust and shared perspectives between diverse partners). Overall, there was a view that successful partnerships needed to be 'appropriately resourced and supported'. For example:

A successful partnership has the right skill mix, level of influence and leadership and is appropriately resourced and supported. Public health's effectiveness in partnerships has become restricted as our role has reduced over time due to diminishing resources – this has resulted in the prevention role being limited and eroded over time. Partnership takes time and that may be a luxury because of reporting

limits and separate agendas. Partnership-work can take a long time to be established (NHS Board, 74)

This should extend to ensuring local partnerships are appropriately resourced to empower communities at a local level. (Partnership, 56)

6.16 It was noted that at present there was not the capacity for core public health staff to engage with Community Planning processes. Moreover, there was comment from a range of respondents that public resources in general as well as some specific elements of public health resourcing (e.g. resource for health promotion initiatives, resource for the prevention role) had diminished over time; there was a widespread view that reduced resources for the public health effort had resulted in less effective partnerships.

6.17 Partnerships also require additional resources to undertake more effectively their role in dissemination and the sharing of good practice. It was recognised that the wider context of financial pressures has the potential to make partnership working more difficult.

Adopt an inclusive approach

6.18 Respondents highlighted the very wide range of individuals and organisations who have a part to play in (partnerships concerned with) public health. Overwhelmingly, respondents affirmed the importance of adopting an inclusive approach, utilising contributions from the broadest possible array of stakeholders.

6.19 There were many comments from respondents from all sectors, to the effect that including partners beyond health and social care was vital. The list of stakeholders considered to be relevant included the wider public health workforce, the voluntary and third sectors, local authorities, communities and the public. In terms of substantive policy areas, respondents reiterated their views that all areas were relevant.

To effectively strengthen and support partnerships, we need to broaden the definition of the "public health workforce". This includes not just specialists but all those who work (paid/unpaid) in the areas of health, wellbeing, travel, employment, food, environment, land planning, housing, education, poverty etc. Anyone with a role in improving economic, social and environmental conditions should be viewed as making a contribution towards improving public health. (Third sector, 35)

Public health workers should actively seek to increase the partners they work with and interact cleverly with other agencies and even other sectors to tackle the underlying causes. (Partnership, 26)

6.20 Respondents suggested that one way to cement these relationships across the wide range of stakeholders was to agree shared outcomes, and to promote joint working, shared projects, and joint problem solving. Influence and persuasion were thought to be important ways of working within these contexts.

> *At local levels Public Health should seek to foster a cohesive collaborative approach with partners across the public sector and the whole of the community to achieve its objectives. It will require being persuasive as its direct authority is limited. (Other organisational respondent, 114)*

Build on existing structures (CPPs, HSCPs, IJBs)

6.21 Community Planning Partnerships were seen to be at the heart of the public health endeavour, and the main mechanism by which improvements in public health can be achieved at a local level. Some respondents commented that the public health function would, in many ways, fit better within local community planning arrangements, rather than within health boards alone, since it is community planning partners who have access to many of the levers for tackling health inequalities.

> *We see Community Planning routes as key to influencing and enacting change to address inequalities. Requiring Local Authorities and others to champion Public Health for example through Community Planning Partnership obligations like the public health aims in the Single Outcome Agreement, Early Years Collaborative champions, etc. There is untapped potential for similar priorities such as tackling poverty. (NHS Board, 81)*

> *We also believe that the reduction of health inequalities should be the main statutory objective of Community Planning Partnerships. (Third Sector, 95)*

6.22 In addition, respondents commented that Health and Social Care Partnerships, and Integration Joint Boards offered new opportunities for partnership development. However, there appeared to be some disagreement (or confusion) about whether health and social care partnerships were primarily conceived as public health organisations.

> *So far the national ambition for HSCP's has not been to create HSCP's as overtly public health organisations within the legislation, with only one core outcome related to the wider public health endeavour and no requirement for health improvement or public health to be included in integration schemes. (Partnership, 42)*

Strengthen asset-based approaches to working with communities

6.23 Respondents were positive about the 'direction of travel' which had been identified by the Christie Commission (and others) which focused on building community empowerment and strengthening asset-based approaches (i.e. building on what people have, rather than focusing on need and deprivation). It was thought that this was an important agenda for partnership development and that partnerships would be improved and strengthened if they engaged more, and more effectively, with communities.

> *The current direction for supporting community empowerment and co-production is positive. More needs to be done in enabling public sector organisations and staff to work in this way. (Partnership, 47)*

> *Information, resources and training are needed to help public services shift away from a centrally-driven service supply model to an enabling model, supporting and working alongside community organisations, local interest groups and wider communities to create a more participative, empowered and healthier Scotland. This could build on a growing interest amongst public health partners in co-production, asset-based approaches and participative democracy. (Third sector, 34)*

6.24 This agenda would involve developing trust and learning across all partners and cultures (including informal and formal sectors); mobilising the public as a resource; increasing public involvement in partnerships; and developing mutual respect and understanding for complementary roles and skills.

6.25 The Community Empowerment Bill was thought to be a helpful lever for giving communities a stronger say in decisions that affect them and, potentially, bringing about better partnership working with communities. Respondents emphasised that public health needs to develop ways of working with communities. This would involve public agencies and partnerships developing better listening skills, and including the public routinely as full partners in public health matters.

Develop stronger partnerships with the third sector / voluntary sector

6.26 There was a concern expressed – mainly, but not exclusively by the third sector – that public agencies and public health leaders did not fully engage with the third sector and did not treat the third sector as an equal partner in relation to the public health agenda. This was expressed in a variety of ways including that:

- Trust in smaller locally based organisations can be lacking
- Voluntary and community organisations are not adequately resourced and this prevents them from fulfilling their potential role in improving public health

- Relationships between the statutory and third sectors needs to change so that there is mutual trust and respect
- Third sector and voluntary groups are able to access marginalised groups in a way which is not always fully recognised
- The contracting arrangements in Scotland inhibit partnership working between the public, private and voluntary sectors.

6.27 For example:

> *Public Health can learn from third sector partners who have long experience of engagement with 'targeted' group, for example CHEX and VHS and it would be important to encourage more cross sectoral dialogue within the extended Public Health community. (Partnership, 94)*

Enhance sharing across (organisational and sectoral) boundaries

6.28 Respondents emphasised the importance within a partnership context of sharing across boundaries. It was not enough to have a joint board, a joint strategy, and a shared set of goals. The sharing had to be real and practical. Respondents suggested sharing the following :

- Money and resources
- Data, intelligence, information, evidence, research (including linked data)
- Appropriate 'tools' and understanding of 'what works'
- Assessment, evaluation and interpretation skills
- Ideas and experiences.

