2015 Review of Public Health in Scotland

Strengthening the Function and Re-Focussing Action for a Healthier Scotland

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The Scottish Government
Riaghaltas na h-Alba

2015 REVIEW OF PUBLIC HEALTH IN SCOTLAND: STRENGTHENING THE FUNCTION AND RE-FOCUSSING ACTION FOR A HEALTHIER SCOTLAND

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Ministerial Foreword

It is my pleasure to provide a foreword to this important and timely report which emphasises the need for collective action focused on improving health and wellbeing for all of Scotland's people.

I am grateful to the Public Health Review Group, and Dr Hamish Wilson as Chair, for the work undertaken in the preparation of this report, as well as to everyone that has supported and engaged in the review process that informed this report. This Public Health Review Report provides a comprehensive picture of the current public health endeavour in Scotland - the strengths and successes, and the challenges and areas for improvement. The report reiterates the breadth of public health activity, covering both physical and mental wellbeing, undertaken by a range of professionals across the NHS, Local Authorities, the third sector, and through communities and by individuals. All of this activity goes towards creating a healthier population, addressing health inequalities and reducing the potential for ill-health. The National Conversation on *Creating a Healthier Scotland* has been finding out what really matters to people and their families in terms of improving health and living healthier lives, as well as the future of health and social care services. The Conversation will take account of the engagement and findings of this review of public health.

We have had a number of successes in Scotland, and on some issues we are recognised as leading the way. But there is clearly more that needs to be done as the issues we face are complex, combining an ageing population; enduring inequalities; and changes in the pattern of disease requiring action to address the determinants of population health, as well as particular health priorities. We need to be ready to respond effectively to all these challenges.

The Review Group's recommendations provide a clear basis for further work to strengthen and re-focus the vital public health function in Scotland for the future. Thinking about our structures and public health leadership will be an important activity for Government in the coming months. I welcome and support the proposal for a single Public Health Strategy for Scotland, setting out the wider population health priorities and the contribution that many partners can make to tackle these challenges. Such a document would be a significant parallel strategic statement to the National Clinical Strategy.

Supporting and developing our multi-disciplinary public health workforce, which is recognised as extending beyond the NHS, and ensuring effective partnership working across the public and third sectors on population health are also vitally important.

The recommendations within this report provide clarity on the steps we need to take in Scotland and the next phase is to work with stakeholders to take forward implementation. We can achieve the best use of our resources and our collective endeavour in Scotland so that we have a positive and lasting impact on creating a healthier Scotland.

Maureen Watt

Executive Summary

Conclusions and Recommendations

1.   This Review of Public Health in Scotland has identified the need for the function to be clearer about its priorities and delivered in a more coherent manner. The changing organisational context (including the clear emphasis on partnership and integration and the importance of community empowerment and engagement) has implications for how public health is organised and operates. Major public health challenges such as obesity, mental health problems and inactivity, together with the persistence of health inequalities, require a concerted population health response, achieved through the organised efforts of society. They cannot be addressed solely through treatment. The evidence received by the review group emphasised the cost-effectiveness of preventive approaches and a wide appetite for a more active public health effort in Scotland. The Review Group's recommendations seek to support that through:

   a. Further work to review and rationalise organisational arrangements for public health in Scotland. This should explore greater use of national arrangements including for health protection.
   b. The development of a national public health strategy and clear priorities;
   c. Clarification and strengthening of the role of the Directors of Public Health(DsPH), individually and collectively;
   d. Supporting more coherent action and a stronger public health voice in Scotland;
   e. Achieving greater coordination of academic public health, prioritising the application of evidence to policy and practice, and responding to technological developments;
   f. An enhanced role for public health specialists within Community Planning Partnerships (CPPs) and Integrated Joint Boards (IJBs); and
   g. Planned development of the public health workforce and a structured approach to utilising the wider workforce.

2.   The Executive Summary outlines the review process and key themes which inform these recommendations. These are expanded on in the full report.

Public Health Review

3.   The Public Health Review has been given a specific remit to examine public health systems and functions and their contribution to improving population health and reducing (health) inequalities. Ministers have asked for recommendations to seek to strengthen the contribution; maximise the effectiveness and efficiency; and ensure the responsiveness and resilience of the public health function in Scotland for the future.

4.   The material described in the first part of this summary, and in Part 1 of the report, reflects the population health and policy analysis undertaken to ensure recommendations are made on the basis of a good understanding of public health. The second part of the summary, and Part 2 of the report, describe the key themes emerging from the engagement processes undertaken by the review (full report published separately at www.gov.scot/publichealthreview-analysisofresponses-engagementpaper), and the additional research evidence commissioned around the

specific areas of public health leadership, partnership and workforce (summary report published separately at www.gov.scot/publichealthreviewresearchreport-keyfindings). Collectively this work reflects the review process and has been undertaken on behalf of the Review Group. The Group's recommendations take account of all these strands of the review.

Population Health in Scotland

5.   Good health is beneficial for individuals and families, and also strengthens capacity for participation in learning, employment, caring, and many other activities. In short, good health is a resource for society.

6.   The population health challenge remains complex and persistent and current measures are not seen to be sufficiently accelerating improvement in the country's public health:

- Life expectancy is increasing, but is not improving equally or improving to the levels seen in other Western European countries. Scotland continues to experience 'excess' mortality, even when deprivation is accounted for. There is no single explanation.

- The overall challenge is to increase the years of life that people in Scotland live in good health. Behaviours detrimental to health remain prevalent and the burden of disease is now with longer-term conditions and associated with lifestyle and economic and social circumstances. An increasing proportion of people live with multiple conditions including, in particular, concurrent physical and mental health conditions.

- The impact of the public health challenge is greater in the more deprived sections of the population than the more affluent. The importance of tackling poverty and inequalities is reiterated in this report given the clear links between social deprivation and poorer health outcomes. Greater equality in society is associated with better population outcomes on a range of domains. Scotland, like many countries, continues to see a stark difference in the life circumstances, experiences and outcomes of people in different groups. These differences are perpetuated across generations. The challenge of impacting on these inequalities has been identified as one of the top priorities for Local Government and Scottish Government.

7.   Specific population health priorities in Scotland now encompass health inequalities with their social determinants, inactivity, nutrition, obesity, and poor mental wellbeing, concurrent with the demography of an ageing population. Solutions go beyond the direct control of public health and require work across complex systems, far beyond NHS and health boundaries, to influence wider agendas, policies and programmes, and these require new ways of working.

8.   Addressing these challenges matters for individuals and communities as there is a significant burden of disease and suffering that is avoidable, especially among the less affluent, and having caring responsibilities can preclude carers from working or living full and meaningful lives. It matters for health and social care services and wider public services as the sustainability of services depends on improving

population health. It matters for a flourishing and successful Scotland as a healthy working population contributes to sustainable economic growth.

9.   In a number of areas of public health, both within the health sector and beyond, Scotland is recognised as being at the leading edge. In each case there has been bold, committed, leadership with local and national political support; effective partnership working; an applied evidence-base; clear accountability and monitoring processes; a critical mass of effort and investment; and action at national, regional and local levels. Creating the conditions for similar success across the breadth of population health in Scotland is now the immediate task to enable effective responses to ongoing and emerging local, national and international challenges for the benefit of current and future generations.

10.   At the centre of the public health endeavour is the core public health workforce, largely employed in the NHS in Territorial Health Boards and National Boards, but also within Local Authorities and Academia. Responsibility for public health action also rests with the wider NHS, with national and local governments, the pivotal role of CPPs and IJBs. The third sector, other public services, communities and the private sector make a major contribution, as does the wider workforce across the public sector and voluntary and community sectors. These are considerable organisational and people resources, but not all of the potential is currently being realised.

11.   Public health supports the shift to prevention and to tackling the inequalities in our society with a wide-range of preventative approaches shown to be cost-effective. Given the significant and rising costs associated with ill-health, there is both an economic and health benefit from taking a public health approach.

12.   The landscape of public sector reform provides new opportunities for Public Health to respond to both the persistent and the emerging challenges facing Scotland's health. Responses to the engagement processes undertaken as part of this review indicate that the public health community in Scotland wants to be supported to capitalise on these opportunities.

Public Health Review – Key Themes
13.   Some clear themes emerged from across the various sources - the material generated during the review from the engagement process supported by the research analysis and the population health and policy analysis. There were strong messages about the importance of both national and local perspectives and the need for greater coordination between these. The process highlighted the need for greater visibility and a clearer identity for the public health function. The challenges and opportunities for public health featured the need to respond more effectively to large-scale strategic challenges (such as the desired shift to prevention) and to focus more clearly on identified priorities. The desire for strengthened leadership from individuals and organisations was a reoccurring theme, including to increase impact in partnership areas including IJBs and CPPs. There was also clear support for the fundamental importance of effective partnership working as a prerequisite for better population health. The value of the existing workforce came through strongly, but the process also noted the changing nature of the workforce and the challenges of supporting and strengthening multi-disciplinary public health.

14.   Many of the themes and issues are in fact interconnected. The main report presents these findings in more detail, with specific discussion on the key themes.

1. *Organisation* – the perception of there being a cluttered public health landscape; the need for greater efficiencies; more clarity on organisational roles; better links with Local Authorities and Community Planning; and taking forward those actions which could be categorised as 'once for Scotland' nationally.
2. *Strategy* – the need for a single, over-arching public health strategy for Scotland and clear priorities.
3. *Leadership* – the need for strengthened local and national leadership across the breadth of public health endeavour, including the role of Directors of Public Health (DsPH).
4. *Evidence* – the importance of data, information, intelligence, research and evidence as a basis for public health decision-making and action.
5. *Partnership and collective responsibility* – the need for responsibility for public health to be shared widely across different organisations, sectors, communities and individuals to ensure we are able to address the determinants of population health, as well as particular health priorities. This includes Local Authorities and the third and voluntary sectors.
6. *Workforce* – the need to respond to the challenges associated with a dispersed workforce involving varied skills and professions to ensure a robust, resilient and competent workforce of the future, and that new talent can be attracted to the field of public health.

Implementation
15.   Implementation of the recommendations in the report, and outlined at the start of this summary, will require an overarching implementation plan to ensure that all elements are taken forward as a subsequent phase of the public health review. Delivery of a future public health strategy will require the contribution and collaboration of many partners, recognising that responsibilities for addressing public health issues sit not only within the health sector but also with national and local governments; public, private and third sectors; and communities and individuals.

PART 1. BACKGROUND, CONTEXT AND RESOURCES

Introduction

1. Scottish Ministers announced in November 2014 that they had asked for a review of Public Health in Scotland and had established a Review Group to take this forward and report back in 2015. The purpose of the review was to consider the role of the public health function in the context of the emerging policy landscape and current and future public health challenges, and to recommend how the function could be strengthened to respond more effectively to the opportunities and challenges.

2. There were a number of areas specifically identified for inclusion within the review and these formed part of the terms of reference agreed between Ministers and the group (Annex A). The group was asked to examine public health *leadership* and influence, both within the health sector and more widely, and to recommend how these could be developed further to deliver maximum impact. A second consideration concerned how public health featured in community planning and health and social care integration, and how the potential of *partnership* opportunities could be used to maximise the successful implementation of public health measures. The third area was *workforce* – workforce planning and development, succession planning and resourcing.

3. In establishing the review, Ministers sought recommendations that would strengthen the contribution of Public Health in Scotland; maximise the effectiveness and efficiency of the public health resource; achieve consistency where this would enhance quality and impact; and ensure the responsiveness and resilience of the public health function for the future.

4. The Review Group was convened in December 2014, under the chairmanship of Dr Hamish Wilson, with membership as listed in Annex B, and supported by a secretariat from within the Scottish Government. The review process (see Annex C) incorporated: analysis of population health in Scotland; stakeholder engagement through written responses and workshops; research analysis; and meetings with specific stakeholders.

5. The material described in Part 1 of this report reflects the population health and policy analysis undertaken to inform the recommendations and ensure these are made on the basis of a good understanding of public health. Part 2 of the report describes the key themes emerging from the engagement processes undertaken by the review, and the additional research evidence commissioned around the specific areas of public health *leadership, partnership* and *workforce.* The Review Group's recommendations take account of material described in both Part 1 and Part 2.

Public Health

6. Public health is the science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society. Some key features help to distinguish a public health approach from other approaches to improving health and wellbeing, such as those delivered through personalised health and care. Based on the definitions used by the Faculty of Public Health, we can describe public health as:

   a. Being *population based* – concerned with the factors that make populations (e.g. communities, cities, regions, countries) healthier or unhealthier;
   b. Emphasising collective responsibility for health, its protection and disease prevention – through *the organised efforts of society*;
   c. Recognising the role of the state, and of *the underlying socio-economic and wider determinants of health and disease*, including the distribution of power, resources and opportunities within and across populations; and
   d. Involving *partnership* with those who contribute to the health of current and future populations.

7. Professionals from medical, dental and other non-medical backgrounds train to become specialists in public health. This training involves competence in nine key areas (Table 1) relating to the three domains of public health practice – namely health protection, health improvement, and improving health services. Public health data analysis and intelligence provide a foundation for these three domains of practice.

Table 1 Core and Defined Competency Areas of Public Health Practice[1]:

	Competency Area
1	Surveillance and assessment of the population's health and wellbeing.
2	Assessing the evidence of effectiveness of interventions, programmes and services intended to improve the health or wellbeing of individuals or populations.
3	Policy and strategy development, and implementation.
4	Strategic leadership and collaborative working for health.
5	Health improvement.
6	Health protection.
7	Health and social service quality.
8	Public health intelligence.
9	Academic public health.

8. *Health protection* involves: immunisation programme effectiveness; ensuring the safety and quality of food, water, air and the general environment; preventing the transmission of communicable diseases; and managing outbreaks and the other incidents which threaten the public's health.

9. *Health improvement* incorporates a broad set of activities to create the circumstances for better health and reduced health inequalities within

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[1] As set by the Faculty of Public Health as the standard-setting body for public health practice in the UK.

populations. It includes attention to: prevailing cultures and values; the health impact of policies and programmes across the wider determinants of health (housing, employment, transport, poverty, etc.); behaviour-change interventions; and support for community-led action to improve health.

10. *Improving health services* supports the planning and development of services to ensure that they meet the needs of the populations they serve. Activities include needs assessment; support for inequalities-sensitive services; clinical governance; audit; and effectiveness. Screening services – such as those to detect changes indicative of specific health problems including cervical cancer, breast cancer and bowel cancer – are also part of the public health contribution to health services.

11. *Public health intelligence* underpins all of the above three domains of public health practice. It includes the surveillance and monitoring of population health and the determinants of health and wellbeing; support for evidence-based practice; and assessment of the effectiveness of policies, programmes and services.

Population Health in Scotland

12. The nature and scale of the population health challenge changes over time, and each iteration takes longer to pass for the more deprived sections of the population than it does for the more affluent. During the 20th century life expectancy increased, communicable diseases became less common and better controlled, non-communicable disease became more prevalent, and an increasing proportion of people developed and lived with multiple morbidities. The burden of disease now lies with longer-term conditions and is associated with lifestyle, and the nature of wider social, economic and environmental factors in society. Scotland's health is also characterised by the years of life lost on account of deaths from 'external causes' such as suicide, violence, alcohol and drug-related mortality among young adults.

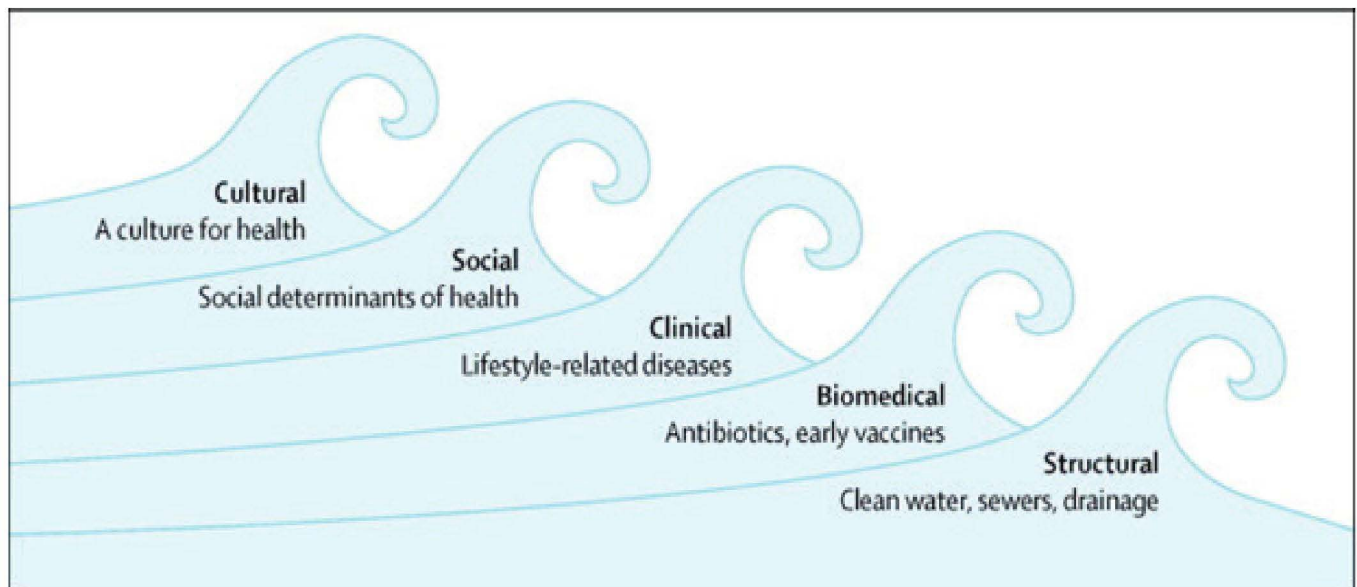13. Some features of our population health in Scotland are particularly worthy of note:

    i.   *We have lower life expectancy than our European counterparts, and there is no single explanation for this.* On average people in Scotland die younger than in any other country in Western Europe, Scotland's life expectancy having increased more slowly than other European countries since the 1950s. Mortality rates in Scotland are higher than would be expected on the basis of population characteristics and levels of socio-economic deprivation. This phenomenon of 'excess mortality' is evident for Scotland as a whole, but is particularly concentrated in West Central Scotland.