6.29 In each case, respondents thought partnership working and partnership effectiveness would be improved by the sharing of assets across organisational and sectoral boundaries. For example:

> *National agencies could provide greater support to the Community Planning Partnerships by providing appropriate 'tools' and support and the evidence of what works. (Partnership, 56)*

> *Public Health has a strong empirical tradition and has many strengths in the assessment and interpretation of evidence. So one way in which the discipline can add value is to share this expertise and help disseminate the messages across a wider range of partners. The work of ScotPHO is an example of an area where Public Health expertise can inform and strengthen the evidence base for wider Partnership work. (Partnership, 71)*

6.30 The issues about where to locate expertise (at national, regional or local level) and how to ensure that this expertise was used to best effect across the

whole of the Scottish landscape were raised again. However, this was discussed in greater detail in Chapter 3 and is not repeated here.

6.31 A number of quite practical suggestions to improve partnerships were also made. These included the development of guidance on effective partnership working and improving IT. In particular it was thought that there was a lot of published material available on the key elements of partnership working and these could usefully inform the development of public health partnerships. For example:

> *There is a wide research literature on the composition and effectiveness of partnerships, and it is clear that distilling and translating this into guidance on creating and sustaining partnerships that have as their sole focus the delivery of public health objectives would be a useful start (Public health forums and networks, 62)*

> *There is an extensive literature on the nature of effective partnerships, and applying that knowledge in each instance and context is a founding principle. (National NHS organisation, 79)*

Examples of good partnerships

6.32 Finally, respondents highlighted from their own perspectives and experiences, some examples of well-functioning public health partnerships. The Scottish Health Protection Network, the Public Health Observatory and ScotPHN, and the North of Scotland Public Health network were all mentioned in this regard.

7 MAINTAINING A CORE PUBLIC HEALTH RESOURCE (Q4)

7.1 Question 4 of the Engagement Paper asked respondents: 'What would help to maintain a core / specialist public health resource that works effectively, is well-coordinated and resilient?' Ninety-six (96) respondents made comments in relation to this question.

7.2 It was not always clear from respondents' comments whether the points they made were primarily addressing the first part of the question – i.e. what would help to maintain a core / specialist public health resource? – the second part – what would help the core public health resource to work effectively, be well-coordinated and resilient – or both. Note also that many comments were not restricted to discussion about needs of the *core / specialist* public health resource (as identified in the question), but also included comment about the wider workforce as well. Moreover, some respondents (including some NHS Board respondents) specifically commented that 'the core public health workforce' needs to be more clearly defined.

7.3 Three key themes were raised in relation to this question. These were: action at a national level; workforce issues; and collaboration and networking. Leadership issues were also discussed in relation to this question, but have not been included here as they are discussed in detail in Chapter 5.

Action at a national level

7.4 Respondents identified two main actions which could be taken at a national level. These were: the development of a national strategy and the creation of a national centre for public health.

Development of a national strategy or shared vision for public health

7.5 It was thought that having a shared vision for public health in Scotland would help to join up the efforts of Government, academia and national and local agencies involved in the delivery of public health functions. It would also clarify priorities for action – particularly action to address health inequalities – and bring about better co-ordination of national level functions.

National centre for public health

7.6 The development of a 'national public health resource unit' or a 'centre for public health' was suggested by some respondents. It was suggested that this national resource should have 'strong leadership, working at the most senior level', be 'well-resourced' and have an 'influential and multidisciplinary team'. Its range of functions could include:

- Contribute to the development of local policy and practice (through collaboration with public health practitioners)
- Offer learning and workforce development opportunities

- Provide research and evaluation services
- Support access to literature
- Manage a fund to support the development and dissemination of public health information and education
- Have a key role in the dissemination and interpretation of information (including information about good local practice).

Workforce

7.7 Nearly all respondents made comments related to workforce issues. Within this main theme, there were several sub-themes namely: diversity of the public health workforce; clarity about who the workforce is; creation of a workforce development plan; training; career progression and pathways; and public health registration. These subthemes are discussed in turn below.

Diversity of the public health workforce

7.8 The diversity of the public health workforce was seen to be a strength and an important contributor to flexibility and resilience. Respondents felt this diversity should be encouraged, and that the review should consider not only the core public health workforce, but also the wider workforce and its role in improving public health.

7.9 The diversity stems from the wide range of backgrounds, (both professional and non-professional), which are found amongst the individuals who comprise the public health workforce, as well as the wide range of skills (both specialist and generalist) and knowledge.

> *The diversity of that core workforce should be acknowledged and supported; …This would encompass roles such as doctors, dentists, health improvement practitioners, environmental health specialists and health visitors, but also a much wider range of roles within and beyond the health service including data analysts, researchers, community development workers, evaluation specialists and strategic planners. (Research / academic, 99)*

Clarity about who the workforce is

7.10 At the same time, there was a view that the public health workforce needs to be properly identified. It was thought that the clarification of different roles within public health would help co-ordination; avoid duplication; and ensure quality, efficiency and sustainability. Clarity of roles would also help local partners know what they may expect from public health practitioners and specialists. It was suggested that resilience would come from ensuring that public health has 'an ongoing sense of its own identity'.

> *What proportion of Scotland's early years workforce – from child minders to play group leaders – are either treated or see themselves*

– as key contributors to public health in early childhood? The likely answer – "very few' – underscores the need for Public Health to recognize and embrace its already existing (albeit largely unrecognized and unsupported) allies and practitioners. (Third sector, 108)

7.11 There were suggestions that particular groups of experts (for example, health psychologists and health economists) should also be considered as part of the 'core' public health workforce.

Creation of a workforce development plan

7.12 Respondents occasionally suggested that a national workforce development plan was needed for the public health workforce and wanted to see this as a recommendation of the review. Two specific points were that:

- Workforce planning should address the *capacity* of the specialist workforce, ensuring that there is a 'critical mass' of specialist staff working at national, regional and local levels.
- Public health roles should be reviewed and job descriptions brought up-to-date.

7.13 Some respondents made reference to the ongoing work of the Public Health Workforce Development Group in identifying the practitioner workforce.