    ii.   *There are high levels of preventable mortality and morbidity in Scotland's ageing population.* According to the UK Global Burden of Disease Study (Murray, 2010) the leading risk factors for disease are: tobacco and second hand smoke, high blood pressure, high body mass index, physical inactivity and low physical activity, alcohol use and poor diet. Underpinning these risk factors is a complex picture of economic, social, biological and environmental factors which influence behaviours and outcomes.

    iii.   *Continued increases in the levels of overweight and obesity in the population have the potential to overturn the life expectancy gains achieved through behavioural and health service responses to heart disease and diabetes in recent decades.* At present over 64% of the adult population in Scotland is overweight or obese (27% obese). In comparison with other Organisation for Economic Co-operation and Development (OECD) member states (Scotland, UK and 15 other nations) Scotland ranks fifth highest for overweight (including obesity) and sixth highest for obesity alone. At school entry just under 23% of children are at risk of overweight and obesity (with 10% at risk of obesity). Prevalence increases with age up to age 75. On the surface the rate of increase in obesity is slowing, however this masks the now-evident socio-economic inequalities, particularly marked for children.

iv.   *Health inequalities persist across a range of outcomes, including the marked difference in the number of years people live in good health between our most and least deprived citizens.* There is a clear relationship between deprivation (however measured) and population health. Our more deprived citizens live shorter lives and more years in poor health. Moreover, the greatest health benefits from services, programmes and opportunities often fall to the more affluent. Tackling health inequalities is a matter of social justice, and involves actions that operate across the whole social gradient, as well as those tailored to the needs of the most vulnerable and 'at risk' groups (Marmot, 2010).

v.   *We have high levels of multi-morbidity – in particular concurrent physical and mental health conditions.* A striking (and increasing) number of people are living with multiple conditions impacting on their health, wellbeing and ability to function. Mental illness is associated with a 15 year reduced life expectancy compared to the general population, mainly due to cardiovascular disease. Multi-morbidity is also associated with multiple medication and dependence on a range of health and social care services, including unpaid and informal caring. The ageing population contributes to this trend, yet many younger people are also living with multiple conditions, signalling a future challenge. The onset of multi-morbidity occurs 10–15 years earlier in people living in the most deprived compared with the most affluent areas of the country, and deprivation is particularly associated with multi-morbidity that includes mental health conditions. There are concerns too for the mental wellbeing of Scotland's unpaid carers. Mental wellbeing decreases as the number of hours spent caring increases. The number of hours spent caring is highest in deprived areas.

vi.   *Despite improvements in a number of dimensions of mental health, considerable challenges remain. Mental health problems are common and greatly affect life chances. Social inequalities in mental health are enduring and persistent.* The UK Mental Health Foundation estimates that 1 in 4 people will experience a diagnosable mental health problem each year: source Office for National Statistics Psychiatric Morbidity Report (Singleton, Bumpstead, O'Brien, Lee, & Meltzer, 2001). The World Health Organisation (WHO) estimates 40% of the European disability burden is due to chronic mental ill health (World Health Organisation, 2001). Despite the ongoing reduction in suicide rates (overall and in terms of inequality), suicide is the leading cause of death in Scotland among people aged 15-34 years and is strongly related to deprivation. There is concern about the increasing prevalence of suicide among middle aged men (suicides in Scotland is most common among men aged 35 to 55). The incidence of dementia is also rising, reflecting efforts to increase awareness and improve diagnosis, and also associated with population ageing.

vii.   *Despite considerable improvements in dental health, marked inequalities still exist.* Dental decay is the single most common cause for children being admitted to hospital for a general anaesthetic in Scotland and presents a particular burden for the most deprived groups. As a result of

major effort there is no gradient in dental registration between the most and least deprived areas.

14. In summary, specific population health priorities in Scotland encompass health inequalities and their societal determinants, inactivity, nutrition, obesity, and poor mental wellbeing, concurrent with the demography of an ageing population. There are therefore pressing public health challenges at every level: ongoing challenges to support the shift towards prevention; to protect the health of the population and address risk factors; complex social, economic and cultural challenges; and new threats to health and wellbeing. The difficulty for public health is to combine focussed action on clear current priorities alongside wider system influence and 'holism' (it all matters). The overall challenge is to increase the years of life that people in Scotland live in good health - Healthy Life Expectancy (HLE) - and to reduce the inequalities in health that exist in Scotland.

15. Public Health has recognised that new population-based approaches are now needed, giving rise to the concept of a fifth wave of public health (Hanlon, Carlisle, Hannah, Reilly, & Lyon, 2011). Looking historically (Table 2) (Hanlon, Carlisle, Hannah, Reilly, & Lyon, 2011) and (Davies et al, 2014) the first wave of public health was associated with great structural work such as the provision of clean water to urban areas. The second wave saw the emergence of medicine as science. The third wave was characterised by the redesign of social institutions (including the establishment of the NHS and the welfare state) and the role of everyday life and lifestyles on our health was explored. The fourth wave has been dominated by recognition of the influence of social determinants. The best of what these previous four waves can achieve needs to be preserved. However, it is argued that a different approach – a fifth wave of public health – is needed in the 21st Century (Hanlon, Carlisle, Hannah, Reilly, & Lyon, 2011) (Davies et al, 2014) to address modern phenomena and epidemics. This approach would differ radically from its forerunners. It is likely to be characterised by enabling government, greater interdependence and co-operation across sectors and geographies, and involvement of the public more individually and personally in improving and maintaining their own health. Davies argues that a fifth wave which is 'cultural' in character is inevitable – essentially a society where healthy behaviours are the norm, supported by the physical, social and economic environment.

Table 2 Making the case for a 'fifth wave' in public health (Davies et al, 2014)

Cultural
A culture for health

Social
Social determinants of health

Clinical
Lifestyle-related diseases

Biomedical
Antibiotics, early vaccines

Structural
Clean water, sewers, drainage

Policy context

16. In considering the future arrangements for Public Health in Scotland, the Review Group recognised the need for the public health function to align with and support the wider policy landscape and to be effective in helping to address current and future resource, sustainability, service and demographic challenges. There is an opportunity for the core public health workforce to be more directly influential, as well as being instrumental in advocacy and support for others in delivering public health outcomes.

17. The influential work of the Christie Commission on the Future Delivery of Public Services in Scotland (Christie, June 2011), which reported in 2011, highlighted, among other things, the need for public services to shift their focus more significantly towards prevention and to operate more effectively in partnership (including with the communities they serve).

18. The current priorities of the Scottish Government, reflected in the Programme for Government 2015-6 (The Scottish Government, 2015), combine an economic strategy centred on delivering inclusive growth; a clear and consistent focus on tackling inequalities; and a commitment to protecting and reforming public services.

19. Scotland's Economic Strategy (The Scottish Government, 2015) recognises that more equal societies form the foundation for more sustainable and resilient economies. Social and economic policy goals are integrated within the strategy, for example in its emphasis on Fair Work; education, skills and health; place and regional cohesion; and tackling cross-generational inequality. As well as recognising that a more equally healthy and skilled country is necessary, the

strategy seeks to support a fairer distribution of economic and social benefit across the population.

20. In 2015 the Scottish Government also took forward a public discussion on what a Fairer Scotland would look like in 2030 and the actions that would be needed to make that a reality. This process involved public dialogues in a range of formats, considering policy priorities for tackling inequalities. Health inequality was a central part of this conversation.

21. The Parliament's Health and Sport Committee report in January 2015, and the subsequent Scottish Parliament debate on health inequalities, demonstrated cross-party political support for reducing inequalities and underlined the wider context for Public Health in influencing others to take action to address the social and wealth inequalities that drive health inequalities.

22. The Community Empowerment (Scotland) Act (2015) made provisions for a required focus on reducing socio-economic inequalities in relation to local and national outcomes, opening-up possibilities for greater power and decision-making at local levels. It seeks to ensure that individuals and communities are empowered and able to influence decisions, priorities and service delivery. This builds on the recognition of the contribution of Local Government in delivering local services responsive to need, providing enabling conditions for community wellbeing, and working in partnership to deliver priority outcomes.

23. Local Government is an essential partner with Scottish Government in public service reform. Public service reform in Scotland has included reinforcement of the important role for Community Planning Partnerships (CPPs), with shared ownership of priorities set out in Local Outcome Improvement Plans (LOIPs). CPPs provide the basis and potential for real collaborative working and leadership and influence to achieve effective public health measures through a whole systems approach at the level of Local Authorities and communities.

24. Greater integration of services is also being achieved by bringing together health and social care through the creation of Integration Joint Boards (IJBs). Together with NHS Boards and Local Authorities, these IJBs are required to demonstrate their contribution to tackling health inequalities and improving healthy life expectancy. Contributing processes include more joined-up working and budgets; a greater focus on prevention and population-based health improvement; and person-centred care.

25. During 2015-16 the Scottish Government is building on its 2020 Vision for Health with a national conversation on the future of health and social care to help shape a transformational change in Scotland's approach to population health and the delivery of health and social care services by 2030. The narrative for this national conversation includes a focus on prevention, with more effort, creativity and resources going into stopping issues of ill health before they occur, and with individuals and communities being responsible for promoting, and being empowered to manage, their own health and wellbeing.

26. In summary, new ways of working; a focus on inequality; a demonstrable shift to preventative approaches; and community empowerment are all prominent features of the language of public services and Government in Scotland, seeking innovative and effective ways to respond to increasingly constrained resources and growing demands and expectations. These policies offer opportunities for improved population health, and also require a more equally healthy population for their delivery.

27. Annex D sets out the main policy and legislative developments relating specifically to Public Health in Scotland since the late 1990s. These demonstrate a continued emphasis on the role of services in preventing ill-health **and** improving and protecting the public's health and well-being. There are consistent messages, for example in relation to the importance of early years and the need for health impacts to be taken into account in all areas of policy. Public health core work has drawn on a wide evidence base and developed into a very broad set of issues and programmes of action.

28. The current Review of Public Health in Scotland considers how the public health function can develop further and how it can provide leadership and action in partnership with others to increase its effectiveness in shaping policy and responding to the current and emerging population health challenges facing Scotland.

Public health capability and capacity

29. The organisational landscape within which the public health function in Scotland is structured is described in Annex E. This summarises the organisational responsibilities at national, regional and local levels, and the partnerships within which public health needs to operate to be effective. What follows is a description of the public health workforce and the capacity of the function within Scotland.

1. <u>Core workforce</u>
30. Public health is a multidisciplinary specialty in the UK, currently overseen by three Regulators: the General Medical Council (GMC), General Dental Council (GDC) and the UK Public Health Register (UKPHR). The UKPHR is responsible for regulating and keeping a register of accredited Public Health Specialists from disciplines other than medicine and dentistry.

31. There are three categories of specialists from disciplines other than medicine and dentistry in Scotland registered or aspiring to registration with UKPHR: generalist specialists trained through the conventional route, generalist specialists by portfolio and defined specialists by portfolio. The UK-wide Faculty of Public Health training scheme is expected to be the only future training route for all specialists, but does not provide the opportunity for NHS staff to train within current roles or for staff within other structures (e.g. local authority, third sector) to train.

32. A Public Health Skills and Knowledge Framework has also been developed and is overseen by the Public Health Online Resource for Carers, Skills and Training (PHorCast). Its purpose is to define skills required for public health in the broadest terms for employing organisations and practitioners to look at skills development and career pathways for the whole range of disciplines in public health, and to create pathways running from entry level to specialist level. NHS Education for Scotland (NES) and Health Protection Scotland (HPS) jointly sponsor work to promote the development of the health protection workforce. This includes implementation of the 'Framework for Workforce Education Development for Health Protection in Scotland' (NES /HPS) (from 2006) which is currently being reviewed.

33. Environmental Health in Scotland is a graduate only profession with Environmental Health Officers (EHOs) holding a degree level qualification awarded by a Royal Environmental Health Institute of Scotland (REHIS) accredited university. In addition, EHOs must also hold a Post Graduate Diploma in environmental Health awarded by REHIS before practicing as an EHO in Scotland.

34. The Centre for Workforce Intelligence (CfWI) was commissioned by NHS Health Scotland (NHSHS) on behalf of Scottish Government to carry out a mapping of the core public health workforce in Scotland. The approach taken was based on CfWI's similar workforce mapping exercise in England in October 2014. The CfWI has defined the core public health workforce as: "***All staff engaged in***

public health activities that identify public health as being the primary part of their role."

35. There are some limitations of the data used in the report due to tight timescales for conducting the work. Data were collected from different sources and at different times. The report therefore provides an impression of scale and distribution of the public health workforce (see Table 3) rather than an accurate enumeration.

Table 3: Summary of the core public health workforce in Scotland (2015)
(Centre for Workforce Intelligence, 2015)

	Role	Summary description	Estimated numbers (headcount)
1	Public health and dental public health consultants, specialists and specialist trainees	Work at a strategic or senior management level or at senior level of scientific expertise to influence the health of entire communities	189
2	Directors of Public Health (DsPH)	Responsible for determining overall vision and objectives for public health both within local Health Boards (14) and national Health Boards (4) *[these are also included within Public Health consultants above]*	*[18]*
3	Public health academics	Lecturers, researchers and teachers employed in higher education, whose primary focus is public health	360
4	Public health managers and practitioners	Work across the system and at all levels delivering public health programmes in health improvement, e.g. smoking cessation, alcohol dependency	970
5	Public health scientists	Perform scientific role in support of public health objectives	50
6	Intelligence and knowledge professionals	Staff employed in data analysis, informatics and presentation of public health information	370 to 660
7	Health visitors	Work as part of a primary healthcare team, assessing the health needs of individuals, families and the wider community	2,185
8	School nurses	Nurses who advise and support pupils within schools on preventing illness and remaining healthy	500
9	Public health nurses *(excluding health visitors and school nurses which are listed separately)*	Nurses who advise people in the community on preventing illness and remaining healthy. Work mostly in health protection, e.g. TB, infection prevention and control, HIV	640

	Role	Summary description	Estimated numbers (headcount)
10	Environmental health professionals	Work in improving, monitoring and enforcing public and environmental health standards. Environmental health officers are core to the delivery of health protection in Scotland, including the joint health protection team.	980
	Total		**6,250 to 6,540**

36. Taking roles 1 to 6 and 10 from Table 3 as comprising the core specialist public health workforce in Scotland yields a headcount estimate of approximately 3000. Half of these - at least 1515 staff - work in the NHS (Table 4). A significant number of academic staff (at least 360) contribute to the core public health function from posts out with the NHS. Environmental Health Professionals make up 980 posts in the core specialist public health workforce - the majority working within Local Authority environmental health departments. In addition, a number of EHOs work within other statutory organisations such as the Scottish Environmental Protection Agency (SEPA) and the Health and Safety Executive (HSE). Some work within the NHS and others in private industry or the voluntary (third) sector.

37. Looking at the data further, Table 4 shows that, of the 1515 NHS staff, approximately 25% work within National Boards and 75% within Territorial Boards. The majority of public health and dental public health consultants, specialists, specialist trainees and public health practitioners work in Territorial Boards; and a significant proportion (75%) of intelligence and knowledge professionals work in the National Boards (estimated as 215 within National Services Scotland (NSS), 30 in Healthcare Improvement Scotland (HIS) and 20 in NHSHS, excluding the Scottish Public Health Observatory (ScotPHO) staff). The CfWI report notes (CfWI table 9 (Centre for Workforce Intelligence, 2015) that a further 400 to 500 staff in analytical roles (not recorded as core public health) work within Public Health Intelligence in NSS.