Training

7.14 Respondents saw training as a key component in ensuring that a multi-disciplinary public health workforce works effectively and is resilient. While some called for a nationally agreed and recognised training programme for the core public health workforce, others argued that the strengths of the current Scottish Public Health Training Programme should be recognised. The training delivered jointly by NHS Education for Scotland and Health Protection Scotland for the health protection workforce was particularly singled out for praise.

7.15 Suggestions in relation to training included:

- The need to modernise current training programmes – so that content goes beyond 'core competencies' to include exercises that reflect the challenges facing the future public health workforce
- The provision of regular 'multi-disciplinary training opportunities', bringing together the wider public health workforce to increase awareness of roles and responsibilities within public health
- Investing resources in specialist public health professional groups
- Supporting Continuing Professional Development opportunities for the wider workforce.

Career progression and pathways

7.16 Respondents repeatedly highlighted the importance of developing career pathways – not only *into* the profession, but between different public health roles. The point was made that the transition between public health practitioner and specialist is rare, primarily due to a lack of career development support and current arrangements for the regulation of public health specialists. While respondents supported the move towards opening up senior posts to individuals without a clinical background, they also felt this needed to be accelerated. There was a view that without clear opportunities for career progression, the profession will not attract strong candidates, thus putting at risk the resilience of the workforce.

> *Supporting a professional infrastructure for non-clinical public health staff is key to provision of a sustainable, skilled and affordable workforce to provide the necessary public health function for the future. (National NHS organisation, 46)*

Public health registration

7.17 Some respondents wanted to see a resolution to the debate over registration of practitioners in public health roles. The absence of a public health practitioner registration was a concern for some, and there was a call for this to be addressed. Specifically, it was suggested that workforce development initiatives (including the ongoing workforce review) should allow UK public health practitioner registration by individuals working across a range of sectors.

> *The absence of a PH practitioner registration is a significant concern and should be mandatory requirement in time. Investment in a national registration scheme and associated development support is a priority and requires to recognise the spectrum of experience and expertise within a large group of staff. (NHS Board, 9)*

7.18 The issue of registration was raised again in comments at Question 5, and is discussed further in Chapter 8 of this report.

Collaboration and networking

7.19 Respondents focused on the importance of collaboration and networking in relation to maintaining an effective, well-coordinated and resilient workforce. The general comments related to the importance of working across boundaries. There were more specific comments about the importance of linking to community planning, and to strengthening links with academic public health. These are discussed below.

Collaboration across boundaries

7.20 Respondents commented on the importance of collaboration across individual NHS Boards / and organisational boundaries; this could be particularly useful in the context of small NHS Boards and would help to join up the public health effort across local, regional and national levels.

7.21 This collaboration was already in place through existing public health networks. These networks were seen to facilitate the sharing of experience and expertise and the co-ordination of national / regional functions and responses, thus promoting resilience and maximising effectiveness. The Scottish Public Health Network and the North of Scotland Public Health Network were both specifically mentioned as positive examples of cross-boundary collaboration.

> *There is likely scope for more collaboration with public health teams across Board /organisational boundaries as evidenced by work through the North of Scotland Public Health Network (NoSPHN) and ScotPHN. (NHS Board, 85)*

7.22 There was also a suggestion that there should be further exploration of the use of 'a shared service approach' (as advocated by The Christie Commission) to increase the capacity of the public health resource, to avoid duplication wherever possible, and to facilitate to co-ordination and delivery of programmes between national and local levels. Examples of successful public health programmes involving national and local co-ordination of services included: the Childsmile Programme in oral health, the national immunisation and screening programmes, the Sexual Health and Blood-borne Virus Network.

> *To be effective, well-coordinated and resilient, we should be prepared to consider structural and organisational change where that may achieve better national and local identity, quality and sustainability, ensuring a critical mass for essential public health operations nationally and locally where appropriate. This may be achieved under shared services programme or network arrangements. (Senior public health staff groups, 89)*

Links to community planning

7.23 The issue of partnership has been discussed in detail in relation to Question 3 (see Chapter 6). In their comments at Question 4, respondents often highlighted effective partnership at a local level as the key to an effective public health resource. The point was made that pressures on public funding, together with demographic and structural changes, created significant challenges to resilience. Respondents therefore saw it as imperative that public health is well connected to local community planning partnerships,

which provide the local mechanism for tackling health inequalities in a more co-ordinated and focused way.

Links to academic public health

7.24 Respondents thought that relationships with academic and other research organisations was important in supporting the effectiveness of public health, and in providing independent advice based on academic rigour. The academic public health community was described as a ‘substantial resource with great potential’.

7.25 However, some suggested that academic public health was not always perceived as part of the core public health resource. The point was made that the links between academic research and the delivery of services is ‘patchy’. There was a view that the public health community should support a shift in academic public health towards greater dialogue to ensure that public health research is more relevant and more likely to have an impact.

7.26 Some also wanted to see increased funding for public health research, and it was suggested that greater use of joint posts (part funded by one partner and part funded by another) could potentially help in bringing about better integration between academic and service work.

8 PROVIDING OPPORTUNITIES FOR PROFESSIONAL DEVELOPMENT AND WORKFORCE SUCCESSION PLANNING (Q5)

8.1 Question 5 in the Engagement Paper asked: 'How can we provide opportunities for professional development and workforce succession planning for the core public health workforce?' Ninety-one (91) respondents made comments in relation this question.

8.2 There was substantial overlap between the comments made at Question 5 as compared with Question 4. In fact, in their responses to Question 5, several respondents simply referred back their responses to Question 4, making statements such as, 'Please see the response to Question 4 above' or 'I have mostly answered this in Question 4'. However, comments at Question 5 in relation to workforce development and training were often more detailed than comments made in Question 4.

8.3 It was also notable that comments made at Question 5 were not limited to the issue of professional development and workforce succession planning *for the core public health workforce.* Many respondents also made comments (particularly in relation to professional development) that related to the *wider public health workforce* as well.

8.4 Respondents' comments are discussed in relation to 5 main themes: workforce planning; importance of developing the wider workforce; career progression and career pathways; registration of the public health workforce; and training opportunities and programmes, including resourcing. The issue of leadership was also raised in relation to Question 5, but these comments have been analysed with the other material on leadership (see Chapter 5).

Workforce planning

8.5 Within the general theme of workforce planning, there were three sub-themes namely: identification of the 'core' workforce, the need for a workforce development plan, and the need for succession planning. The context for much of this discussion was that the current workforce was ageing, and there were decreasing numbers of experienced staff.