38. Table 4 Information in CfWI report on workforce within Territorial and National Boards (2015) (Centre for Workforce Intelligence, 2015) source Table 4, 5, 7, 8 and 9 of CfWI report

	Role	Territorial Board (WTE)	National Board (WTE)	Total NHS	Other (WTE)	Sum Territorial+ National + Other
1	Public health and dental public health consultants, specialists and specialist trainees	145 (103.6)	16 (12.9)	161 (116.5)	28*	189
2	Directors of Public Health (DsPH)	[14]	[4] Equivalent status	18		[18]
4	Public health managers and practitioners	895 (785)	76 (45)	971 (830)		971
5	Public health scientists		35 (in HPS)	35	20**	55
6	Intelligence and knowledge professionals	83 (at least)	265 (at least)	348 (at least)	26***	374
	Total	**1,123**	**392**	**1515**	**74**	**1589**

[1] DsPH have also been counted as Public Health consultants or specialists
*28 UKPHR defined generalist or defined specialists working for Territorial Boards and National Boards in senior posts not formally appointed as consultants
** Public Health England (PHE) staff working in Scotland at the Centre for Radiation Chemical and Environmental Hazards at Glasgow
*** ScotPHO staff

39. The report does not attempt to estimate the number of staff working in each of the public health domains. It instead refers to earlier work by ScotPHN, published in 2011, which identified 128 whole time equivalents as Consultants in Public Health employed in Scotland in February 2010, of whom 82% were Consultants in Public Health Medicine or Dental Public Health. A summary breakdown of their areas of focus indicated that:

- Around half of Territorial Health Board consultants had generic roles, while a quarter focused on health protection, a fifth on health and social care services and a sixth on health improvement.
- All but two of the 14 Territorial Health Boards had dedicated provision for health protection, but only about half had similarly dedicated consultant-level resource for health improvement and health and social care services.
- There was expert provision nationally at consultant level for health protection, health improvement and health intelligence, but none for health and social care services.
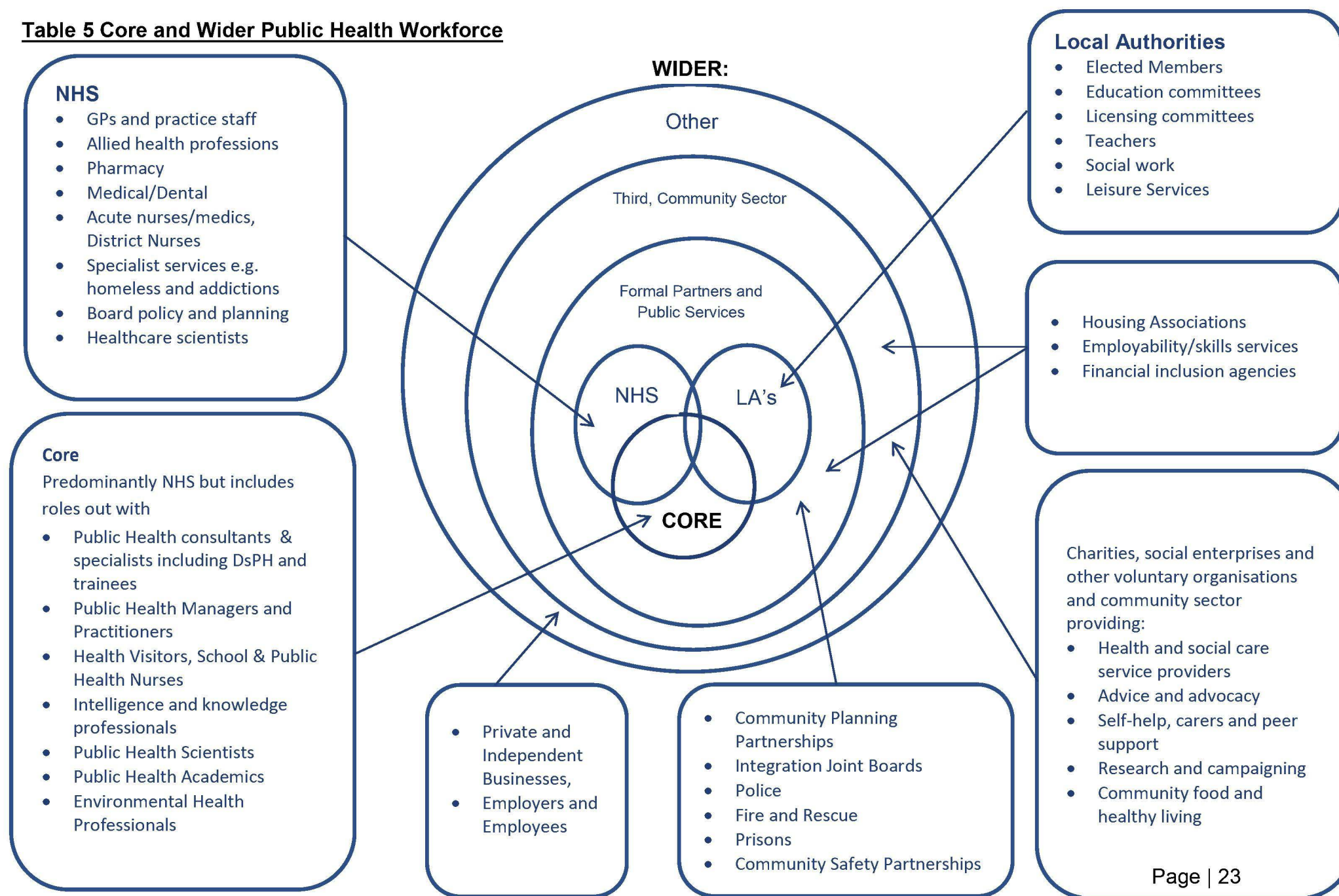
40. Most Boards have access to dental public health consultants, but over the years posts have been difficult to fill and some have been shared across Board boundaries.

2. Wider public health workforce

41. In addition to the core public health workforce, many other professional groups, practitioners in different disciplines, organisations and individuals make an essential contribution to protecting and improving the public's health and wellbeing. There is almost no limit to the range of groups and organisations whose staff fall into this category. Examples include: medicine; nursing; pharmacy; dentistry; allied health professions; police; fire and rescue services; teachers; social work and social care; licensing officers; welfare rights; housing; transport; planning; employability and leisure services; voluntary and community sector organisations (some focussed explicitly on health issues, such as community food and health initiatives and mental health projects; others contributing through action on wider influences on health, such as poverty and greenspace); and services located in government, scrutiny or private sector bodies, including those ensuring healthy and safe working environments; responsible for travel infrastructure; or setting welfare system parameters. Collectively these comprise the wider public health function. They clearly represent a considerable human resource, some of the potential of which remains to be realised.

42. The Scottish Health Promotion Managers' Group (SHPM) described Public Health engagement with the wider workforce as "principally driven by an acknowledged shared common agenda that is not always defined by traditional health outcomes but will include outcomes known to contribute to positive health outcomes such as educational attainment; financial inclusion; community resilience etc. The pursuit of such outcomes is a function of public health. The wider workforce includes both statutory partners/players with responsibilities defined in legislation (e.g. Community Safety Partnerships) as well as voluntary sector / charitable agencies whose contribution to health outcomes is determined by organisational constitutions and governance structures (e.g. Charities). Additionally the wider workforce may contain individuals and community activators or action groups with specific aligned motivations. All of these players should be recognised as legitimate and valued partners."

Table 5 Core and Wider Public Health Workforce

NHS
- GPs and practice staff
- Allied health professions
- Pharmacy
- Medical/Dental
- Acute nurses/medics, District Nurses
- Specialist services e.g. homeless and addictions
- Board policy and planning
- Healthcare scientists

Core
Predominantly NHS but includes roles out with
- Public Health consultants & specialists including DsPH and trainees
- Public Health Managers and Practitioners
- Health Visitors, School & Public Health Nurses
- Intelligence and knowledge professionals
- Public Health Scientists
- Public Health Academics
- Environmental Health Professionals

WIDER:

Other

Third, Community Sector

Formal Partners and Public Services

NHS   LA's

CORE

Local Authorities
- Elected Members
- Education committees
- Licensing committees
- Teachers
- Social work
- Leisure Services

- Housing Associations
- Employability/skills services
- Financial inclusion agencies

Charities, social enterprises and other voluntary organisations and community sector providing:
- Health and social care service providers
- Advice and advocacy
- Self-help, carers and peer support
- Research and campaigning
- Community food and healthy living

- Private and Independent Businesses,
- Employers and Employees

- Community Planning Partnerships
- Integration Joint Boards
- Police
- Fire and Rescue
- Prisons
- Community Safety Partnerships

3. Resource Cost

43. In this report we have derived an estimate of core public health workforce costs. This estimate recognises the uncertainties associated with the staff numbers, uses available data sources to estimate salaries, and includes assumptions on staff grades and number of working time equivalents[2]. It is therefore presented as an indicative calculation for illustrative purposes. An estimate of staff costs associated with the core public health workforce, as defined by the CfWI, yields approximate workforce costs of £227 million per annum. This estimate includes NHS and non-NHS staff.

44. The estimate for the core public health function workforce (roles 1&2, 3,4,5,6 and 10, in Table 6) is approximately £126 million. The best estimate of NHS-funded core public health function workforce costs (roles 1&2, 4, 5 and 6, in Table 6) is £74 million. In the context of wider NHS workforce costs of £5.6 billion per annum, the public health function workforce (£74 m) equates to around 1.3%[3].

Table 6 Core Public Health Function resource costs (source: Scottish Government analysts)

	Role	Estimated headcount from Table 3	Estimate (staff cost £m)
1 & 2	Public health and dental public health consultants, specialists and specialist trainees includes role (2) DPHs	189	17
3	Public health academics	360	20
4	Public health managers and practitioners	970	33
5	Public health scientists	50	2
6	Intelligence and knowledge professionals	370 to 660	14 to 30
7	Health visitors	2,185	68
8	School nurses	500	11
9	Public health nurses (excluding health visitors and school nurses which are listed separately)	640	22
10	Environmental health professionals	980	32
	Total Core Public Health as defined by CfWI	**6,250 to 6,540**	**£219m to £235m Midpoint £227m**

[2] Nurses: http://www.nhscareers.nhs.uk/explore-by-career/nursing/pay-for-nurses/;
Environmental Health Officers:
http://www.payscale.com/research/UK/Job=Environmental_Health_Officer/Salary,
http://www.myworldofwork.co.uk/node/20268,
https://nationalcareersservice.direct.gov.uk/advice/planning/jobprofiles/Pages/environmentalhealthofficer.aspx;
Academics: average professorial salary https://www.timeshighereducation.co.uk/features/times-higher-education-pay-survey-2015/2019360.article,
http://www.prospects.ac.uk/higher_education_lecturer_salary.htm.
NHS staff costs: http://www.isdscotland.org/Health-Topics/Finance/Costs/ and average employer costs for public health medics in Scotland data source 2013/14 NHS pay bill file extract in ISD
[3] NHS staff costs http://www.isdscotland.org/Health-Topics/Finance/Costs/ Table R100.

Effective and resilient Public Health: capacity and cost-effectiveness

45. The OECD predicts that the cost of health care will double by 2050 based on current trends. A substantial proportion of costs are associated with health issues that may be reduced through effective population-based actions. For example, obesity accounts for 1-3% of total health expenditure in most countries; mental illness costs the economy £110 billion per year in the UK and represents 10.8% of the health service budget; the costs of health inequalities, in terms of total welfare loss, are estimated at 9.4% of GDP. Health and social care services alone cannot create the conditions required for a healthy, flourishing population. Moreover, the National Institute for Health and Care Excellence (NICE) has shown that many public health interventions are more cost-effective than clinical interventions (using cost per QALY) and some are even cost-saving (Kelly, 2012).

46. The case for investing in public health has recently been summarised by the WHO Europe (WHO, 2014). Recognising the significant and unsustainable increases in costs associated with ill-health, this report describes the economic and health benefits of taking a public health approach. It sets out the costs associated with failing to address current public health challenges, summarises evidence on the cost-effectiveness of public health approaches, and outlines the returns on investment achieved through delivery of preventive interventions.

47. It is estimated (WHO, 2014) that only 3% (range 0.6 – 8.2%) of national health sector budgets is currently spent on public health. Individual-level approaches cost five times more than interventions at the population level and, in general, investing in upstream population-based prevention is more effective at reducing health inequalities than more downstream prevention.

48. In Scotland we do not routinely estimate the total expenditure on public health. Within the Scottish Government Health Budget spend under the heading Improving Health and Better Public Health in Table 4.03 is an estimated £313.6 million in 2015/16 including £73.5 million for the Integration Fund[4] This includes expenditure on immunisation of £20.9 million, central allocation of £40.09 million to tackle alcohol misuse and £55.6 million on health improvement and health inequalities. In addition a proportion of the expenditure of NHS Boards and National Boards in Table 4.02 of the Scottish Draft Budget 2015-16 (£9.47 billion) will be on public health departments and to support public health outcomes, and is at the discretion of Boards. The 2015/16 budget sees health resource spending increase by £409 million and takes total health spending to over £12 billion for the first time. While we cannot give an estimate of the percentage of public health expenditure, it will be a significant sum in its own right but a relatively small percentage of overall NHS spend. Improving Health and Better Public Health amounts to 2.6% of the total £12 billion NHS expenditure[5].

49. At the heart of this current Review of Public Health in Scotland is the need to ensure that this expenditure delivers maximum value for money. This will require

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[4] Scottish Draft Budget 2015-16: Table 4.03
[5] Scottish Draft Budget 2015-16: Table 4.03

a public health function which is resilient, has the right capability and capacity, and is directed at those activities where it can make the most impact.

50. A resilient and effective public health infrastructure ensures that the core functions can continue to be delivered in light of new public health priorities, emergent challenges and changing contexts. Dimensions of public health capacity that should be considered in this regard are summarised in Table 7. There is also the need for strategic resilience within public health to sustain the capacity and the relationships within health protection to manage outbreaks and public health incidents. The skills and competencies need to be maintained and the capability to escalate and sustain a response needs to be assured.

Table 7: Dimensions of public health capacity (Aluttis et al, 2014)

Dimension	Description
Organisational structures	The infrastructural ability of a system to contribute to goals of public health
Resources	The allocation and provision of human and financial resources necessary to carry out public health activities
Partnerships	Collaboration between organisations for effective public health practice
Workforce	Qualified human resources with sufficient skills and knowledge; availability of training options
Knowledge development	The knowledge base that provides information on the health of the population and that supports evidence-based public health policy and interventions at all levels
Leadership and governance	The ability and willingness of governments to improve public health by developing and implementing effective public health policies and by expressing qualities in leaderships and strategic thinking
Country specific context	The political context and other characteristics of a country that may have an influence on public health policies and capacity building efforts

51. In assessing where a public health function can make most impact there has been recent work in Scotland and internationally exploring the cost-effectiveness of population health interventions. *Best preventative investments for Scotland – what the evidence and experts say* (NHS Health Scotland, 2014) examined available evidence (which it stated was limited but growing) coupled with expert opinion to identify the best investments for preventing poor health, reducing 'failure demand' and narrowing health inequalities. In its summary it stated that "in general, prevention 'upstream', addressing the economic, social and environmental causes of health inequalities, is cost-effective. It is more likely to reduce health inequalities than either treatment of illness or 'downstream' measures to change behaviours delivered to individuals". ScotPHO has also modelled estimates of the impact of some interventions on health and health inequalities (The Scottish Public Health Observatory, 2014).

52. An international study ACE - Assessing Cost-Effectiveness in Prevention (University of Queensland and Deakin University, Melbourne., 2010), conducted in Australia, reviewed the cost-effectiveness of 150 preventive health interventions, addressing areas such as mental health, diabetes, tobacco use, alcohol use, nutrition, body weight, physical activity, blood pressure, blood

cholesterol and bone mineral density. The largest impact on the health of the population arose from regulatory and tax measures. Other cost-effective measures included many screening programmes and immunisation and drug and alcohol treatment programmes, smoking cessation and preventative measures to improve mental health.

53. WHO has shown a wide range of preventive approaches to be cost-effective (WHO, 2014), including those that address environmental and social determinants of health (e.g. promoting walking and cycling, safer transport, green spaces, healthy employment), promote resilience (e.g. improving mental health and reducing violence), and support healthy behaviours (e.g. tobacco and alcohol legislation, reducing dietary salt and sugar, increasing physical activity, nursery toothbrushing), as well as vaccination and screening.

54. Focussing on the implementation of approaches, additional messages from previous UK reviews have emphasised the importance of population engagement with health issues (the 'fully engaged' scenario) to achieving a shift to prevention and the delivery of cost-effective interventions (Wanless, 2002 and 2004) and of taking action across the whole social gradient, not just with some segments in society, in order to reduce health inequalities (Marmot, 2010).

55. Two recent reviews have considered the focus of Scotland's approach to tackling health inequalities and how current resources are used: NHSHS's Health Inequalities Policy Review (Health Scotland, 2013) and Audit Scotland's 2012 report on health inequalities in Scotland (Audit Scotland, 2012). The latter focused on how resources are allocated and on delivery mechanisms through Primary Care, CPPs and NHS Boards, reporting that the Scottish Government allocated an estimated £1.8 billion over the three financial years from 2008/9 – 2010/11 for issues related to health inequalities. Although these two reports focus differently on the approaches taken in Scotland – the former being more concerned with the policy content, the latter with governance, resource allocation and delivery mechanisms – both sets of recommendations suggest the need for a clearer focus on population health in Scotland, greater coordination across structures and levels of action, and the need for partnership-based action informed by public health intelligence and evidence.

56. The subject matter of these recent reviews – addressing health inequalities – reflects the ongoing need to make progress on that issue. In a number of other areas of public health Scotland is recognised as being at the leading edge. The leadership shown on tobacco control; the government's commitment to tackling the price and availability of alcohol; the quality, uptake and effectiveness of our childhood immunisation programmes; the considerable improvements in oral health; the drop in violent crime achieved as a result of the country's focus on violence reduction and safer communities; and the investment being made to ensure that Scotland's children have a good start in life – all of these, and many other examples, illustrate public health achievements delivered through 'the organised efforts of society' for Scotland.

57. In each case, there has been bold, committed, leadership with local and national political support; effective partnership working; an applied evidence-base; clear accountability and monitoring processes; a critical mass of effort and investment; and action at national, regional and local levels.

2015 REVIEW OF PUBLIC HEALTH IN SCOTLAND: STRENGTHENING THE FUNCTION AND RE-FOCUSSING ACTION FOR A HEALTHIER SCOTLAND

PART 2: FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

58. The material described in Part 1 of this report was drawn from documentary and data analysis undertaken to inform the considerations of the Review Group and to ensure that the conclusions and recommendations made were informed by a good understanding of the history of public health, the nature and scale of the function in Scotland, current and future challenges, and wider policy issues.

59. Here, in part 2 of the report, findings are presented from the engagement processes undertaken by the review and the additional research evidence commissioned. These relate to the particular remit of the review, to examine:

- public health leadership and influence, both within the health sector and more widely;
- 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; and
- workforce planning and development, succession planning and resourcing within the multi-disciplinary core public health workforce.

60. The Review Group's recommendations take account of material described in both Part 1 and Part 2.

Themes emerging from the Review of Public Health in Scotland

61. Some clear themes emerged from the material generated during the review process: from the contributions to the engagement exercise, the findings of the research review, and the policy and data analysis undertaken to inform the Review Group's deliberations. Collectively these reflect a wide range of perspectives and information. Across these sources there were strong messages about:
    a. the importance of both national and local perspectives, and the need for greater coordination between these different levels;
    b. the need for greater visibility and a clearer identity for the public health function;
    c. the challenges and opportunities for public health, including the need to respond more effectively to large-scale strategic challenges (such as the desired shift to prevention) and to focus more clearly on identified priorities;
    d. the desire for strengthened leadership from individuals and organisations, and in partnership areas including IJBs and CPPs;
    e. the fundamental importance of effective partnership working as a prerequisite for better population health; and
    f. the nature of the workforce and the challenges of supporting and strengthening multi-disciplinary public health.

62. What follows expands on these general themes under a number of headings, although many of the themes and issues are in fact interconnected. The report also mentions some additional specific issues highlighted through the review process and provides additional information and commentary where these relate to specific conclusions and recommendations.

1. Organisation

63. There was seen to be a cluttered public health organisational landscape in Scotland, with more clarity needed on organisational roles and responsibilities and, importantly, how they join up.

64. The responses to the review made frequent reference to the need for clarity about what might best be done at national, regional and local levels, which prompted this specific question being asked of stakeholders at the engagement workshops. There was a widespread sense that coordination between levels was currently weak, and that the status quo could be improved. The importance of balancing national or regional approaches with local activity was emphasised.

65. There was general agreement that activities that could be categorised as being delivered "once for Scotland" would be best taken forward at national level, and a view that some activities were currently being duplicated by 14 local public health functions. Stakeholders noted the opportunities for greater efficiencies where more could be done at a national level than currently, leading to greater coordination, resilience and a reduction in duplication. It would be necessary to maintain and enhance speed and flexibility of response, and important to recognise that local level arrangements/implementation may differ (for example in rural compared with urban areas).

66. Responsibility for the different domains of public health lies in different national bodies. NHSHS has the predominant national responsibility for population health improvement and tackling inequalities. HPS, within NSS, has responsibility for health protection at a national level. While ISD, as part of the *Public Health and Intelligence Strategic Business Unit* within NSS, has a national role in providing health intelligence, there is no national body specifically responsible for public health intelligence, and a number of national bodies make a contribution. There is no single organisational locus for the public health contributions to improving health services. These organisational arrangements potentially contribute to the lack of coherent, coordinated public health leadership in Scotland. Moreover, there remain questions about the balance of resource and effort between national, regional and local activity in each of the domains of public health.

67. The local positioning of much of public health was seen as a strength: it enables public health staff to interact with local decision making structures; to be an integral part of the planning and delivery of local services; to build strong relationships and partnerships; and to influence local partners. Stakeholders noted the need to engage with local communities and organisations, and to act at a local level. Access to local-level data and information was also regarded as being important in order to understand the composition, health needs and assets of local populations and trends in the determinants of population health.

Research and evaluation of local policies and approaches was seen as a highly valued public health role.

68. Responses highlighted the need for clear links between the public health function and Local Authority and Community Planning structures, particularly in relation to strengthening action on the wider determinants of population health. There was recognition that some local communities face multiple challenges and that this calls for multi-faceted responses, working closely with communities themselves to develop more holistic approaches which meet their needs as well as possible. A number of respondents commented that the public health function should be better aligned with, and more accountable to, local community planning arrangements (Griesbach & Waterton, 2015).

69. There was less clarity about the role of regional structures, including those that might coordinate work across several NHS Board or Local Authority areas. Stakeholders noted the potential for more shared services approaches including, for example, for the health protection function (Griesbach & Waterton, 2015). The value of the North of Scotland Public Health Network, in its particular context, was also clearly recognised. The need for better integration at national level also raised issues about the potential benefits of some further regional-level arrangements.

70. The *written engagement questions* specifically prompted reflection on how best to organise the public health landscape in Scotland to ensure the most appropriate balance of functions at national, regional and local levels. Respondents recognised that the delivery of the public health function may need to change in response to the changing organisational and policy landscape, including the emphasis being placed on organisational and partnership responsibilities for addressing health inequalities and the wider determinants of health. Some responses suggested there needed to be a single strong national public health organisation, while others saw threats in the possible reorganisation of the public health function, with concern about the centralisation of the public health resource impacting on local relationships and responsiveness to local needs (Griesbach & Waterton, 2015). At the same time there was a concern that the drive towards localism may make it harder to deliver change on a national basis (Griesbach & Waterton, 2015). In short there was general recognition that some organisational change may be necessary, but no consensus about what that change should be.

71. Stakeholders also felt that the mechanism for connecting national and local public health roles and responsibilities could be improved in Scotland. Supporting evidence for this emerged from the *research analysis* commissioned by the Review Group (Curnock, 2015). This examined evidence on the relative merits of different governance and accountability structures. Among the different approaches adopted internationally there is a dynamic balance between the scope and scale of national and local infrastructures for public health. This balance changes over time and varies between countries according to their political context, structures, social attitudes and history of participative decision-making (Allin et al., 2004; Brownson et. al., 2012; Jakubowski & Saltman, 2013). International country case studies (including England, France and Sweden)

demonstrate the tendency to counterbalance devolved responsibilities with national accountability and direction.

72. The benefits of a nationally-led and largely centralised public health infrastructure include: the capacity to employ strategic approaches to addressing health issues with global roots, with clear alignment between vision, strategy and objectives; the ability to address inequalities of access and resource when implementing and coordinating actions; and stronger core infrastructure for issues such as IT and health intelligence. These strengths sit in tension with the benefits of power being devolved to localised regions, which include: more democratic decision-making with greater engagement and access to the population; locally responsive strategies with opportunities for experimentation; and the ability to utilise local drivers for implementation. However, localised governance may be susceptible to inefficiencies of scale, unnecessary variation and exacerbation of inequalities, and individual interest agendas (Allin et al, 2004) (Jakubowski & Saltman, 2013) (Rayner, 2007).

73. The *research analysis* (Curnock, 2015) concluded that there "will always be a shifting dynamic balance between local and national, and therefore there is no single 'right' solution. There is no apparent direct relationship to better population health outcomes and the balance between local and national governance for public health. Each country seeks to find the balance between these that best fits its culture, politics and values."

2. Strategy

74. The Review Group and respondents noted the current lack of an overarching public health strategy for Scotland, including priorities, clear responsibilities and anticipated outcomes. Through the review process the development of a national public health strategy was proposed as one of the main mechanisms to bring about a more cohesive and coherent approach across Scotland.

75. By providing a coherent national approach and an agreed set of priorities, a national strategy would also provide a focus for the public health leadership effort. In particular a national strategy would provide the basis for a new set of leadership arrangements (more clearly aligned to national priorities), as well as improving the accountability of leaders (Griesbach & Waterton, 2015).

76. There was strong support from the *engagement responses* for directing the public health endeavour towards reducing inequalities in health and for making this more explicit in the focus for public health in Scotland. This would require bold leadership, reallocation of resources to areas of greatest need, tailoring of interventions to better meet the needs of different groups, and a focus on empowerment and social renewal. National Government would need to lead the way and create the context for all public services to demonstrate these features. The engagement responses noted the threats to population health from austerity and current welfare reform policies, and their effects on the most vulnerable individuals and families in Scotland.

77. The *research analysis* highlighted that no single approach can be identified as the basis for a highly effective public health function. "The effectiveness of the

public health system is dependent not only on the skills, leadership, cohesion and adaptability within the various components and levels of that system, but also on the wider political, cultural and resourcing context in which the public health system operates" (Curnock, 2015). In line with this, one of the conclusions of the *research analysis* concerned the need for clarity about the 'leadership ask' in relation to both the specialist public health function and to the wider challenge of improving the public's health in view of emergent priorities (such as an ageing population, socioeconomic inequalities and the globalised social and cultural context).

3. Leadership

78. The importance of strengthening public health leadership was clearly expressed during the review process from a range of quarters, and *engagement responses* identified that Public Health needs to be more visible and the vision more clear.

79. In considering the dimensions of leadership that are needed, the following features were recognised:
    a. enhanced leadership at all levels within and across the public health function (not solely located within a few senior leaders);
    b. leadership that is cross-functional, working across the whole system that promotes and protects population health;
    c. leadership (including advocacy) for priority public health issues;
    d. leadership of the specialist public health workforce.

80. The *research analysis* and *engagement analysis* both highlighted the challenges facing public health leadership in Scotland. Stakeholders commented specifically on the challenges arising from changes to the public sector landscape and the need for the public health function to have a clear locus in influencing local structures, in particular CPPs and the new IJBs. Both areas of work recognised the need to provide leadership over complex systems, extending beyond NHS and health boundaries, to influence wider agendas, policies and programmes (Griesbach & Waterton, 2015). Stakeholders also wanted to see the public health leadership role of professional leads and interaction between Scottish Government and external organisations more clearly articulated e.g. Chief Medical Officer (CMO), Chief Dental Officer (CDO), Chief Pharmaceutical Officer (CPO), public health roles of Scottish Government, NHSHS, and Joint Improvement Teams, etc. (Griesbach & Waterton, 2015)

81. Improving population health, and within this the focus on prevention and tackling inequalities, is a strategic approach and should be an integral part of how leaders plan and make use of available resources to improve outcomes, prevent harm and ensure sustainability of public services in future years. There are a number of existing senior leadership forums in Scotland[6] which provide the opportunity to strengthen the role of Public Health and to increase public health understanding and practice in other disciplines.

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[6] Health and Social Care Leadership Advisory Board, The National Leadership Unit (NLU) in NES, Scottish Leaders Forum (SLF)

82. Through the engagement processes respondents stated that leadership at national level was vital. This should include leadership from Scottish Government, COSLA, national organisations, and professional groups (e.g. Scottish Directors of Public Health (SDsPH).

83. The Scottish Government's commitment to public health was well regarded and seen as being demonstrated in both policy and legislation. Stakeholders welcomed the Scottish Government's 'strategic focus on inequalities' and its recognition of the impact of the wider determinants of health, but there was a desire for more focus from the Scottish Government on public health as a key component of the health portfolios and for better coordination across ministerial portfolios on the wider determinants of health and inequality. (Griesbach & Waterton, 2015)

84. Stakeholders continued to see serious threats to the public health endeavour from powerful multi-national business interests (Griesbach & Waterton, 2015) and mentioned the crucial role of Government in developing more effective responses. More generally, the complex cultural change required to organise the efforts of society in order to protect and improve the public's health implies a role for Government in enabling that change to take place. Examples given to the Review Group included the need for a shift in focus from target setting to more 'upstream' activity, and from traditional performance management to an approach that supports systems change and enables long-term action, prevention, shared partnership responsibilities, and new types of relationships with communities.

85. Stakeholders also emphasised that leadership and action should reflect the breadth of the public health endeavour. Public health leadership needs to be demonstrated in areas as diverse as employment, education and skills development, poverty and welfare reform, planning, housing, children's services, and climate change (Griesbach & Waterton, 2015). Some of the engagement responses specifically stated the importance of non-NHS staff, including third sector and community champions, taking on leadership roles in these areas (Griesbach & Waterton, 2015).

86. The *research analysis* (Curnock, 2015) stated that emergent public health challenges (such as an ageing population, socioeconomic inequalities and the globalised social and cultural context) require new approaches to public health leadership (Beaglehole, R & Bonita, R , 2004); (Czabanowska et al, 2014); (Hanlon P. , 2013). In addition, the number of potential stakeholders with a public health agenda is 'wider than ever' (associated with increased recognition of the social determinants of health) and the nature of public health practice has shifted (Czabanowska et al, 2014) (Davies et al, 2014) (Koh H. K., 2009). Table 8 summarises some of these leadership functions, both in relation to the public health workforce and the wider agenda of improving population health.

Table 8: Features of leadership

Specialist and practitioner public health workforce
- Shaping, organising, networking, connecting, advocacy, gathering disparate groups together with a shared focus on a specific outcome (Day, M., Shickle, D., & Smith, K., 2014) (Koh H. K., 2009); (Mackenbach, J., & McKee, M., 2013)
- Identification of opportunities within seemingly 'chaotic' constantly changing environments with uncertain outcomes and an ability to employ systems-thinking (Czabanowska et al, 2014) (Hunter, 2009) (Koh H. K., 2009)

- Enthusiasm, vision and credibility underpinned by a commitment to social justice (Czabanowska et al, 2014) (Griffiths, S., & Hunter, D. J., 2007) (Koh H. K., 2009) (Rechel, B. 1., & McKee, M, 2014)
- Collaborative, flexible leadership as a function of group aims or values (as opposed to authoritarian or technocratic models) situated in a relational community rather than attached to individuals or specific roles ((Brownson, 2012) (Czabanowska et al, 2014) (Howieson et al, 2013) (Koh H. K., 2009) (Rayner, 2007)

Wider leadership to improve population health
- 'Leadership without authority' embedded within multi-sector alliances; galvanising civil society through traditional and social media; building bridges with academia and practitioners; national bodies who can serve as a convener of diverse organisations; encouraging the cultural shift toward active citizenship; participation in emergent public fora that nurture 'public interest leadership' (Davies et al, 2014) (Drehobl et al, 2014) (Howieson et al, 2013); (Lachance et al, 2015) (Mackenbach, J., & McKee, M., 2013)

- Influence through political astuteness and persuasion (Hunter, 2009) (Koh H. K., 2015); (Mackenbach, J., & McKee, M., 2013) (Rayner, 2007) (Rechel, B. 1., & McKee, M, 2014)

- Environments of innovation, creativity, imagination and continuous learning (Czabanowska et al, 2014) (Rayner, 2007) (Czabanowska et al, 2014) (Rayner, 2007)

4. Directors of Public Health

87. The Directors of Public Health (DsPH) in Scotland have an important national and local leadership role to play, and the local role is perhaps more clearly described in expectations set out by Territorial Boards in the Faculty of Public Health's

specimen job description for a Director of Public Health in Scotland (Faculty for Public Health, 2013) . The job description describes the high profile senior leadership qualities required as the most senior advocate for public health within the Board and on behalf of the populations served by the post: The *engagement responses* yielded a similar list of features and skillset that stakeholders are looking for from Public Health Leadership in Scotland (Griesbach & Waterton, 2015):

- 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.
- 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.

88. Stakeholders emphasised that DsPH are valued locally. They have a vital role to play in linking the domains of public health, using public health intelligence to advocate for population health, supporting the role of partnerships, and raising

the profile of public health. The local leadership role is evolving in relation to supporting the new IJBs, local authority committees, and CPPs.

89. Stakeholder responses also indicated, however, that the DPH role had become diluted over time and could be strengthened, including in relation to its contribution to national policy (Griesbach & Waterton, 2015). DsPH were seen as providing a link to the Scottish Government and there was an expressed desire to develop their role in bridging local and national policy. There is an expectation that DsPH should provide local leadership and also deliver coherent national leadership as a Group of Directors.

90. In addition, the Review Group recognised that there are currently vacant DPH posts in Scotland and the potential for further vacancies in the near future. A focus on workforce planning and talent management, with investment specifically made in a future cohort of DsPH, will be of critical importance for the resilience and effectiveness of the function.

5. Evidence for action
91. The importance of data, information, intelligence, research and evidence featured prominently in the review process, with stakeholders emphasising the need for action and interventions to be informed by the best possible public health intelligence. This need was recognised both at a national level (national level data sets) and a local level (translation of data into local level action).

92. In general the available data, information, intelligence and analysis and evidence are of good quality. However, the review process highlighted the need for more coordination to ensure that the public health research and intelligence activities undertaken in Scotland are relevant to priorities; evidence is clearly presented and duplication is minimised; and for research processes to focus on processes of change and address the gap in translation of evidence into practice.

93. Academic Public Health and other research organisations could be better connected to policy and delivery processes: the intention would be to foster an environment for exchange of information, expertise and (potentially) resources between organisations.

94. The review has recognised the scale and value of the public health data, research and academic assets in Scotland, and the developments taking place in research-service collaborations. Scotland is a highly regarded host of international conferences and has conducted public health research which is genuinely world leading. These are strengths on which Public Health can build.

6. Collective responsibility: advocacy and partnership
95. To address the determinants of population health, as well as particular health priorities, responsibility for public health needs to be shared widely across different organisations, sectors, communities and individuals. Greater emphasis should be placed on this sense of collective responsibility. The core public health workforce should lead the collective effort, recognising that many population health challenges are the type of 'wicked problem' that can only be overcome

through partnership working and a shift to prevention within and across systems. Political leaders have a critical role to play in this regard.

96. The *research analysis* highlighted that this sense of collective responsibility is reinforced internationally through the Health in All Policies (HiAP) approach ☐ a cross-sector approach that systematically takes into account the health implications of decisions across public policies in order to improve population health and reduce inequalities. This plays an important role in the European Health 2020 policy framework (Leppo et al, 2013) (McQueen, 2014). Conditions which reinforce and sustain this approach include a supportive political context with legal backing, development of policy proposals across sectors with an ability to seize policy-making opportunities, processes for inter-sectorial communication and implementation, resources (such as joint budgeting or delegated financing), and the technical skills and governance structures to implement policy decisions and evaluate their impacts on health and its determinants (Leppo et al, 2013) (McQueen, 2014) (Ståhl et al, 2006) (Wismar et al, 2012).

97. Effective partnerships are essential for an effective public health function. Recent policy in Scotland seeks to strengthen partnership working across public sector bodies, with the third and independent sectors, and with communities. This is a supportive cultural and policy environment which aligns with the public health agenda.

98. The *engagement responses* echoed these themes and stressed the need for partnerships to be appropriately resourced, with a request for more dedicated public health capacity and also for increased time to nurture, build and sustain partnerships (Griesbach & Waterton, 2015). The *engagement responses* proposed an inclusive approach for partnerships, utilising contributions from the wider public health workforce; the voluntary and third sectors; Local Authorities; communities; and the public (Griesbach & Waterton, 2015). The focus of the responses was on supporting existing partnership structures.

99. The engagement process also highlighted a current lack of understanding both about the scope of public health and the activities which comprise it (Griesbach & Waterton, 2015). There was a request for clarification on the various contributors to the public health endeavour and how they join up (the development of a national strategy was felt to be a helpful mechanism for achieving this). Respondents felt that there would be significant value in achieving a better (shared) understanding of the public health function and priorities, and of the partnership endeavour associated with improving health and reducing inequalities.