Identification of the 'core' workforce

8.6 Respondents thought that there needed to be clarity about who the core public workforce are, and the skills and capacities required by this group to deliver their functions. It was noted that a mapping of the core public health workforce in Scotland is currently being carried out by the Scottish Public Health Workforce Development Group, and it is anticipated that this will give a useful basis on which to agree continuing professional development and succession planning.

More clarity around what is core would inform the debate about succession planning and development. (Partnership, 24)

Need for a workforce development plan

8.7 There were calls for *both* a national workforce development plan – not only for the core workforce, but also for the wider workforce, *and* local workforce planning strategies. It was thought that these documents needed to be regularly reviewed to ensure they kept pace with developments.

We believe that there should be a national public health workforce development plan which is owned by the relevant professional bodies representing the wider public health workforce and resourced centrally. (Third sector, 95)

Need for succession planning

8.8 Respondents' comments about workforce planning were closely related to comments on succession planning. Respondents believed that succession planning was needed, not only at senior levels, but also junior levels – which is made difficult by specialist staff being largely funded on short-term contracts.

8.9 It was pointed out that the small number of public health specialists across Scotland makes it difficult to predict the number of trainees required each year in order to ensure adequate replacement. It was noted that there are now vacancies available, but insufficient specialists to fill them, and a particular challenge was noted around recruitment of specialists in the central belt. There was concern that failure to fill senior level posts over time may result in the posts being removed.

8.10 A further challenge to succession planning (and to the professional development of the workforce) identified is the number and diversity of education and training routes, and the wide variety of agencies involved.

Importance of developing the wider workforce

8.11 Respondents thought that the robust development of the wider public health workforce was essential to deliver public health outcomes, both in terms of health behaviour change, but also in terms of reducing health inequalities. Respondents again emphasised the need for better career pathways from the wider public health workforce into the specialised public health function.

Part of this work would implicitly promote, recognise and respect the wider workforce, and contributions to public health from many sources. (National NHS Organisation, 79)

8.12 Specific suggestions included:

- Reviewing the roles of NHS Education for Scotland, Health Scotland and Education Scotland in delivering training across the whole of the public health workforce
- Reaffirm (and build on) the work of the UK Faculty of Public Health, and People in Public Health, in relation to identifying core competencies for the public health workforce at different levels.
- Developing of specific types of training for the wider workforce – examples from Fife were highlighted in relation to "Reducing health inequalities training", "Welfare reform training" and "Health literacy".

Career progression and career pathways

8.13 This was a major theme in relation to Question 5. However, comments often repeated views expressed in response to Question 4 about the need to widen opportunities for career development and leadership and specifically, the importance of better – and more clearly defined - career progression for non-medical public health staff.

> *There are clear routes into Consultant in Public Health roles, including leadership positions. However the career progression for other staff working in Public Health is less clear and is often banded at a much lower level. Enabling multiple routes into leadership positions may be of benefit. (Royal college or other professional grouping, 70)*

8.14 The point was made that, although career pathways are slowly opening up for non-medical staff in the UK, this is happening more quickly in England and Wales than it is in Scotland. A training programme delivered by Public Heath Wales, which is open for both qualified medical doctors and individuals from other disciplines related to public health, was cited as a positive example of how to speed up this process. The point was also made that as long as public health specialists continued to come primarily from medical backgrounds, the perception that the most important determinant of health is health care would continue. This risked undermining efforts to involve other agencies in addressing the wider determinants of health.

8.15 The issue about lack of career progression was also mentioned in relation to specific roles within the public health workforce. For example, it was noted that there is no established career path for health protection nurses or public health officers.

8.16 There was a call for more flexible career pathways, more flexible opportunities to develop careers outside formal training programmes, and the strengthening of links between the public health workforce and academia.

Registration of the public health workforce

8.17 The issue of public health practitioner registration was frequently raised again in response to Question 5. This was described as 'a significant concern', and some respondents argued for mandatory registration of this group within the public health workforce. The benefit of this was that it would result in a recognition of the experience and expertise, and greater development of the wider public health workforce.

> *Mandatory registration might help to identify specialist public health professionals and ensure maintenance of core competencies. (Royal colleges or other professional grouping, 83)*

8.18 However, the point was also made that many health and social care professionals are already required to maintain a professional registration, and sometimes a dual registration with a second regulatory body, which could act as a barrier to their willingness to identify as a public health practitioner. Indeed, it was suggested that mandatory registration 'may stifle entry to the profession'; as had reportedly been the case with the mandatory registration for health improvement staff in Wales. It was suggested that one way of avoiding multiple registrations might be to ask existing regulators to establish public health registers within other professions, as currently happens with non-medical prescribing.

8.19 It was noted that there may be opportunities to learn from the operation of other UKPHR schemes elsewhere in the UK, particularly in Wales.

> *We might also learn from other local UKPHR practitioner schemes, e.g. Wales and consider supporting an advanced practice registration process. (NHS Board, 85)*

Training opportunities and programmes, including resourcing

8.20 Within the wider theme of training, there were several sub-themes. Each of these is described briefly. It should be noted again, that training was often discussed not only in relation to the core / specialist workforce, but also in relation to the wider workforce.

Resource / funding available for training

8.21 Respondents thought that personal development review and planning was important to enable staff to develop. However, respondents frequently highlighted the difficulties for staff to take advantage of CPD opportunities and other forms of training, due to lack of funding. The point was also made that the lack of capacity in the workforce in some areas made it difficult to give staff the time out from their jobs to take advantage of training opportunities. Training provision was described as 'fragmented and sporadic' and variable across disciplines / organisations.

Relevant CPD opportunities from professional societies and other organisations are plentiful within the UK; however, Health Boards in Scotland often lack the resources to allow their staff to attend these. (Individual, 87)

We note that training/CPD budgets are not consistent within disciplines in public health. The budget is a soft target for savings and would need to be allowed for in professional development support. There are few opportunities for secondments in or out – resilience is low due to annual cost savings (NHS Board, 74).

Suggested types of training

8.22 Respondents suggested a range of mechanisms (including in-house or local mechanisms) for supporting workforce development within existing budgets. These included:

- Joint training of staff: on a peer basis, or through professional trainers
- Peer audit processes: to improve practice and standardise approaches to service delivery
- Shadowing and peer mentoring opportunities: both within and across services
- Staff supervision: including making use of annual reviews and feedback to staff
- The use of attachments and secondments: including rotations into national agencies to refresh and extend expertise.
- The use of staff recognition awards and rewards: to recognise achievements.