100. Stakeholders indicated that a clearer articulation of the partnership contribution made by the public health workforce (for example through its population health perspective, population needs assessment, evidence and prevention focus) would also be helpful. This would help to raise the profile and understanding of this contribution and to make clear that this role extends beyond 'health' initiatives to advocacy and action on the wider determinants of health and inequality. The need for a shared language within partnerships to describe and build a better understanding of public health was also highlighted. Establishing

shared partnership outcomes was regarded as essential for successful partnerships and for working towards longer term change.

101. The responses received in this review process argued that genuine sharing of resources (financial, human, physical assets, data, evidence, and other forms of intelligence) across organisational boundaries needs to be at the heart of partnership. It was felt that the contracting/funding arrangements in Scotland should support and reinforce partnership working between the public, private and voluntary sectors.

102. There is extensive *research literature* which describes factors that facilitate (or provide challenges to) successful partnerships. These are summarised in Table 9 below.

Table 9: <u>Task and people focused facilitators of partnership working</u>, categorised in relation to Implementing (Imp) or Sustaining (S) phase

Task focused facilitators of Partnership Working	People focused facilitators of Partnership Working
Consideration given to alternative approaches to achieving outcomes; explicit consideration of the degree of involvement of each group to maximise resources; and agreement of pre-determined exit strategy (I) Source: (Carlisle, 2010); (Graham et al, 2015) (O'Mara-Eves et al, 2015)	Senior representation and senior engagement (I) Source: (Boydell & Rugkasa, 2007) (Stern & Green, 2005)
Clear success criteria / goals / aims / purpose (I) Source: (Boydell & Rugkasa, 2007), (Graham et al, 2015) (Hunter & Perkins, 2012) (Shaw et al, 2006), (Taylor-Robinson et al, 2012)	Participation of 'boundary spanners' – individuals who bridge organisations ('across'), connect with the policy agenda ('upward') and with communities ('downward'), partners with local or 'insider' status, boundary spanning mechanisms. (I) Source: (Carlisle, 2010) (Eilbert & Lafronza, 2005); (Oliver, 2013); (Powell, Thurston & Bloyce,, 2014) (Rugkasa, Shortt & Boydell, 2007) (Stern & Green, 2005) (Taylor-Robinson et al, 2012)
Transparent frameworks and fair conduct for decision-making (I) Source: (Marks, 2007) (Shaw et al, 2006); (Stern & Green, 2005) (Taylor-Robinson et al, 2012)	Where there is community involvement: community and front-line workers are primary drivers (engagement is empowering rather than consumerist), not just for 'representation' (I) Source: (Carlisle, 2010) (Carr et al, 2006) (Eilbert & Lafronza, 2005) (Marks, 2007); Marks, 2007; (Stern & Green, 2005)

Clear accountability structures and governance requirements which are similar across organisations or an ability to adapt to alternative structures; organisational performance management systems that include collaboration within criteria of each partner (I) Source: (Boydell & Rugkasa, 2007) (Carr et al, 2006) (Hunter & Perkins, 2012) (Marks, 2007); (Powell, Thurston & Bloyce,, 2014) (Stern & Green, 2005))	Collaborative leadership rather than 'control and command' (S) Source: (Carr et al, 2006) (Ferlie et al, 2010) (Hunter & Perkins, 2012)
Sufficient funding, infrastructure and resources; willingness to share information and resources; joint appointments (I) Source: (Carlisle, 2010) (Ferlie et al, 2010) (Hunter & Perkins, 2012) (Marks, 2007) (O'Mara-Eves et al, 2015) (Stern & Green, 2005) (Taylor-Robinson et al, 2012)	Appropriate communication, shared language, responsiveness (S) Source: (Carr et al, 2006) (Shaw et al, 2006) (Taylor-Robinson et al, 2012)
Connections and 'joined up thinking' between local and national agendas and between different national agendas, as well as policy stability (I) Source: (Carr et al, 2006) (Hunter & Perkins, 2012) (MacGregor & Thickett, 2011) (Shaw et al, 2006)	Time and space to develop trust and goodwill and enable 'emergence' and 'evolution' of activities; capacity to work through conflict; protection from top-down restructuring (S) Source: (Boydell & Rugkasa, 2007) (Carlisle, 2010) (Carr et al, 2006) (Hunter & Perkins, 2012) (MacGregor & Thickett, 2011) (Marks, 2007) (McMurray, 2007); (Shaw et al, 2006)
Shared geographical boundaries with an approach to planning organised at a similar level (I) Source: (Carlisle, 2010) (Marks, 2007) (Taylor-Robinson et al, 2012)	Job security, organisational stability and low turnover of staff; previous history of working together (S) Source: (Carr et al, 2006) (Hunter & Perkins, 2012) (Marks, 2007) (Powell, Thurston & Bloyce,, 2014) (Taylor-Robinson et al, 2012)
Permission to experiment to solve problems; ability for local 'customisation'; and an ability to frame problems and solutions differently from what training and professional customs may suggest (S) Source: (Ferlie et al, 2010) (Hunter & Perkins, 2012) (Pate et al, 2010) (Fischbacher & Mackinnon, 2010)	Shared values and priorities built on an evidence base that spans sectors; support for 'off-line' development spaces where different perspectives can be discussed (I) Source: (Carlisle, 2010) (Eilbert & Lafronza, 2005) (Ferlie et al, 2010) (Stern & Green, 2005) (Taylor-Robinson et al, 2012)
Commitment to outcome evaluation with published results; shared perceptions of 'good evidence'; access to high quality data; capacity to track multiple inputs and outputs over a long period; adaptive	Secure professional and organisational identities set within the context of strong identity for the partnership itself and the removal of unnecessary organisational symbols that emphasise

system to enable feedback from learning; continuum of outcome achievement (short and long-term) (S) Source: (Carr et al, 2006) (Eilbert & Lafronza, 2005) (Graham et al, 2015) (Hunter & Perkins, 2012) (Powell, Thurston & Bloyce,, 2014) (Taylor-Robinson et al, 2012)	cultural differences (S). Source: (Ferlie et al, 2010) (Pate et al, 2010)

103. Designated support from the public health function will be needed to support CPPs and Health and Social Care Partnerships (HSCPs) to maximise their public health contributions and to assess impact. Both offer opportunities for a partnership focus on prevention and public health. An important role of the specialist public health function within wider partnerships is to counter pressure to shift attention away from the preventative agenda towards high-profile downstream issues by locating health issues within an evidence-based public health framework.

104. There is also a need to support specific partners within CPPs, including providing support to Local Authorities. The necessity to support these partners and partnerships has implications for how the public health workforce is deployed. Responses to the review highlighted the very real challenge of ensuring the provision of support to local partnerships while maintaining the necessary critical mass needed to ensure a comprehensive public health function and avoiding dilution of input to key strategic organisations.

105. Review findings specific to Health and Social Care Integration, Community Planning, NHS Boards, Local Authorities, the third Sector and Communities are summarised in the following sub-sections.

6.1 Health and Social Care Integration
106. The overarching statement for health and social care integration set out in the National Health and Wellbeing Outcomes Framework is that "health and social care services should focus on the needs of the individual to promote health and well-being, and in particular to enable people to live healthier lives in their community" (Scottish Government, 2015). "Key to this is that people's experience of health and social care services and their impact is positive; that they are able to shape the care and support that they receive; and that people using services, whether health or social care, can expect a quality service regardless of where they live" (Scottish Government, 2015).

107. Currently there is one core outcome for integration related to the wider public health endeavour. The National Health and Wellbeing Outcomes also require Boards, Local Authorities and Integration Authorities to contribute to reducing inequalities through the services that they provide.   The Scottish Government has issued a number of Guidance and Advice documents to support the Public Bodies (Joint Working) (Scotland) Act 2014.

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108.   From a public health perspective the *engagement responses* sought to ensure that HSCPs are also created as public health organisations. At IJB (or equivalent) level the over-riding purpose should be for strategic plans to reflect the needs of their population, reduce the health gap and give appropriate priority to population health improvement, health protection and prevention of ill-health, alongside delivery of health and social care services.

109.   The engagement responses identified that Public Health specifically has an important role in supporting this process through strategic and service needs assessment; the provision of quality information, evidence and advice; and supporting capacity building and organisational development for IJBs or equivalents. Health Improvement Teams are an integral part of HSCPs in most areas and have an important role in working with communities, providing health improvement services, and connecting national policy and local activity.

110.   The engagement analysis also noted specific opportunities arising from closer integration between the NHS and Local Authorities, including working together for shared outcomes; raising the profile and effectiveness of public health approaches in primary care (e.g. via GP and pharmacy contracts) and social care; and facilitating a population approach to service planning and opportunities for combined efforts, resources, and training.

6.2 Community Planning Partnerships

111.   CPPs were seen in the *engagement responses* to be at the centre of the public health endeavour and the main mechanism by which improvements in public health can be achieved at a local level (Griesbach & Waterton, 2015) with a clear link to the determinants of health. CPPs can be a key way through which local partners collectively coordinate and tackle public health challenges as part of work on shared local priorities. Community Planning LOIPs will reflect the priorities set by the CPP based on their understanding of local needs and circumstances, and there is a crucial role for Public Health to provide the evidence and expertise to inform and support the priorities for improvement within CPPs.

112.   The 2012 Audit Scotland report on Health Inequalities (Audit Scotland, 2012) highlighted the leadership role of CPPs, alongside the leadership role of Government, for tackling health inequalities, recognising that activity to tackle inequalities involves bringing together organisations, clarifying roles and responsibilities, and ensuring sufficient shared ownership of initiatives across a range of sectors, organisations and boundaries. This report also noted the associated challenges, given different organisational cultures and governance. The report described mixed CPP performance with different levels of priority being given to health inequalities in different CPP areas. The engagement process for the current review similarly portrayed a mixed picture.

6.3. NHS Boards

113.   NHS Boards have corporate responsibility for the protection and improvement of their population's health **and** for the delivery of frontline healthcare services. Prevention and whole population approaches have long been a core role for NHS

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Boards. Health Boards should be visible leaders of public health through their own strategies and services, prioritisation and planning processes, and communications.

114. This was also recognised in the 1999 Review of Public Health in Scotland which saw Health Boards developing as "public health organisations", working closely with Local Authorities and others, and having the central role in protecting and improving population health at regional level with health improvement as the raison d'être of Boards. In practice the 1999 Review suggested that this would be evidenced through the following features: "

- The Board will provide high profile leadership for public health;
- Its organisational development will reflect public health values and methods;
- Many of its resources will be devoted to the public health function;
- Clear and shared public health goals and responsibilities will be reflected in the corporate activity of the Board and its partner Local Authorities;
- Board business and decision-making will be driven by public health principles, and informed by the best possible public health intelligence;
- The Board will drive the development of effective, well-managed multi-agency partnerships for health, with particular emphasis on partnerships with Local Authorities; and
- Boards are accountable for their role in health improvement and need a framework for public health governance."

115. Currently each NHS Board has a Local Delivery Plan (LDP) which contains within it the performance contract between the Scottish Government and the Board. From 2015/16 NHS performance is measured against LDP Standards (previously HEAT targets and standards) and Improvement Priorities (which contribute towards delivery of the Scottish Government's Purpose and National Outcomes; and NHS Scotland's Quality Ambitions). These Standards are largely focused on treatment and waiting times, including some with a specific focus on improving performance in areas of deprivation. 'Health Inequalities and Prevention' is one of six key strategic priorities and 'Antenatal and Early Years' is another, also strongly recognising the role of prevention. There is still, however, some way to go towards delivering on the recommendation in the 1999 Review which described a position where public health principles would be central to the ways in which Boards operate. The information gathered for the current review indicated that the performance targets and public/political expectations of Boards have tended to emphasise other priorities which guide investment and attention away from a focus on population health improvement, prevention and health protection.

116. This shift requires a change in thinking about health policy, recognising the respective roles of health care and the determinants of health in shaping the health of populations (Wilkinson & Marmot, 2003). The challenge for Health Boards is to reflect the wider perspective of creating the conditions for good health in their corporate functions and the services they provide (in a similar way to the repositioning of the fire service from treating to preventing fires). This would be apparent from Health Boards' ambitions and exemplar activities where there is a direct role – e.g. as an employer, procurer of services, and in

implementation of Health Promoting Health Service duties; as a member of wider partnerships; in ensuring equity of access to services; and in their relationship to local communities.

6.4 Local Government

117.   Local Government is also an important and equal 'sphere of government' in Scotland which is directly accountable to its electorate. The political leadership and democratic accountability for public health improvement offered by Local Authorities, individually and collectively, is essential to the public health and wider prevention agenda.

118.   Local Government plays a pivotal public health role given the prominence, scope and scale of its contribution to supporting public health outcomes and addressing health inequalities. During the review Local Authorities were also regularly recognised for their role as statutory partners within CPPs. Like NHS Boards, Local Authorities have a number of facets to their public health role, both as a partner to the collaborative effort and also in their own right. The challenges for Local Authorities is similar to that of Health Boards - to operate as public health organisations through demonstrating their impact on population health through their corporate processes, core functions and services.

119.   Local Authorities provide specific services and functions which impact on the public's health and are often underpinned by statutory duties (for example, environmental health and consumer protection are directly responsible for contributing to public health and safety). Local Authority responsibilities for key service areas such as social care, housing, education, employability and leisure also have a relatively well defined relationship with health inequalities and health improvement while wider responsibilities in relation to licensing, welfare reform, anti-poverty measures, planning and community development are often less well recognised for the important contribution they can make to public health.

6.5 Third Sector and Communities

120.   The *engagement responses* highlighted the opportunity for public health agencies and leaders to develop stronger partnerships with the third / voluntary sector, enabling this sector to be "third among equals" in partnerships, with its skills and experience being better utilised. In its report, *Living in the Gap,* Voluntary Health Scotland suggests that the third sector lacks influence over statutory services (Voluntary Health Scotland, 2015). The third sector *engagement responses* to the review expressed the view that the relationship between the statutory and third sectors needs to change so that there is greater mutual trust and respect (Griesbach & Waterton, 2015). The third sector can enhance the public's health. In particular it has access to marginalised groups and an important role to play in reaching, working with, and empowering local communities.

121.   Community empowerment, reinforced through legislation, has been a key theme in the review. The redistribution of power, and the associated enabling of a sense of control, can contribute to tackling health inequalities. Increased involvement in decision making within one's community can also increase feelings of belonging and participation. Stakeholders have highlighted, through

the *engagement process,* that partnerships could be improved and strengthened if they engaged more effectively with communities. Strengthening asset-based approaches in working with communities was felt to be a valuable way of focussing on capacities and capabilities, rather than on need and deprivation. Community empowerment and co-production present a major opportunity for public health, not least in terms of building resilient communities.

122.   There was general agreement that public health practitioners should be 'doing things with, not to' local communities and that activity should focus on supporting and developing co-production approaches to achieving outcomes (Scottish Public Health Network (ScotPHN) , 2015). The roles of Local Authorities, NHS Boards and other bodies in supporting community development and the individual and community resilience, which significantly contributes to better health outcomes, was also emphasised. The vital contribution to be made by the third sector and wider workforce in this wide context was highlighted.

123.   The importance of co-production to reforming public services in Scotland, empowering communities and reducing inequalities, has been referred to as part of the "Scottish Approach" which covers (Ferguson, 2015): 1. assets or strengths of individuals and communities; 2. Co-production: policy developed with, rather than done to, people; and 3. Improvement – local ownership of data to drive change. This clearly underlines the importance of public health building on the good work that already exists to strengthen and value the role of communities in public health work.

7. Workforce

124.   The current workforce was described in the responses to the review as being highly skilled, professional, knowledgeable, committed and enthusiastic (Griesbach & Waterton, 2015). Other qualities included objectivity, the ability to offer an independent view and voice, advocacy for the public health function, flexibility, adaptability, and responsiveness. (Griesbach & Waterton, 2015). The CfWI report - mapping the core public health resource in Scotland (Centre for Workforce Intelligence, 2015) - shows a relatively small (compared to NHS staffing), but nevertheless significant, core and specialist public health workforce in Scotland. However, the public health workforce is dispersed, risks further dilution, and lacks a clear programme and structure for development.

125.   The workforce priorities in Scotland identified through the review relate to the core workforce at all levels (practitioner, specialist, consultant, directors of public health) and also to the wider workforce. They include:
- development of a public health resource that is clear in its own identity;
- development of leadership capacity (as described in paragraphs 78 to 86);
- development and implementation of succession planning and career pathways which support/accelerate a multidisciplinary workforce (all disciplines, including medical);
- maximising the potential of the NHS workforce to contribute to, and influence across, the three domains and enhance intelligence;
- structured approach to developing the wider workforce contribution to public health.

7.1 Workforce Development

126.   The different levels of the core workforce and the wider workforce– all have specific needs. Leadership (covered earlier) is important at all levels. *Engagement responses* commented on the training requirements of the workforce. There was a general view that leadership and influencing skills could be improved and more training opportunities were needed, both for the core and wider public health workforce. There was also comment that there should be greater opportunities for senior people from backgrounds other than medicine to take on public health leadership roles. There was a view that public health leaders require considerable skill in influencing, lobbying and advocating for local populations.

127.   It was noted that the development of leadership and management capabilities across the NHS is a key priority of the 2020 Workforce Vision. Responses noted the value in the leadership programmes currently provided within the NHS in Scotland. However there was a view that a specific public health leadership training programme could be beneficial for the core (specialist) public health workforce. There were also comments that the leadership aspect of post-specialist public health training could be developed further and that the inclusion of leadership skills in postgraduate courses and continuing professional development should be more systematic and consistent.

128.   There has been a strong call for practitioner registration (whether the purpose is for the assurance of individuals themselves through professional value or for the public through quality assurance) and the Scottish Public Health Workforce Development Group (SPHWDG) (a cross-disciplinary group in Scotland chaired by NHSHS on behalf of the CMO) has agreed in principle to consult on a scheme to support public health practitioners towards registration, seeking views from stakeholders.

129.   The workforce development group has also agreed to re-activate a scheme to help people to meet the requirement of the specialist registration scheme for a defined period. This would run in addition to the UK-wide Faculty of Public Health training scheme.