8.23 Respondents also wanted to see enhanced CPD programmes that included 'place-based approaches', co-production methodologies, collaborative leadership, and service user involvement. It was suggested that NHS Health Scotland and the Scottish Public Health Practitioners Network could play a role in the development and / or delivery of such programmes.

8.24 Some suggested that community planning partners (including partners in the third sector) could be involved in the development and delivery of training at a local levels, and that specialist training programmes could be delivered in partnership with professional bodies.

Training programmes

8.25 There was also generally positive comment about current training programmes, including those delivered by NES, STRADA, and the programme for health protection staff developed jointly by NES and Health Protection Scotland.

A similar model to the STRADA training could be adopted to help with professional development within Public Health. This would ensure that it was easily accessible, affordable and providing the same messages and information from a national perspective. (Partnership, 13)

Any programme should be aligned with a broader and agreed strategy, for public health overall and with an integrated professional development plan, and with milestones that record and ensure progress. The health protection workforce has the best developed arrangements in this regard. (National NHS Organisation, 79).

9 TOPIC SPECIFIC RESPONSES

9.1 As has been set out earlier, the public health function is a very broad endeavour, encompassing activities and efforts across the domains of health improvement, improving health services and health protection, and in the area of public health intelligence. The responses to the engagement paper reflected this: with some responses directed at the totality of the public health function while others gave more topic focused responses.

9.2 The topic specific responses were themselves highly diverse, for example, covering issues such as alcohol, smoking, asthma, cancer, cerebral palsy, optometry, dentistry, environmental health and occupational health, among others. Respondents often used their responses to describe the work that their organisation does, and to show how that work contributes to public health.

9.3 Relative to other topic focused responses, the topic discussed most frequently was in relation to early years / children and young people. Key issues raised in these responses are presented below.

Early years priorities

9.4 Many respondents from across all sectors discussed the importance of focusing on the early years in relation to improving public health; it was widely accepted that investment in these early years – and in particular a focus on primary prevention in the early years – was vital to address health inequalities.

9.5 In addition to these general comments, however, six respondents provided more detailed submissions on this topic / life course stage, with five identifying specific priorities for action. There was some overlap between the focus of the comments from these six respondents, and also a wide diversity of specific points made in relation to the early years agenda. A range of contextual factors were also highlighted. The focus on the first 1000 days of a child's life (from conception to age 2) was seen to be particularly important.

9.6 Specific priorities for action identified (often by a single respondent) covered:

- Reducing child mortality. It was noted that the UK has one of the highest child mortality rates in Europe. Specific elements which would contribute to this included: maximising health and wellbeing during pregnancy, reducing injury and poisonings, promoting health and wellbeing and reducing risk taking behaviours and reducing healthcare amenable deaths
- Improving routine surveillance systems for child health. It was noted that investment in child health surveillance was weak in comparison to adult / older people surveillance systems. This would include improvements to

newborn screening (it was noted that there are no national standards for this at present), routine surveillance of disabled children, a more consistent approach across the country to the provision of paediatric ENT and opthalmology services, and a consistent approach to the provision of children's services in the context of health and social care integration

- Improving maternal nutrition and health and infant feeding and nutrition. This includes increasing preconceptual nutrition, increasing uptake of Healthy Start vouchers, increasing breastfeeding rates, reducing smoking in pregnancy
- Reducing unnecessary (medical) intervention in childbirth
- Focussing on wider factors relating to poverty, social isolation, and mental health and wellbeing. These factors are important in general but are especially important during pregnancy and the early years
- Improving relationships and trust between parents and health care professionals as well as between children and parents / guardians.

10 COMPARISONS BETWEEN SECTORS

10.1 As noted at the start of this report, the responses to the engagement paper included a very diverse range of views, and there was not necessarily a unified view, even among respondents within a single sector. However, there were some differences in focus and emphasis between respondents in different sectors, and this chapter explores those differences – specifically between health organisations, local government organisations, partnership bodies and the third sector.[7] The focus in this chapter is on the views expressed by each sector *which were distinct* from those expressed by other sectors.

10.2 Health organisations often discussed all three domains of public health as well as the fourth area of public health intelligence. Thus, in setting out the perspectives of health organisations below, an attempt has been made to draw out some of the key points made by this group in relation to the different domains. Local government organisations and partnerships often equated 'public health' with the health improvement domain, while also occasionally highlighting the importance of public health intelligence. Responses from the third sector contained comments in relation to all the domains of public health.

10.3 The engagement paper did not specifically ask for views on the organisation of the public health function. However, respondents frequently raised this issue – often in the context of a discussion about the lack of co-ordination between national and local public health functions, and the poor visibility of public health among local partners.

Perspectives of health organisations

10.4 The responses from health organisations comprised 42 responses in total – 23 from NHS Boards, 7 from public health forums and networks, 6 from senior public health staff groups and 6 from national NHS organisations. The latter group included organisations with national responsibilities for two of the domains of public health, namely health improvement (NHS Health Scotland) and health protection (National Services Scotland). NSS also has a leading role in the area of public health intelligence. It is relevant that coverage of the domains of public health varied substantially between the respondents in this group and thus there was a particularly diverse range of perspectives.

10.5 Among the health organisations, recurring themes included a lack of capacity (particularly in relation to some specialist roles), duplication of effort, fragmentation of the workforce, and confusion about which organisations were leading on particular aspects of public health. These were all identified as weaknesses in the public health function as currently delivered.

[7] For the purposes of this analysis, health organisations include NHS Boards, senior public health staff groups, public health networks and national NHS organisations.

10.6 Health organisations often acknowledged that there was currently poor co-ordination between national, regional and local public health functions, and a need for clarity about what should be delivered at each of these levels. There was a recurring view that the development of a national strategy for public health would help to address this. There was some mention that a single national Centre for Public Health might also be created.

10.7 Some respondents offered detailed comments about organisational structures that they believed would offer improvements -- as well as those they thought would *not* be beneficial. Other respondents expressed concerns about *any* kind of reorganisation. There was no clear consensus about which structure would be best for public health, and there were also mixed views about whether a 'shared services approach' represented an opportunity or a threat.