130.   The multi-disciplinary nature of public health raises equality issues also. Despite the progress made to date with support for multidisciplinary public health, there are still historical barriers in Scotland relating to appointments, and to equal pay and performance structures for specialists from a non-medical background. During the review the Specialist Group in Scotland argued for a more systematic and equitable structure for career development that links across disciplines, and practitioner and specialist career pathways. It argued that this evolution would better utilise the existing resource, create standardised practice and strengthen succession planning.

7.2 Career progression

131.   The *engagement responses* called for career pathways to be developed from the wider workforce into the core workforce, with the potential for progression within the core workforce to the specialist workforce by recognised routes. The

development of pathways from the NHS into the wider workforce and other sectors should also be a goal.

132.   The engagement responses also noted that the (older) age profile of the existing workforce and decreasing numbers of experienced staff warranted attention to workforce succession and development planning in order to sustain and make the best use of the specialist public health resource. REHIS, in its response to the review, similarly noted concerns with regards to the falling numbers of EHOs and Food Safety Officers (FSOs) employed by Local Authorities and the need to act to safeguard environmental health services in Scotland.

133.   Public health is distinctive as an area of practice in the health sector and it reaches into other sectors of public and voluntary service where important resources also lie. There are conventional routes toward specialist practice, originally medical but (as noted above) now spreading out to other disciplines to reflect the potential that wider contributions and backgrounds can bring. This change reflects the need to nurture the wider, practitioner and specialist workforce, and create career progression pathways that balance:

- the changing challenges for public health;
- workforce requirements and future capability;
- the need for a pipeline of future leaders and talent management to ensure their development to meet capacity requirements and fulfil key functions;
- expectations of people with public health skills who wish to progress; and
- the blend of traditional routes to career progression with new and atypical routes, encompassing the contributions of specialists and leaders from other disciplines and sectors.

7.3 Recognising and supporting the wider workforce

134.   The *engagement responses* highlighted that there are opportunities to develop the public health roles of wider NHS and other public service staff, building an inclusive approach to the contribution of people from diverse backgrounds and all sectors. There are specific opportunities to acknowledge, more overtly, the particular contribution to be made by primary and community care professionals. Respondents argued that the robust development of the wider public health workforce was essential to enhance influence and impact and deliver public health outcomes, not only in terms of health behaviour change, but also in reducing health inequalities. These points reflect the importance of investing in the wider workforce, as set out in recent reports from The Royal Society for Public Health (RSPH) (Royal Society for Public Health, 2015) and (Royal Society for Public Health, 2014).

135.   The wider workforce is already engaged in public health activity in Scotland in many ways. However engagement responses indicated that plans to harness the potential of the wider workforce need to develop still further, particularly in ways to structure or facilitate involvement of the wider workforce. It will be useful in Scotland to monitor and draw from the work of the RSPH on wider workforce. The review supports the RSPH view that health is everyone's responsibility and

that there is the opportunity to grow the contribution of the wider workforce as part of the organised efforts of society towards improving health and wellbeing and reducing health inequalities.

Recommendations

136. Based on the above findings and conclusions, and informed by the wider context described in Part 1 of this report, the following recommendations are made by the Review Group.

1. Organisational Arrangements

137. *The current organisational arrangements for Public Health in Scotland should be reviewed and may need to be rationalised.* This should explore greater use of national arrangements (including for health protection, public health intelligence and other areas deemed 'once for Scotland'), more collaboration between Boards at a regional level, activity that should clearly remain at local level, and how the three levels connect.

138. **The NHS Scotland Shared Services Programme**[7] has identified Public Health services for review within its 'Health Portfolio'. In taking this forward the findings of the Public Health Review should be used to define the strategic direction for public health in Scotland. The shared services work should also be used to underpin the development and delivery of the overarching review of organisational arrangements for public health in Scotland.

139. *The Health Protection Oversight Group and the Scottish Government should build on the creation of the Health Protection Network to ensure effective leadership and coordination for health protection in Scotland..*

140. The engagement responses noted a cluttered public health organisational landscape in Scotland, with more clarity needed on the roles and responsibilities of different bodies and, importantly, how they join up. Objectives to be met in considering alternative structures include:
    a. Achieving greater national cohesion, accountability and leadership across the various domains of public health. The current arrangements, with responsibility for different domains sitting within different organisations, lessens the effectiveness, awareness and understanding of the totality of the public health effort. The Scottish Government should consider any additional measures needed to provide a more coherent and more widely owned organisational structure. This should include allocating national responsibility for each of the domains of public health and the underpinning public health intelligence function, either clearly to existing national organisations or to a single national public health organisation.
    b. Achieving a clearer allocation of the public health responsibilities sitting at national, regional and local levels, and associated accountabilities.

    c. Sharing of resources across public bodies to ensure the most effective use of Health Intelligence Services, and the development of local strategies for health intelligence.

    d. Supporting all public bodies, and specifically Health Boards and Local Authorities, to become more overtly exemplar Public Health Organisations, demonstrating core public health principles and activities. The core work of Health Boards should recognise the central place that prevention should have in promoting and protecting the health of the population, while maintaining the existing important focus on safe, equitable and effective care services. These principles are equally applicable to Local Authorities and other public facing organisations. Public health should be made more explicit as part of the remit for public sector bodies and be reflected in how they carry out their activity.

2.   Strategy for public health

141. *A shared vision should be developed for public health with common goals and outcomes agreed as part of a Public Health Strategy for Scotland*. The strategy should include the following features:

    a) focus on identified public health priorities (including (in)activity, diet and nutrition, obesity, mental wellbeing);

    b) provide a clear public sector and public health focus on addressing inequalities;

    c) support the necessary shift to action on prevention;

    d) make tangible the health in all policy approach – a cross-sector approach that systematically takes into account the health implications of decisions across public policies in order to improve population health and reduce inequalities;

    e) channel knowledge of what works into practical action; and

    f) demonstrate governance to ensure accountability and measurement of progress against outcomes.

142. The absence of a clear national strategy for public health was reflected in the perceived lack of cohesion in the public health work being carried out in Scotland. There is the potential for a Public Health Strategy, together with the National Clinical Strategy (in development), to provide an overarching strategic context for the delivery of health and care services in Scotland reflecting the triple aims of: improving population health, improving the quality and safety of care, and securing best value from health and social care services. The Public Health Strategy would also reflect the wider determinants of health and involve action by other sectors and services.

143. Delivery of an ambitious strategy for public health in Scotland will require attention to the infrastructure, capacity, effectiveness and resilience of the public health function. The following recommendations are intended to support this.

3.   Leadership

144. There has been strong public health leadership from many individuals and on a range of issues in Scotland, but the current and emerging challenges require strengthened leadership on a number of fronts.

145. ***The role and contribution of the Directors of Public Health should be clarified and strengthened*** . The DPH role is pivotal to an effective public health function and there is a need to support DPH leadership individually and as a group. This will require: (a) clarity about expectations and accountability in light of new organisational landscape and the move to multi-disciplinary public health (b) the development of a more effective national leadership group with real impact at national level, determine resourcing of Group, including dedicated resource for a Chair, and clarify relationship to Government) (c) coordinated recruitment and development for a new cohort of leaders to fill vacancies and ensure ongoing succession planning.

146. ***The new Public Health Strategy should be used to generate a stronger public health voice and more coherent action at all levels.*** More consistent messages echoed throughout Scotland by all sectors will be essential and will help to raise the profile and increase the influence of public health. Political leadership is also needed to achieve improvements in public health, demonstrated jointly from Scottish Government and Local Government, with strong cross-portfolio commitment reflecting the wide policy responsibility for determinants of health.

4.   Public health intelligence and evidence for action

147.   Public health intelligence underpins the three domains of Public Health and should continue to underpin public health activity in Scotland and the work that follows on from the review. The mapping of the core public health workforce in Scotland (Centre for Workforce Intelligence, 2015) identified the significant scale of the public health research and academic resource. Through the review there have been consistent messages about the importance of evidence-based interventions; the need for population-based data sets, at national and local levels, to inform priorities; and the strength of the existing resources in Scotland. To build on these strengths, the following recommendations are made.

148. ***Action should be taken to achieve greater coordination of academic public health in Scotland,*** *building on successful models of collaboration in other fields, to develop a more strategic collaborative mechanism for public health research in support of the national strategy.*

149. ***Priority should be placed on ensuring that public health policy and practice is more strongly underpinned by research and evidence – and that the research and intelligence functions in public health are focussed on being policy and practice-relevant.*** This will require culture changes within policy, delivery and research organisations, as well as collaborative action to build the evidence base, incorporate a range of types of evidence, and to demonstrate the effectiveness and value for money of public health approaches.

150.   Technological and other data developments provide opportunities that the public health function needs to grasp. It is, therefore, also recommended that ***the public health intelligence specialists in Scotland should rise to the information age opportunities in public health through greater use of big data and technological responses, underpinned by a public health data and technology strategy.***

5. Partnership

151. ***Public Health consultants and other core public health staff should be highly visible and play a strategic influencing role in CPPs and HSCPs.*** Recommendations include:

   a) Public Health, as a discipline, needs to be represented and contribute effectively to the work of senior CPP and IJB groups such as the Strategic Planning Group in all local areas.

   b) The Director of Public Health Report will continue to provide independent advocacy and a voice for public health actions and responses across the Board's area and reflect the specialty's wider responsibilities for the population's health. The Report will reflect the priorities for action set by Community Planning Partnerships, Integration Joint Boards, NHS Board services and Local Authorities, and help to inform ongoing activity as part of the collective effort to improving population health and tackling inequalities.

152. These recommendations are contained within guidance set out by the Review at Annex F on the public health contribution needed by Local Authorities, IJBs and collectively through CPPs in order that the impact on population health can be strengthened. An important dimension will be to consolidate the public health contribution to be made by the third sector as part of these partnership arrangements.

6. Workforce

153. ***There should be a workforce development strategy for public health in Scotland*** Features should include:

   a. Workforce vision which supports delivery of the public health strategy; provides a leadership statement; describes the breadth (both NHS and wider) of the current workforce; supports multidisciplinary public health; strengthens the role of NHS workforce in Public Health; and recognises the role and requirement for engagement with local government, third sector and, more generally, the wider workforce in delivering public health outcomes;

   b. Workforce development covering leadership development, supporting and developing staff in existing roles, post specialist development, talent management and preparing staff for future roles, developing the public health roles of the NHS workforce;

   c. Workforce Planning including: workforce deployment, development of a career pathway for the core public health workforce and succession planning;

   d. Training: identify opportunities for training across all domains of public health and cross professional joint training to ensure a progressive, integrated and cohesive approach to education and training informed by the well-developed NES approach for Health Protection;

   e. Registration: to consult on and develop progressive arrangements for practitioner registration where this adds value to the public health endeavour; and

   f. A structured approach to informing, supporting and utilising the contribution of the wider workforce in pursuit of public health outcomes.

7. Conclusion

154. This Review of Public Health in Scotland has identified the need for the function to be clearer about its priorities and delivered in a more coherent manner. The changing organisational context (including the clear emphasis on partnership and integration, and the importance of community empowerment and engagement) has implications for how public health is organised and operates. Major public health challenges such as obesity, mental health problems and inactivity, together with the persistence of health inequalities, require a concerted population health response, achieved through the organised efforts of society. They cannot be addressed solely through treatment. The evidence received by the Review Group emphasised the cost-effectiveness of preventive approaches and a wide appetite for a more active public health effort in Scotland. Our recommendations seek to support that through:

   a. A review and rationalisation of organisational arrangements for public health in Scotland, including national coordination of the health protection function;
   b. The development of a national public health strategy;
   c. Clarification and strengthening of the role of the DsPH, individually and collectively;
   d. Supporting more coherent action and a stronger public health voice in Scotland;
   e. Achieving greater coordination of academic public health, prioritising the application of evidence to policy and practice, and responding to technological developments;
   f. An enhanced role for public health specialists within CPPs and IJBs; and
   g. Planned development of the public health workforce and a structured approach to utilising the wider workforce.

155. Implementation of these recommendations will require an overarching implementation plan to ensure that all elements are taken forward as a subsequent phase of the public health review. Delivery of a future public health strategy will require the contribution and collaboration of many partners, recognising that responsibilities for addressing public health issues sit not only within the health sector but also national and local governments; public, private and third sectors; and communities and individuals.

Annex A. Terms of Reference for the Public Health Review Group:

The public health function, with its strong focus on prevention, equity and quality, is integral to health service values and aims in Scotland, and to public services reform. The focus for the review is on how to widen and deepen the influence of Public Health –both as a public service function and an important outcome for Scotland. The core question is: "How can we be more effective in tackling health and social inequalities and increasing healthy life expectancy in Scotland in a sustainable way?" In light of this the Review Group has been asked to progress the following.

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 on reducing health inequalities for the future.

To examine:
- public health leadership and influence, both within the health sector and more widely;
- workforce planning and development, succession planning and resourcing within the multi-disciplinary core public health workforce; 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.

To make recommendations to:
- strengthen the contribution of Public Health in Scotland in light of current and future population health challenges and the emerging policy and organisational contexts;
- maximise the effectiveness and efficiency of the public health resource in Scotland;
- achieve consistency where this will enhance quality and impact; and
- ensure the responsiveness and resilience of the public health function for the future.

Annex B. Membership of the Public Health Review Group

1. **Dr Hamish Wilson (chair)** (Vice Chair Healthcare Improvement Scotland).
2. **Professor Marion Bain** (Medical Director, NHS National Services Scotland and Co-Chair, Scottish Association of Medical Directors)
3. **Calum Campbell** (Chief Executive, NHS Lanarkshire)
4. **John Carnochan OBE** (Co-founder of the Violence Reduction Unit. Technical adviser to the World Health Organisation)
5. **Dr Derek Cox** (Retired Director of Public Health)
6. **Ron Culley / Paula McLeay** (Chief Officer Health and Social Care, COSLA)
7. **Dr Aileen Keel CBE** (Director, Innovative Health Care Delivery Programme, Farr Institute)
8. **Angela Leitch** (Chief Executive, East Lothian Council)
9. **Dona Milne** (Consultant in Public Health, NHS Lothian)
10. **Prof Sir Lewis Ritchie** (James Mackenzie Professor of General Practice, Centre of Academic Primary Care, University of Aberdeen; former Director of Public Health, NHS Grampian)
11. **John Ross Scott** (Chair, Orkney NHS Board)
12. **Susan Siegel** (Public Partner)
13. **Mr Grant Sugden** (Chief Executive, Waverley Care)
14. **Professor Carol Tannahill** (Director, Glasgow Centre for Population Health)
15. **Margie Taylor** (Chief Dental Officer, Scottish Government)
16. **Fraser Tweedie** (Public Partner)
17. **Dr Kevin Woods** (Former Director-General for Health, Scottish Government and former DG of Health, New Zealand.)

Support at Scottish Government
1. **Heather Cowan** – Policy Lead , Public Health Division
2. **Fee Goodlet** – Business Manager, Public Health Division
3. **Donald Henderson** – Deputy Director, Public Health Division
4. **Dr Duncan McCormick** – Senior Medical Officer

Annex C. Methodology for the Public Health Review

(a) Analytical input provided by the Scottish Government.

8.   (b) Comments sought openly from individuals and organisations in relation to five questions contained in an engagement paper on the subject of public health strengths, weaknesses, opportunities and threats (SWOT analysis) and on leadership, partnership and workforce. 117 responses were received and independent research consultants were appointed to undertake analysis and have provided a full report which is available at www.gov.scot/publichealthreview-analysisofresponses-engagementpaper.

(c) A series of four regional engagement events organised on behalf of the Review Group by the Scottish Public Health Network (ScotPHN), to explore further some of the themes emerging from the responses. These were held in Dundee, Edinburgh, Glasgow and Inverness and attended by a mix of attendees from public health, the wider NHS, Local Authorities, the third sector and the public. ScotPHN have made available a report and the outputs on their website http://www.scotphn.net/projects/public-health-review-engagement/

(d) Meetings conducted by Heather Cowan and Hamish Wilson, on behalf of the Review Group, with key interest groups including: the Scottish Directors of Public Health, the Multi-Disciplinary Specialist Public Health Network, the Scottish Public Health Registrars Group, the Scottish Health Promotion Managers, the Scottish Public Health Network, the North of Scotland Public Health Network, Consultants in Dental Public Health Networks, National Specialist Training Committee for Public Health/Medicine, Royal Environmental Health Institute of Scotland (REHIS). Also meetings and/or telephone conference calls with individuals to inform the review including : Sir Harry Burns,former Chief Medical Officer for Scotland and Professor of Global Public Health, International Prevention Research Institute, Strathclyde University; Cerilan Rogers, retired Director National Public Health Service for Wales; Dr Carolyn Harper, Director of Public Health and Medical Director for Northern Ireland's Public Health Agency; Shirley Cramer CBE, Chief Executive Royal Society for Public Health; Dr Kate Ardern MBChB, MSc, FFPH, Executive Director of Public Health for the Borough of Wigan.

Following a number of these meetings, further material was generated for the Review Group's consideration.

(e) *Research analysis* was carried out which covered analysis of evidence/research literature, including a review of international evidence on health policies and different governance and accountability structures to inform the Review Group. A Summary report is available at www.gov.scot/publichealthreviewresearchreport-keyfindings

(f) A series of meetings of the Review Group to consider this material alongside additional presentations from experts including: Jonathan Marron, Director of Strategy, Public Health England; Tracey Cooper, Chief Executive, Public Health Wales; Claire Stevens, Chief Officer, Voluntary Health Scotland; Andrew Fraser, Chair, Scottish Public Health Workforce Development Group.

Annex D. Public health policy: recent history

1. The 1999 White Paper *Towards a Healthier Scotland* (Scottish Executive, 1999) established the public health agenda in Scotland following devolution. It set out a 3-level approach to better health involving action focussed on life circumstances, lifestyles and health topics, with an overarching focus on tackling health inequalities. It called for a concerted drive to improve child health, a sustained focus on priority diseases, and established a cross-government approach supported by local demonstration projects.

2. Around the same time the 1999 *Review of the Public Health Function in Scotland* (Scottish Executive, 1999) was carried out. It confirmed the need for public health to have a high profile within Health Boards and Local Authorities, recommending that Boards develop as public health organisations and that there be a "health in all policies" approach to policy making. Like the current review there was a focus on strong leadership and on relationships and partnerships. The 1999 *Review of the Public Health Function in Scotland* focused largely on the specialist workforce, and there was a subsequent Review of Nurses' Contributions to improving the Public's Health (Scottish Executive, 2001). Following the 1999 *Review of the Public Health Function in Scotland* there was activity and enthusiasm, particularly around the creation of the Public Health Institute for Scotland. Nevertheless, despite the passage of time, some of the issues identified in the 1999 review remain relevant now and tackling them has become even more important.

3. In 2003, the Scottish Executive's paper *Improving Health in Scotland – The Challenge* (Scottish Government, 2003) described the health improvement challenges and the importance of clarity and shared aims with cross-sector senior level leadership. The paper detailed the Government response, with 44 actions across four areas: early years, teenage transition, the workplace and the community. These actions included the creation of a new Directorate for Health Improvement within the Scottish Executive, and the creation of NHSHS (through merging the Public Health Institute for Scotland with the Health Education Board for Scotland) to lead national activity on health improvement.

4. HPS was established by the Scottish Executive in 2005 to strengthen and co-ordinate health protection in Scotland. Health Protection Scotland took over the functions of the Scottish Centre for Infection and Environmental Health (SCIEH), and has since developed as part of a Division of NHS National Services Scotland.

5. Scotland has a strong tradition of specialist dental and oral public health. In 2005 the Scottish Executive published *An Action Plan for Improving Oral Health and Modernising NHS Dental Services* which set out the strategic direction, inter alia, for tackling poor oral health. The measures identified, supplemented by further developments after 2007, have involved both upstream and downstream approaches for tackling a public health problem. The crucial role of partners in the community (e.g. child development officers in nursery schools) was also emphasised.

6. In 2007 the Scottish Government launched *Better Health, Better Care: Action Plan for NHSScotland* (Scottish Governement, 2007). Its central message was the development of a "mutual" NHS in Scotland, with patients as partners in care and the opportunity for individuals to take more control of their own health and to have more say in how the NHS is run. The action plan supported delivery of a 'Healthier Scotland', with actions to make progress on health improvement, tackling health inequality and improving the quality of health care.

7. As part of the *Better Health, Better Care Action Plan*, the Scottish Government established a Ministerial Task Force on Health Inequalities, which reported in 2008. This report, *Equally Well* (Scottish Government, 2008), reinforced the cross-government approach needed for tackling inequalities and the role to be played by all sectors in society. It established a set of principles for policies to have a greater impact on health inequalities, identified critically important roles for the NHS, re-stated the importance of activity in the early years, and examined the interface between health inequalities and the Government's commitments to make Scotland Greener, Safer and Stronger, and Wealthier. The report identified a number of actions brought together in an implementation plan. There have been subsequent reviews following publication of *Equally Well* in 2008. The most recent, reporting in March of 2014, established a central role for CPPs, emphasised the need for a greater focus on delivery and highlighted the need for inequalities work to more successfully broaden out noting that Equally Well had largely remained a health and well-being initiative.

8. The Public Health etc. (Scotland) Act 2008 set out the duties of Scottish Ministers, Health Boards and Local Authorities to continue to make provision to protect public health in Scotland. These are without prejudice to existing duties imposed on the Scottish Ministers and Health Boards in the National Health Service (Scotland) Act 1978 and existing environmental health legislation. Protecting public health is defined in terms of "protecting the community, or any part of the community, from infectious diseases, contamination or other hazards that constitute a danger to human health".

9. *A Force for Improvement: the Workforce Response to Better Health, Better Care* (Scottish Government, 2009) was published in 2009 and emphasised the role of all NHS staff in Scotland in promoting better public health, with every interaction offering an opportunity for health improvement and for individuals and communities taking responsibility for their own health and wellbeing. It set out the workforce response in the context of five core workforce challenges: tackling health inequalities; shifting the balance of care; ensuring a quality workforce; delivering best value across the workforce; and moving towards an integrated workforce.

10. *The Health Works, a review of the Scottish Government's Healthy Working Lives Strategy* published in 2009 (Scottish Government, 2009) underlined the Scottish Government and COSLA commitment to working together to tackle the causes of ill health and social inequalities. It emphasised the importance of addressing health as a barrier to work as a key mechanism for reducing poverty and deprivation; contributing to the Scottish economy through increased productivity; and helping individuals to sustain and improve their own health and wellbeing.

Recommendations were also made about improving access to support for employees with ill-health and for improvement in the understanding by healthcare professionals of the links between health and work, and the importance of encouraging return to work as a key health outcome. A review in 2013 (Scottish Government, 2013) looked at implementation of the 25 key actions that aimed to encourage employers to be more proactive in supporting the health and wellbeing of workers and noted the increasing awareness that work is a key social determinant of health.

11. The Health Protection Stocktake Working Group was established in autumn 2010 to ensure that the arrangements put in place in Scotland in 2005 were still effective. The final National Health Protection Stocktake report was published in 2012 (Scottish Government, 2012). Further work, published in 2013, carried out by the National Planning Forum on behalf of the NHS Chief Executives, included a number of key recommendations, one of which was the establishment of a national health protection governance structure for Scotland. This newly formed obligate network, the Scottish Health Protection Network, consists of a number of topical and enabling groups and is overseen by the National Health Protection Oversight Group.

12. The Scottish Government's *Healthcare Quality Strategy for NHS Scotland* (Scottish Government, 2010) is a development of *Better Health, Better Care* (2007). In 2011 the Scottish Government set out the 2020 Vision, which gives the strategic narrative and context for taking forward the implementation of the Quality Strategy. The Vision is that by 2020 everyone is able to live longer healthier lives at home or in a homely setting. These two strategic documents, together with the major programme of reform through the integration of health and social care under The Public Bodies (Joint Working) (Scotland) Act, provide the main strategic and legislative context for health and social care services today. The Scottish Government is currently building on its 2020 Vision for Health to shape a transformational change in Scotland's approach to population health and the delivery of health and social care services by 2030.

Annex E. The structural and organisational landscape

1. Scottish Government

156.   The Scottish Government has devolved responsibilities which include health, education, justice, rural affairs, housing and the environment. Its stated purpose is to "focus government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth". The Scottish Government sets out five strategic objectives underpinning this purpose, including a "Healthier Scotland", and 16 National Outcomes which include people living "longer, healthier lives" and "tackling the significant inequalities in Scottish society", as well as giving children "the best start in life". The National Performance Framework supports an outcomes-based approach to performance. Public health work is central to the delivery of a number of the national performance indicators.

157.   Since November 2014 there have been three Ministers sharing portfolio responsibility for aspects of public health: Cabinet Secretary for Health, Wellbeing and Sport; Minister for Public Health; and Minister for Sport, Health Improvement and Mental Health.

158.   The Scottish Government has a Public Health Division (since October 2015, operating as two divisions: Health Protection and Health Improvement and Equality) and, since January 2015, a Directorate of Population Health Improvement, which includes within it the Public Health Divisions and which works closely with Health Analytical Services and the Chief Medical Officer's Directorate. The dental public health strategic component falls within the Dentistry Division, under the Chief Dental Officer. All have a direct role in improving the public's health, as well as working with other areas of the Scottish Government which also have a direct contribution to make.

2. NHS Scotland

159.   Most of the core public health workforce in Scotland is employed within NHSScotland in the 14 Territorial Boards and four National Boards. The wider NHS workforce also makes a crucial public health contribution, including through the delivery of services, employment practices, leadership and resource allocation decisions, and partnership working.

2.1 Territorial Board

160.   The 14 Territorial Health Boards have corporate Board level responsibility for the protection and improvement of their population's health and for the delivery of frontline healthcare services. Each has a public health team led by a Director of Public Health (DPH). These public health teams are responsible for providing services across all of the domains of public health and for working in partnership within the Health Board and with external organisations and communities to improve population health outcomes. In a few areas the DPH is a joint appointment between the NHS Board and the Local Authority. Public Health Directorates vary in size, organisation and linkages.

161.   The development of IJBs (HSCPs) in Local Authority areas (and the lead agency model in Highland) has led to Health Improvement Teams being located

as part of these integrated bodies in some parts of the country. Other specialist public health inputs are provided from Territorial Boards and National Boards.

2.2 Directors of Public Health

162. The DsPH role is central to the effectiveness of public health across the country, ensuring locally-sensitive responses to national priorities and policies. A ScotPHN report (Scottish Public Health Network (ScotPHN), 2010) on the Role of the Director of Public Health described 13 functions agreed to be part of the role, as follows.

Table 10: Role of the Director of Public Health
(i)providing public health advice to the NHS Board;
(ii)providing public health advice to the Local Authority;
(iii) contributing to corporate leadership of the Board;
(iv) producing an independent annual report;
(v) providing leadership and advocacy for protecting and improving health and reducing health inequalities;
(vi) managing the Board's specialist public health team and associated support staff and resources;
(vii)ensuring the Board and its staff have access to timely, accurate and appropriately interpreted data on population health;
(viii)ensuring the implementation of NHS components of Scottish Government public health or health improvement policies;
(ix) overseeing the coordination and effectiveness of screening programmes;
(x) communicating with the public via the media on important public health issues;
(xi) contributing to emergency planning;
(xii)* ensuring all appropriate infection and environmental surveillance and control measures were in place; and
(xiii)* ensuring health needs assessments were carried out.

* i to xi form part of DPH role consistently across Scotland, xii & xiii agreed to form part of the role in all but one and two regional boards respectively.

163. Additionally, DsPH meet collectively and have scope to ensure appropriate consistency of approach across Scotland.

2.3 National Boards

164. The four National Boards with specific strategic roles impacting on public health are NHS Health Scotland (NHSHS), NHS National Services Scotland (NSS), NHS Education for Scotland (NES) and Healthcare Improvement Scotland (HIS).

165. NHSHS is the national health improvement body which works with others in the public, private and third sectors to reduce health inequalities and improve health and wellbeing. It is involved both in developing and disseminating evidence and in shaping policy and programmes to help achieve a fairer, healthier Scotland. ScotPHN and the Scottish Centre for Healthy Working Lives are part of NHSHS.

166. NSS provides a number of support services to the NHS and other bodies in Scotland. NSS also commissions and manages national screening programmes for Scotland. HPS is part of NSS and delivers specialist national services and provides advice, support and information to professionals and the public to protect people from infectious and environmental hazards. NSS also runs the *Information Services Division* (ISD) which provides a range of statistical information and analysis. HPS and ISD are both part of the *Public Health and Intelligence Strategic Business Unit* within NSS.

167. *NES* provides education and training for those who work in the NHS in Scotland, including its core public health workforce, and ensures that the wider workforce's contribution to protecting and improving population health is supported.

168. *Healthcare Improvement Scotland* is the national organisation responsible for providing quality improvement support to healthcare providers in Scotland and for delivering scrutiny activity. It supports and delivers health and care activities which impact on public health, including evidence-based guidelines; public involvement processes; and health care quality and effectiveness assessments.

2.4 Observatory

169. The ScotPHO collaboration is responsible for providing a clear picture of the health of the Scottish population and the factors that affect it, including through improved collection and use of routine data on health, risk factors, behaviours and wider health determinants. It is co-led by ISD and NHSHS, and includes the Glasgow Centre for Population Health, National Records of Scotland and Health Protection Scotland.

3. National Public Sector Bodies

170. There are also a number of public sector bodies with a specific public health remit which operate nationally in Scotland, working with the NHS, Scottish Government, Local Authorities, business and industry, consumers and others. For example, the Food Standards Scotland (FSS) is responsible for ensuring that information and advice on food safety and standards, nutrition and labelling is independent, consistent, evidence-based and consumer-focused. SEPA is the principal environmental regulator, protecting and improving Scotland's environment.

4. Local Government

171. Local Authorities in Scotland play a pivotal role in delivering preventative, universal services; addressing the social inequalities which underpin health inequalities; and improving health outcomes. They are a key partner in the overall effort to improve the public's health and prevent ill-health. Local Authorities can also provide public health leadership through their ability to operate as public health organisations, focusing on the health impact of their own decisions and actions, and by contributing to partnership structures that are similarly concerned with improving population health and wellbeing and reducing health inequalities.

172. Local Authorities share statutory responsibility with Health Boards for the control of communicable disease. They have prime responsibility for environmental health and employ core public health staff, most notably Environmental Health Officers. Local Government services also contribute to the public health function through important work within education, economic development, employability services, cultural and leisure services, responsibilities for the physical and social environments, and a range of other duties.

173. Local Authorities are statutory partners in CPPs and, together with Health Boards, are parent bodies for establishing integrated partnership arrangements under the Public Bodies (Joint Working) (Scotland) Act 2014.

174. The Health and Wellbeing Executive Group provides a focus for COSLA's considerations of public health issues, with COSLA's Leaders' meeting setting policy.

5. *Community Planning*
175. There is one CPP for each Local Authority area. Under the Community Empowerment (Scotland) Act 2015 public bodies work together and with the local community in CPPs to plan for, resource and provide services which improve local outcomes and reduce inequalities in the area. The National Community Planning Group, with membership drawn from strategic leaders in public services and the wider community, helps to inform strategic policy direction for CPPs. As a matter of policy, CPPs are encouraged to focus efforts on addressing a small number of priorities for their area which reflect their understanding of the key needs and circumstances of the area and its communities (likely to include particular deep-rooted and entrenched social and economic challenges) and on which partners can make the most significant impact through effective joint working. Public health challenges frequently feature within these local priorities, either in their own right or as part of related themes.

176. CPPs have Single Outcome Agreements (SOAs) which are intended to demonstrate a clear and evidence-based understanding of place and communities, including the inequalities facing different areas and population groups. Under the Community Empowerment (Scotland) 2015 Act Single Outcome Agreements are given the title of local outcome improvement plans (LOIPs), which CPPs are required to prepare and publish.

177. Community planning brings together all partners responsible for action on wider determinants of health and inequality and for promoting early intervention and preventative approaches. These partners include the Local Authority, Health Board, IJB, enterprise body, Police Scotland, the Scottish Fire and Rescue Service, regional colleges and Skills Development Scotland. Participation with communities lies at the heart of community planning involving the third sector and any community body that has the potential to make a contribution to the CPP.

6. *Integration Partnerships*
178. The integration of adult health and social care services is required, from April 2015, by the Public Bodies (Joint Working) (Scotland) Act 2014, through Health Boards and Local Authorities establishing integrated partnership arrangements

for local adult services and deciding locally whether to include children's health and social care services in their integrated arrangements. Two models of integration are available: Lead Agency (delegation of function and resources between the Health Board and the Local Authority) and IJB (delegation of functions and resources by Health Boards and Local Authorities to a body corporate). This will mean Health Boards and Local Authorities working together effectively to deliver good quality, sustainable care services at local level, including through locality planning arrangements. National outcomes for health and wellbeing apply, and the Integration Partnership is responsible for joint strategic commissioning plans (widely consulted upon with non-statutory partners) for delivery functions and for the integrated budget under their control. Where children's health and social care services are not included within integrated arrangements, they will continue to be planned for and delivered on the current basis by Health Boards, Local Authorities and third and independent sector providers.

7. Third sector

179.   There are a wide range of voluntary and community sector organisations with health interests, and even more with a focus on the determinants of population health. These all contribute to the wider public health function in Scotland. The third sector health organisations come together collectively through national intermediaries including Voluntary Health Scotland, Voluntary Action Scotland, the Health and Social Care Alliance and the Community Health Exchange. Voluntary Health Scotland is the national intermediary and network for Scotland's voluntary health organisations. The Alliance is the national third sector intermediary for a range of health and social care organisations, including for people who are disabled, living with long term conditions or providing unpaid care. Voluntary Action Scotland develops Third Sector Interfaces (TSIs) to support the third sector locally. The Community Health Exchange (CHEX) supports community development approaches to health improvement.

180.   The Scottish Council for Voluntary Organisations (SCVO) is a membership organisation for a wide breadth of Scotland's charities, voluntary organisations and social enterprises.   It estimates that there are around 45,000 formal voluntary organisations across Scotland with over 23,000 organisations regulated as charities by the Scottish Charity Regulator (SCVO/Office of Scottish Charity Regulator, 2010/2011). Health is estimated to comprise 22% of charitable purposes and beneficiary groups are estimated to be children and young people (46%), the community (46%), older people (22%) and people with disability/health problems (22%) (The Work Foundation , 2010).

8. Academic public health

181.   Public health teaching and research takes place in all of Scotland's Universities and many members of the core public health workforce are employed in academic public health within Universities and Research Units. Public Health Research Units in Scotland include the Social and Public Health Sciences Unit in Glasgow, the Scottish Collaboration for Public Health Research and Policy in Edinburgh, and the Health Economics Research Unit in Aberdeen – all of which receive core funding from the Government's Chief Scientist Office alongside research council funding. The Farr Institute, a collaboration between

six Scottish universities and NSS, uses electronic patient records and other population-based datasets for research purposes. The Scottish School of Public Health Research is another cross-university collaborative mechanism to achieve a more focussed academic contribution to public health in Scotland. As a specific investment to develop evidence and insights to tackle urban inequalities, Scottish Government, NHS Glasgow and Greater Clyde, Glasgow University and Glasgow City Council collectively support the Glasgow Centre for Population Health.

182. The Academy of Medical Sciences is undertaking a project that aims to identify the main health challenges the UK population will face by 2040. One of the major focuses of the Academy's activities is to facilitate strong and equitable partnerships between academia, industry and the NHS - along with promoting effective engagement with regulators and policy makers.