10.8 Reference was also made to the Public Health England model. While some saw this type of model as potentially positive and worth considering for Scotland, others described it as not working well. It was thought that this type of reorganisation could lead to: loss of critical mass through fragmentation of the workforce; professional isolation; loss of access to (health board) data; constraints on the independence and advocacy function; loss of influence and ultimately, widening health inequalities.

10.9 It was suggested that 'any structure can be made to work' – and too much focus on finding the 'perfect' structure, rather than one which is 'fit for purpose', would be unhelpful. Nevertheless, health organisations seemed to anticipate that some change may be necessary, and there were requests that any future reorganisation should:

- Identify what the purpose of the public health function is, and what it is intended to achieve
- Be undertaken in a staged way rather than attempting to change everything at once
- Ensure that a 'critical mass' continues to be available within the workforce to be able to respond quickly to unforeseen or 'rare event' pressures (such as flu pandemics)
- Take into account the particular challenges of delivering public health in remote and rural areas.

10.10 Health respondents recognised the importance of partnership working and pointed to the many ways in which they were involved in supporting and working alongside local partnerships. However, they also agreed that more could be done. It appeared that in some cases, partnership working was well developed, while in others, public health professionals were reported to work with a more limited range of partners on a narrowly defined set of 'health' initiatives.

10.11 There were differing views expressed among the health organisations about the implications of health and social care integration to the delivery of the public health. On the one hand, there was a view – and a desire – that public health should have a strong role in the new partnerships. However, there was also a concern that the integration of health and social care may result in further pressure on the capacity of the workforce. There was also a question about the extent to which health and social care partnerships would be able to bring about changes in the wider determinants of health. Thus, it was thought that a strong shift in focus by public health agencies towards these new structures could be counterproductive.

10.12 In discussing the issue of leadership, health organisations tended to speak of the specific leadership role provided by the Directors of Public Health and they offered views on how these roles could be strengthened. For example, respondents thought DsPH should have a key role in the new Integration Joint Boards, but thought that capacity problems made this difficult. Health organisations also suggested that efforts need to focus on recruiting a broader pool of leaders, and that leadership could be strengthened through more integrated partnership working across organisational boundaries.

10.13 In terms of the public health workforce, health organisations referred to the work of the Workforce Development Group and suggested that the Public Health Review should take the recommendations of this group into account.

The perspective of national NHS organisations

10.14 The national NHS respondents who took part in the engagement exercise each operated in different parts of the public health landscape. These responses expressed very different views about the role of the national agencies in the public health endeavour. However, there was general agreement among them that a national public health strategy would help in bringing about greater co-ordination and coherence. Two of the national respondents offered (different) suggestions about the reorganisation of the public health function.

Health improvement

10.15 Health organisations recognised that, to address health inequalities, action would have to be taken outside of the health sector, and that resources should be oriented to reflect this reality. However, there were also concerns that the available resources were inadequate to allow this to happen.

Improving health services

10.16 Many of the NHS respondents saw their organisations / groups as having a major role in improving health (and in some cases social care) services, and adopting a population approach to the delivery of services. This was a key theme particularly among allied health professionals (AHPs), dentists,

pharmacists and the Scottish Ambulance Service. The response from the Public Health Service Improvement Interest Group (PH SIIG) set out in some detail the role of public health in advising on the design of health services to maximise the population benefits of healthcare.

10.17 AHPs, dentists and pharmacists commented on the advisory and supporting role that they have with other health and social care professionals. In particular, pharmacists highlighted their role in working together with other professions and patients to obtain optimal outcomes from the use of medicines and to prevent adverse events.

10.18 Respondents referred positively to national policies (in Patient Safety and Healthcare Improvement) which clearly articulate the relevance of public health to these areas, and they pointed to successful initiatives such as the Health Promoting Health Service. At the same time, there was a feeling that increasing demands on acute services are pulling resources away from prevention and anticipatory care interventions.

Health protection

10.19 Health organisations frequently highlighted the recent Health Protection Stocktake and the recommendations which came out of that exercise. Leadership in this area was seen to be provided by the (new) Health Protection Oversight Group, Health Protection Scotland, and the (new) Scottish Health Protection Network groups.

10.20 The need for a critical mass in the specialist workforce was emphasised – to allow for short-term reorientation of resources to deal with immediate issues (i.e. flu pandemics, e-coli outbreaks, etc.)

10.21 Partnership working in relation to the health protection function involved the development of local joint health protection plans to agree local priorities and support local health protection initiatives. Those with expertise in this area particularly highlighted the importance of working with and learning from third sector partners who have experience of working with particular groups (for example, in relation to needle exchange or sexual health services). They also saw scope for improving links with education, police and animal health and veterinary services in relation to health protection initiatives.

10.22 With respect to workforce development, registration of non-medical public health practitioners was seen to be important within the health protection domain, but was thought to need more support, and there were positive comments in relation to the joint development and implementation by NES and HPS of the ‘Framework for Workforce Education Development for Health Protection Scotland’.

Perspectives of local government organisations

10.23 Altogether, there were 11 responses from local government organisations (including one from the national body, COSLA). This group of respondents thought the top priority for public health should be to reduce health inequalities which meant, from their perspective, taking action to address the wider determinants of health (e.g. in education, employment, physical and social environments, and quality of services). Linked to this, local government organisations wanted the outcomes which the public health endeavour should seek to achieve, to be defined by local community planning partnerships.

10.24 This group highlighted and welcomed the opportunities to develop the involvement of public health staff in community planning; however there was also comment that there is currently not enough capacity within the public health workforce to allow this to happen across the country.

10.25 There was agreement within this group that the health improvement domain of public health (which this group equated with tackling inequalities) needs to be co-ordinated and driven from within local authorities. This would require a rebalancing of public health resources, with more resources allocated to local authorities and / or directed by community planning partnerships (for, amongst other things, investment in the wider workforce and a greater focus on prevention). It was thought that this positioning would give public health greater reach and influence, and would also enable community engagement to become more fully embedded in community planning processes.

10.26 There was a suggestion that a national public health organisation could be beneficial; COSLA suggested that this organisation would 'plan and deliver specialist services which coordinate strengthen and support activities aimed at improving the public's health and protecting the public from infectious and environmental hazards'.

10.27 Local government respondents commented that the public health activity of NHS Boards will increasingly need to operate within the new environment of integrated health and social care partnerships. It was thought that there was an opportunity to make these partnerships into effective public health organisations. This would also provide the context for discussions about the future balance of expenditure between acute services and preventive approaches; the local authority perspective was that acute services were currently drawing resources away from preventative approaches.

10.28 Local authority respondents commented that cultural barriers and the 'hierarchy of professions' prevent health professionals from always being effective advocates for public health. However, the Scottish Health Protection Network was seen to be providing good leadership for the environmental health function in local authorities.

Partnership perspectives

10.29 There were 17 responses to the review from partnership bodies around Scotland – nine from community planning partnerships or subgroups of CPPs, and eight from health and social care partnerships or subgroups of HSCPs.

10.30 These responses mainly focused on the health improvement domain of public health, and provided little comment on either the health protection or health service improvement domains. A clear message from these responses was that the public health function needed to be rebalanced to focus more directly on tackling inequalities as a top priority; this would require the 'definition' of public health to be reframed to reflect this change in focus.

10.31 Public health intelligence (particularly in relation to needs assessment, evaluation and evidence review) was highlighted as very important to partnerships in deciding local priorities and in planning services and interventions. Partnerships valued the input from public health colleagues in providing rigour and 'asking tough questions' in discussions about service planning.

10.32 The lack of capacity within the public health resource was thought to be a problem in some areas, and some respondents highlighted particular difficulties in involving clinical colleagues in local partnerships.

10.33 Health and Social Care integration was a major theme among this group, and several respondents commented that the health improvement function in their area was being relocated into Health and Social Care Partnerships. In other areas, there was a perception that public health had not fully engaged with the integration agenda, and there appeared to be some disagreement among respondents about the extent to which HSCPs were conceived (at a national level) as overtly public health entities.

10.34 Regardless of this, respondents saw an important role for public health in community planning partnerships, and commented that reducing inequality should be the main priority of all CPPs. It was thought that public health could support community planning partners not only in relation to providing good quality intelligence and evidence, but also in helping to build capacity within the wider workforce.

Third sector perspectives

10.35 In all, seventeen (17) third sector organisations submitted a response to the engagement paper. Most of these organisations had a specific topic focus (e.g. alcohol, smoking, asthma, early years, environmental health, food and diet etc.). In addition there were two organisations that described themselves as intermediary and network organisations (Health and Social Care Alliance, Voluntary Health Scotland), two (community) development agencies /

organisations (Glasgow Council for the Voluntary Sector, Community Health Exchange) and one funding organisation (Big Lottery Fund).

10.36 All third sector organisations emphasised the importance of reducing health inequalities and the role of public health in reducing health inequalities. Reducing health inequalities was seen to be the core aim of public health.

10.37 Linked to this focus on inequalities, there was widespread comment from third sector organisations about the importance of taking a very broad view of public health. In particular respondents emphasised that public health was not the sole preserve of the NHS; many partners outwith the NHS were also involved, and their input was crucial to tackling the wider social determinants of health. Moreover, third sector organisations highlighted that national 'upstream' measures (e.g. taxation measures, legislation on tobacco control, and poverty reduction programmes) were also required.

10.38 On the whole, third sector respondents viewed the integration of health and social care as an opportunity for more effective working and better delivery of public health outcomes. However, it was emphasised that the integration of health and social care would only deliver improvements in public health if the third sector / voluntary sector were fully involved, and on an equal footing with statutory services.

10.39 The current situation was seen to be unsatisfactory. Respondents commented that the third sector's role had not been fully realised, and that the resources required for the third sector to operate effectively and to contribute fully to the achievement of public health outcomes were not available. Respondents specifically commented that: i) the signposting from the NHS to the third sector services was inadequate; ii) the core public health workforce currently excluded the third sector; and iii) the short term funding arrangements meant that third sector programmes / projects were often not able to be sustained – even if of proven worth – after an initial pilot period.

10.40 The Community Empowerment Bill was also mentioned by respondents as a positive step. It was thought this would enable community led approaches to health improvement to develop. Again, this came with the caveat that delivering public health outcomes (and specifically reducing health inequalities) would not be achieved without a significant transfer of resources to communities – and by implication to third sector organisations. Comments emphasised the importance of adopting asset-based approaches, focusing on self-management approaches, and working with the public and with communities.

10.41 The comments from the third sector organisations touched on all domains of public health. There was a particular focus on taking a public health approach to improving services (by, for example, supporting self-management, improving screening uptake, being sensitive to the impact of inequalities within services, and reducing variation in the delivery of services), as well as a

substantial amount of comment about approaches to health improvement and health protection.

11 CONCLUDING REMARKS

11.1 Responses to the engagement paper were highly diverse, and represented a wide range of understandings and perspectives about the nature of the public health endeavour, the relationships and balance between the domains of public health, and the organisational structures which would best support a strong public health function.

11.2 Many responses were lengthy and complex. The lack of consistency in the use of key terms in relation to the public health function and the domains of public health, and the proliferation of related terminology meant that it was often difficult to interpret exactly what was being said.

11.3 The theme which provided the greatest amount of consistency and coherence, and which resonated with almost all of those who responded was the importance of focusing on 'reducing (health) inequalities'. There was almost unanimous support for directing the public health endeavour towards this aim and some respondents explicitly said that health inequalities should form part of the formal definition of public health in Scotland. There was agreement across all sectors that reducing health inequalities required action far beyond the domain of the NHS, and that community planning partnerships were the key to this. However, there were different views about what the consequence of this should be in organisational terms.

11.4 On the whole, responses from NHS Boards, other health organisations and the third sector covered all the domains of public health and also discussed the issue of public health intelligence. Many of the professional organisations had a particular focus on the improving health services domain; whereas local authorities and partnership organisations focused to a very substantial degree on the health improvement domain (which they equated with 'tackling health inequalities'). All respondents agreed that public health intelligence was vital to underpin progress.

11.5 There was a great deal of reflection by respondents about how best to organise the public health endeavour. The question of which parts of the public health function were best dealt with at national, regional or local level were returned to repeatedly, especially by NHS organisations. Although no clear conclusions were reached, there was a widespread sense that coordination between levels was currently weak, and that the status quo could be improved.

11.6 There was a strong call from a range of organisations for better coordination between the national organisations; this was sometimes raised in the context of calls for a 'national public health strategy'. Occasionally, respondents also suggested there needed to be a single strong national public health organisation. However, there was no clear view of the form a national

organisation would take, and where it would be positioned in the broader organisational landscape.