183. There are also a number of issue-specific collaborations, such as MESAS (Monitoring and Evaluating Scotland's Alcohol Strategy) for alcohol policy, the Commonwealth Games legacy evaluation process, and Scotland's smoke-free legislation evaluation. In dentistry, the strategy for oral health research has given priority to public health, and the dental academic establishments, particularly in Dundee and Glasgow, are working together to ensure research is relevant and best use is made of resources. What Works Scotland, which was established in 2014, is an initiative involving public health academics working alongside other researchers and service-providers. It is funded by Scottish Government and the ESRC to improve the way local areas in Scotland use evidence to make decisions about public service development and reform, working in an applied way.

9. Networks

184. A number of networks of public health professionals operate in Scotland to enable sharing of expertise, coordination of efforts and collaboration to undertake joint work. There are networks for specific disciplines (e.g. the Dental Public Health Network and Pharmaceutical Public Health Network /Community Pharmacy Network), for special interests (e.g. the Alcohol Special Interest Group), geographical areas (e.g. the North of Scotland Public Health Network (NoSPHN)), and obligate networks such as the Scottish Health Protection Network (SHPN).

185. The Scottish Public Health Network (ScotPHN) is responsible to the SDsPH and NHSHS and its role is to bring together the public health resources within the fourteen Territorial NHS Boards, the National Health Boards, academic public health departments and wider public health agencies, including Local Authorities and the independent sectors. As well as facilitating information exchange, ScotPHN undertakes national prioritised pieces of work. Given the size of Scotland, there is also strength in informal networks which operate (e.g. in a given field/speciality) where core staff know one-another and can agree between them what activity needs to be undertaken and how to resource it.

Annex F. Public Health Contribution to Community Planning and Health and Social Care Partnerships

Public Health Function

1. A public Health function needs to work across all structures to successfully support and influence partners to deliver public health outcomes: NHS, local government, private and voluntary sector, Health and Social Care Partnerships and Community Planning Partnerships. In many areas this is already happening. The Public Health Review endorses this approach and seeks increased leadership and visibility of an appropriately resourced public health function within the NHS and across these partnerships.

2. The work by the Royal Society for Public Health (RSPH) has provided a definition of the contemporary public health workforce encompassing consultants and specialists, public health practitioners and a wider workforce across the academic, public and third sectors (Rethinking the Public Health Workforce (Royal Society for Public Health, 2015) and Tackling health inequalities: the case for investment in the wider public health workforce (Royal Society for Public Health (RSPH), 2014)). Within NHS Board and wider Partnership work there are examples where the local public health workforce can work effectively to common goals for population health and wellbeing and for better services, sometimes using the local Director of Public Health annual report or a needs assessment as a stimulus for action. The Public Health Review has the potential to strengthen synergy and collaboration between the work of public health staff in local and national Health Boards, and between Boards and local partnerships and voluntary organisations, in order to improve local services, leading to better outcomes and contribute to reducing inequalities.

3. Public Health can provide oversight, advocacy and facilitation to help reduce duplication across agencies and maximise outcomes. Public Health has expertise in, and responsibilities for, surveillance and assessment of population health and wellbeing; identification of health problems and hazards in the community; and evaluation of the quality and effectiveness of personal and community health services. This role should drive the analysis and mapping of the activity that supports Health and Social Care Partnerships and Community Planning Partnerships, as well as work within NHS Boards and Local Authorities. It should ensure that the collective effort maximises the potential input and positive impact on the population's health.

Context for partnership working

4. The Public Bodies (Joint Working) (Scotland) Act 2014 provides an environment for more consistent and effective application of public health expertise in preventing premature, disabling illness and death and improving services and quality of life for people who are frail or vulnerable across many health and social care functions of Local Authorities and Health Boards.

5. The Public Health etc. (Scotland) Act 2008 requires NHS Boards, in consultation with Local Authorities, to develop a local Joint Health Protection Plan which provides an overview of health protection (communicable disease and

environmental health) priorities, provision and preparedness for the NHS Board area. The plan reflects agreed local priorities and supports joint health protection working through maintaining local links and delivering joined up approaches.

6. The reforms to community planning contained in the Community Empowerment (Scotland) Act 2015 specify Local Authorities, Health Boards and Integration Joint Boards (health and social care) and others, as statutory partners in Community Planning.

7. The Community Empowerment Act extends the statutory duty of cooperation beyond health, local authority and education, and places a responsibility on all partners to work collaboratively to carry out community planning and to take account of the local outcome improvement plans in carrying out the partner's own functions and to contribute staff, funds and other resources as appropriate.

8. This provides the opportunity for Health Boards and Public Health Departments to get even more involved in supporting Community Planning Partnerships and Integrated Joint Boards, as well as NHS Board services and Local Authorities, in delivering the stated outcomes and also in working closely with partners to inform strategy and delivery so that they can provide a greater contribution to improving population health, tackling inequalities in health, and improving access to services. This opportunity should be capitalised on now as the intention is that partners should already be supporting community planning consistent with the principles in the Community Empowerment Act leading up to its enactment. Public Health can contribute to a public sector prioritising early intervention and preventive spend as envisaged by the Commission on the Future Delivery of Public Services in 2011.

9. In addition Health Boards and Local Authorities, as governance partners under the Act, become collectively responsible for effective community planning. The Public Health Review recommends that NHS Boards make more explicit their specialist public health contributions to working closely with partners to take forward these efforts. This should include advice and support to improve the health, wellbeing and sustainability of local communities; deliver equitable services that reduce inequalities; and evaluate their impact. This will include providing leadership and skills to help ensure that all areas implement a Health in All Policies approach; undertake integrated impact assessment of strategies, policies and plans, particularly resource allocation; and equity audit service delivery.

10. The expectation that Boards should use this ongoing opportunity, exhibit the behaviours and embrace the principles of community planning is contained in the current Local Delivery Plan guidance for NHS Boards for 2015-16 (December 2014), which asks NHS Boards to *"indicate how they will continue to strengthen their approach to community planning during 2015/16, through both their direct contributions and how they demonstrate leadership within the CPP. This should focus on how the CPPs act to improve local priority outcomes which relate to health and wellbeing, and how they shift activity and spend towards tackling inequalities, prevention and community empowerment."*

Public Health role in partnerships

11. Public Health's focus includes developing and improving evidence-based health and social care through the careful assessment and planning for health needs, and the inclusion of prevention strategies, quality considerations, efficiency, equity, and ensuring health impact at a population level over the longer term. There is a synergy between the delivery of health improvement interventions that are integral to the provision of effective health care - such as adult immunisations, that are delivered within Health and Social Care Partnerships - and the work at neighbourhood level to improve local outcomes and reduce inequalities within the context of community planning. Public Health teams have the skills required to ensure that these synergies are realised to achieve better population health and wellbeing outcomes.

12. The potential impact of Public Health working with Community Planning Partners is wider still given that community planning involves a broader range of partnership structures and a clearer focus on reducing inequalities and responsibility around wider determinants of health. For example, Public Health can contribute expertise to Local Housing Partnerships to ensure Local Housing Strategies are drafted with population wellbeing across the life course in mind. Public Health can also effectively contribute to Local Authorities and other partnership work covering areas such as Planning, Education, Transport, Employment and Criminal Justice.

13. Integration Joint Boards' remit also includes strategic planning and performance monitoring across a broad range of health and social care services, incorporating the input of the voluntary agencies, independent sector and others. Public Health can provide support for the development of services that reduce health inequalities while delivering improved health and benefit at a population level by preventing disease and improving health-related outcomes through equitable and appropriate access to, and utilisation of, effective health and care interventions. Similarly, Public Health can provide support for effective delivery of Local Authority services to those most in need, including a focus on early intervention and reducing inequalities.

14. There also needs to be strong links to the shape and balance of wider services provided directly by NHS Boards, primarily acute services. To do this they must ensure equity of current provision of prevention, treatment and care, but also need to make a contribution to Community Planning Partnership work on factors affecting the health and wellbeing of the population. The effects of improvements to care and service developments can last for decades, leading to sustained improvement in population health and sustained delivery against organisational goals and priorities.

15. The Director of Public Health Report will continue to provide independent advocacy and a voice for public health actions and responses across the Board's area and reflect the specialty's wider responsibilities for the population's health. The Report should encompass delivery of all of the essential public health operations while highlighting existing strengths and current and emerging challenges to health and wellbeing. The Director of Public Health Report will reflect the priorities for action set by Community Planning Partnerships,

Integration Joint Boards, NHS Board services and Local Authorities, and help to inform ongoing activity as part of the collective effort to improving population health and tackling inequalities. It is recommended that Public Health, as a discipline, needs to contribute effectively to the work of senior Community Planning Partnership and Integration Joint Board groups such as the Strategic Planning Group in all local areas.

Summary of Public Health input into Health and Social Care Partnerships and CPPs:

Strategic
- Enable organisations to take a "Health in All Policies" approach at national and local level.
- Provide leadership, advocacy and support to partners to reduce health inequalities, such as by shaping actions to reduce barriers to health and improved living and working conditions.
- Advise on approaches to prioritisation to help ensure that our services focus on areas of greatest population need whilst also ensuring a balanced approach to maintain equitable access to more specialist or intensive services for groups of people who have high or particular needs for which effective intervention exists.
- Provide advice and input on integrated impact assessment, and to help ensure that service evaluation and equity audit are undertaken and that robust prioritisation processes are in place, e.g. that proposals for investment, development and change are assessed for likely effectiveness, opportunity cost (foregone alternative use of resources), affordability and value.
- Embed early intervention, preventive and quality improvement approaches at partnership level.
- Public Health, as a discipline, needs to contribute effectively to senior CPP and IJB groups, such as the Strategic Planning Group, in all local areas and within NHS Boards and Local Authorities.
- Joint planning of health protection to ensure resilience of health protection function through Joint Health Protection Plan.

Health Intelligence and Analysis
- Provide advice and oversight and develop a shared understanding across NHS Board areas; Local Authorities; with the IJB; CPP; and other key partners, on population health and wellbeing including patterns of health and disease and the main determinants of health for defined populations.
- Provide independent interpretation of published evidence; available data or other relevant and important knowledge sources; and inform and support evidence-informed and value-based decision making, with the aim of ensuring equitable access to effective, safe, person-centred and integrated health care services.
- Lead and provide support for Health Needs Assessment to identify need and support service redesign and improved resource allocation through the

identification of populations that are most able or most likely to benefit from care.

- Support the use of (integrated) health impact assessment to ensure unintended impacts on people with high levels of need are identified and addressed, and delivery of services tackles health inequalities.
- Support capacity building in HSCPs and Local Authorities through training in epidemiology, demography, data interpretation, and support with more complex analyses (such as health economics) including monitoring and evaluation. This can be facilitated by DPH oversight of allocation of NHS time of academic public health staff, links with academic units and other sources of expert knowledge and skills.

Delivery of services by IJBs/HSCPs, Local Authorities and NHS

- Support the design and delivery of services that meet the needs of all groups, promote accessibility and effective use by the most vulnerable, i.e. proportionate universalism including specific services for vulnerable and marginalised groups, recognising their particular and often greater complexity and level of need, e.g. welfare advice in health settings, inequalities in service access, social support, supported self-management.
- Specialist Public Health directly coordinates and quality assures specific population health programmes such as for screening and immunisation.
- Provide leadership for evidence-based health improvement interventions across Health Board, IJB, Local Authority, third sector and Community Planning, including assets based approaches.
- Maintain local links and delivery of local health protection priorities as identified in the Joint Health Protection Plan.

Annex G. Glossary of Terms

2020 Vision: Set out by the Scottish Government in 2011 to give the strategic narrative and context for taking forward the implementation of the Quality Strategy. The Vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

Chief Dental Officer (CDO): The professional advisor to the Scottish Government and civil service on all matters relating to dentistry.

Chief Medical Officer (CMO): The most senior advisor on health matters in a government. In the Scottish Government the CMO heads up a Chief Medical Officer Directorate responsible for working with Ministers, delivery partners and other stakeholders to protect and improve public health, promote sport and physical activity and to support the generation of robust evidence, and to oversee the clinical effectiveness of healthcare services in Scotland.

Communicable Disease: Any disease transmitted from one person or animal to another; also called contagious disease.

Community Planning Partnership (CPP): There is one CPP for each Local Authority area. Under the Community Empowerment (Scotland) Act 2015, public bodies work together and with the local community in CPPs to plan for, resource and provide services which improve local outcomes and reduce inequalities in the area. Public sector partners include the Local Authority, Health Board, enterprise body, Police Scotland, the Scottish Fire and Rescue Service, regional colleges, Skills Development Scotland, IJB and others.

Consultants in Dental Public Health: Dentists who complete specialist training in epidemiology strategic planning, statistics, health promotion, leadership and management. They fulfil a dual role of principal advisor to the NHS Boards on all matters relating to dentistry and improving the oral health of the public.

Consultants in Public Health Medicine/Specialists in Public Health: Professionals from medical and non-medical backgrounds who train to become consultants/specialists in public health through demonstrating knowledge and competency in nine key areas. Their competence and validity to practice is assessed by the Faculty of Public Health.

Core public health workforce includes DsPH, Consultants/Specialists and those who specialise in one or more of the Domains of Public Health.

Domains of Public Health: There are three key domains of Public Health, defined as Health Improvement, Improving Services and Health Protection. All are underpinned by public health intelligence (information and evidence).

Directors of Public Health (DPH): Heads of the Directorates of Public Health in each Scottish Health Board; chief source of expertise and advice to the Health Board about action needed to protect and improve the health of people in the area.

Engagement Responses: Responses to an engagement paper and through stakeholder engagement workshops. The engagement paper asked 5 questions on the subject of public health *partnership, leadership* and *workforce.* The responses were analysed by an independent external research company to inform the consideration of the Review Group. Stakeholder engagement workshops were also held to build on the themes identified in the engagement responses.

Environmental Health: Environmental health is the branch of public health that is concerned with all aspects of the natural and built environment that may affect human health

Faculty of Public Health is the standard setting body for specialists in public health in the United Kingdom.

Health inequalities are systematic differences in health between different groups in society which are potentially avoidable and deemed unacceptable.

Healthy Life Expectancy: Life expectancy (LE) is an estimate of how many years a person might be expected to live, whereas healthy life expectancy (HLE) is an estimate of how many years they might live in a 'healthy' state.

Integration Joint Board: Established to bring together adult health and social care services, as required from April 2015 by the Public Bodies (Joint Working) (Scotland) Act 2014. The alternative integration model is the lead agency model adopted in Highland.

Non-Communicable Disease (NCD) is a medical condition or disease that is, by definition, non-infectious and non-transmissible among people.

Public Health: the activity associated with "the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society".

Public Health Practitioners work as part of the core public health workforce, often as part of a team led by someone working at a higher level, but also operating independently. They have responsibility for specific areas of work (e.g. smoking cessation, infection control) and work in a wide range of settings and sectors.

Quality Strategy: Scottish Government strategy - Healthcare *Quality Strategy for NHS Scotland* (Scottish Government, 2010).

Research analysis commissioned specifically for this Review to cover analysis of research literature, including a review of international evidence on health policies and different governance and accountability structures to inform the Review Group.

Scottish Directors of Public Health (Scottish DsPH): Group bringing together all Directors of Public Health in Scotland, regularly meeting with the CMO and Scottish Government.

Shared Services: portfolio of programmes, originating from the NHS Senior Leaders' (formerly the guiding coalition) and project managed by NSS, to provide vision for shared services (collaboration, partnership working, joint management arrangements, contractual arrangements to deliver services on behalf of others etc.) which includes within its scope public health and business intelligence (the latter having potential relevance to public health intelligence).

Single Outcome Agreement (SOA): A strategic document produced by each Community Planning Partnership based on the terms of a Scottish Government and COSLA agreed Statement of Ambition on community planning and reflects SOA guidance on priorities, issued by Scottish Government and agreed with COSLA. Under the Community Empowerment (Scotland) Act 2015 these will become known as Local Outcome Improvement Plans (LOIP).

Single Outcome Agreements: Collective term for Single Outcome Agreements of all CPPs. Under the Community Empowerment (Scotland) Act 2015 these will become known as Local Outcome Improvement Plans (LOIPs).

(Social) Determinants of Health: the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequalities.

The public health function (or endeavour) can be defined as "a robust, adequately resourced system that can secure and sustain the public's health, addressing health and associated policy issues at a population level and leading a co-ordinated effort to tackle underlying causes of poor health".

The public's health, population health: The aggregate health status of people in a defined geographic area, as measured using standard indicators of health and wellbeing.

Wider public health function/workforce: In addition to the core public health workforce, many other professional groups, practitioners in different disciplines, organisations and individuals make an essential contribution to protecting and improving the public's health and wellbeing. Collectively these form the 'wider public health workforce'.

Annex H. Abbreviations

AHPs: Allied Health Professionals

CDO: Chief Dental Officer (in the Scottish Government)

CDPH: Consultant in Dental Public Health

CfWI: Centre for Workforce Intelligence

CMO: Chief Medical Officer (in the Scottish Government)

CPPs: Community Planning Partnerships

DPH: Director of Public Health (in Scotland)

EHOs: - Environmental Health Officers

HEAT: Hospital Efficiency and Access Targets

HIS: Healthcare Improvement Scotland

HLE: Healthy Life Expectancy

HPS: Health Protection Scotland

HV: Health Visitor

IJB: Integration Joint Board

ISD: Information Services Division (of NSS)

LOIP: Local outcome improvement plans

NES: NHS Education for Scotland

NHS: National Health Service

NHSHS: NHS Health Scotland,

NSS: NHS National Services Scotland

OECD: Organisation for Economic Co-operation and Development

PHorCast: Public Health Online Resource for Carers, Skills and Training

PSR: Public Service Reform

ScotPHN: Scottish Public Health Network

ScotPHO: Scottish Public Health Observatory

SDsPH: Scottish Directors of Public Health (as a Group)

SHPMs: Scottish Health Promotion Managers

SOA(s): Single Outcome Agreement(s)

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