11.7 The advent of health and social care integration was important in setting the policy context for responses. The responses suggested that organisations were at different stages in developing their arrangements locally for integration and this ‘work in progress’ aspect meant that there was no clear sense (yet) emerging of the impacts of integration on public health. However, there were repeated requests to ensure that public health objectives (including reducing inequalities) should be set for the new Integration Joint Boards. The (re)alignment of public health resources to support these partnerships was discussed, but there were also concerns about a perceived lack of capacity within the specialist workforce to fully engage with this agenda.

11.8 The public health workforce was clearly valued and seen as a strength. Respondents repeatedly highlighted the diverse, multidisciplinary, committed and highly skilled nature of the workforce. At the same time, there was also widespread comment that the wider workforce required investment and the development of a clearer identity, together with training and development opportunities.

ANNEX 1: LIST OF RESPONDENTS

Organisational respondents

NHS Boards (23)

- NHS Ayrshire & Arran, Public Health Department
- NHS Dumfries and Galloway
- NHS Dumfries and Galloway Health Protection Team
- NHS Fife
- NHS Fife Health Promotion Service
- NHS Fife Pharmacy – Strategic Management Team
- NHS Fife, Public Health Department
- NHS Forth Valley
- NHS Grampian
- NHS Greater Glasgow & Clyde, Health Improvement and Inequalities Group
- NHS Greater Glasgow and Clyde
- NHS Greater Glasgow and Clyde, Area Clinical Forum
- NHS Greater Glasgow and Clyde, Area Pharmaceutical Committee
- NHS Highland
- NHS Lanarkshire
- NHS Lanarkshire, Health Improvement Department
- NHS Lanarkshire, Specialist Public Health Department
- NHS Lothian, Public Health and Health Policy Department
- NHS Orkney
- NHS Shetland
- NHS Tayside Directorate of Public Health
- NHS Western Isles
- North of Scotland Planning Group (NOSPG)

Third sector organisations (17)

- Alcohol Focus Scotland
- ASH Scotland
- Asthma UK
- Big Lottery Fund
- Cancer Research UK
- Capability Scotland
- Community Health Exchange (CHEX)
- Glasgow Council for the Voluntary Sector
- Health and Social Care Alliance Scotland
- National Childbirth Trust
- Nourish Scotland
- Quarriers

- Royal Environmental Health Institute of Scotland (REHIS)
- Royal Society of Edinburgh Young Academy of Scotland
- Voluntary Health Scotland
- WAVE Trust
- Young Scot

Partnerships (17)

- Aberdeenshire Health Inequalities Group (HIG)
- East Ayrshire Community Planning Partnership
- East Renfrewshire Community Health and Care Partnership
- Fife Partnership (incorporating the Fife Council's response)
- Glasgow Health and Social Care Partnership (shadow)
- Highland Community Planning Partnership
- Inverclyde CHCP
- NHS Borders and Scottish Borders Council
- North Ayrshire Community Planning Partnership
- North Lanarkshire Partnership
- Orkney Health and Care
- Perth and Kinross CHP
- Public Health Practitioners within Edinburgh Community Health Partnership
- Renfrewshire Community Planning Partnership
- Shetland Partnership Performance Group
- South Ayrshire Health and Social Care Partnership (Strategic Planning Advisory Group)
- South Lanarkshire Community Planning Partnership

Royal colleges or other professional grouping (15)

- British Dental Association
- British Occupational Hygiene Society (BOHS)
- British Psychological Society
- Community Pharmacy Scotland
- National Pharmacy Association
- Optometry Scotland
- Royal College of Paediatrics and Child Health Scotland (RCPCH)
- Royal College of Physicians of Edinburgh
- Royal Colleges of Physicians of the UK, Faculty of Public Health
- Royal Pharmaceutical Society
- Scottish Colleges Committee on Children's Surgical Services
- Scottish Health Action on Alcohol Problems (SHAAP)
- Scottish Public Health Workforce Development Group
- Scottish Registrars in Public Health Group
- UK Public Health Register (UKPHR)

Local authorities (11)

- Aberdeenshire Council Community Substance Misuse Service (Communities Directorate)
- Argyll and Bute Council
- City of Edinburgh Council, Corporate Policy and Strategy Team
- Comhairle nan Eilean Siar
- Convention of Scottish Local Authorities (COSLA)
- East Lothian Council
- Falkirk Council (2 responses)
- Midlothian Council
- North Ayrshire Council
- South Lanarkshire Council, Environmental Services

Public health forums and networks (7)

- North of Scotland Public Health Network (NoSPHN)
- Pharmaceutical Public Health Network in Scotland
- Public Health Service Improvement Interest Group (PH SIIG)
- Scottish (Managed) Sustainable Health Network (SMaSH)
- Scottish Health and Inequalities Impact Assessment Network
- Scottish Public Health Network (ScotPHN)
- South East Scotland Dental Public Health Network

Senior public health staff groups (6)

- Allied Health Professional Directors & Leads
- Association of Directors of Public Health (UK)
- Consultants in Dental Public Health and Chief Administrative Dental Officers Group in Scotland
- Consultants in Public Health Medicine (Health Protection) Group
- Scottish Directors of Public Health
- Scottish Health Promotion Managers

National NHS organisations (6)

- Healthcare Improvement Scotland
- NHS Education for Scotland
- NHS Health Scotland
- NHS National Services Scotland
- NHS National Services Scotland, National Services Division
- Scottish Ambulance Service

Research / academic organisations (4)

- Glasgow Centre for Population Health
- Scotland Rural College (SRUC)
- Scottish Collaboration for Public Health Research and Policy (SCPHRP)
- University of Glasgow, Institute of Health and Wellbeing

Other organisations (5)

- Care Inspectorate
- Chief Nursing Officer's Directorate, Scottish Government
- Police Scotland
- Scottish Natural Heritage and Forestry Commission
- SEPA, Stirling Office

Individual respondents

- Dr Breda Cullen and Professor Tom McMillan
- Dr Margaret Hannah
- Four (4) other individual respondents

social research

The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

This document is also available from our website at www.gov.scot.
ISBN: 978-1-78544-649-8

The Scottish Government
St Andrew's House
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Produced for
the Scottish Government
by APS Group Scotland
PPDAS56546 (02/16)
Published by
the Scottish Government,
February 2016

GSR
GOVERNMENT SOCIAL RESEARCH
Social Science in Government

Social Research series
ISSN 2045 6964
ISBN 978-1-78544-649-8

Web and Print Publication
www.gov.scot/socialresearch

PPDAS56546 (02/16)