ScotPHN report

Scottish Public Health Network (ScotPHN)

New Ways of Working for Public Health: Providing Specialist Public Health Input to Community Planning Partnerships and Integrated Joint Boards

Julie Arnot, Phil Mackie

February 2019

Contents

Acknowledgements

Julie Arnot would like to thank all of those participants who completed the online questionnaire and particularly those who participated in the interviews, and answered the many questions that form the bedrock of this report. Your contribution to this work is appreciated. Thank you also to NHS Health Scotland colleague Emma Kennedy.

Executive Summary

Introduction

Community Planning Partnerships (CPPs) are at the centre of Scottish Government aspirations for public service delivery in local communities. Interwoven with this is the emergence and development of Integrated Joint Boards (IJBs) and ongoing activity towards reforming the public health landscape. To understand how these changes are affecting local public health delivery, ScotPHN has undertaken repeated surveys to tease out public health engagement and alignment with CPPs, and latterly, IJBs. This survey is the latest update in this ongoing work. As in previous surveys, it has used a qualitative approach, specifically interviews primarily with Scottish Directors of Public Health.

Context

The CPP and IJB landscape is not uniform and each has evolved, creating divergent approaches, within as well as between local NHS Board areas. Public health and health improvement engagement with these structures reflects this and there is variability in representation in terms of staff seniority and capacity to meet the competing demands of multiple, complex structures, working across a diversity of themes.

Expertise

Interviewees were reasonably confident that they, or their wider team, were a key source of public health or health improvement expertise, where sought by CPP and IJB partners. Several mentioned that improved communication with other organisations that provide expertise would be useful in supporting collaborative working and coordinated input.

Impact of wider public health reform / national public health priorities

Most interviewees thought that there had been a positive change in their engagement with CPPs or IJBs as a consequence of public health reform. The national public health priorities tended to be viewed as aligning, to a greater or lesser extent, with pre-existing priorities. They also provided a mechanism to influence CPP agendas and enhance activity. The national priorities could be viewed as (beneficially) broad or too wide and difficult to pin down to some key activities.

Community Planning Partnerships

Public health input to CPPs

Public Health and health improvement staff are contributing to CPP core and priority work areas including: LOIP and locality plans; leading or participating on locality, partnership and thematic groups; the development and delivery of actions addressing priorities; needs assessments and evidence reviews; and support for the Community Empowerment Act. Activity varies across CPPs, reflecting capacity to pursue multiple topic areas.

Alignment, engagement and influence

Public health or health improvement team priorities were thought by interviewees, in the main, to align well with those of CPPs and national priorities. Most could point to opportunities to engage with CPPs and to shape, lead and influence the agenda, with most interviewees experiencing little difficulty in getting public health issues on the agenda. Influence varies across CPPs and by topic area. Having influence over the agenda however does not necessarily lead to the desired levels of engagement and action by CPP partners.

Prevention, health inequalities and population health improvement

Responses indicate that there are varying degrees of focus on these themes from CPP to CPP, as evidenced in the LOIPs. Partner understanding was considered to be variable and public health and health improvement interpretations of inequality were not necessarily aligned to those of CPP partners. Moreover, resources and funding are not necessarily targeted at upstream prevention and translating ambition into action is challenging.

The Community Empowerment Act

The extent to which the Act is changing the nature of how public health and health improvement teams interact with CPPs is variable but benefits were identified. The responses pick up on aspects of the Act, with reference to engagement, better understanding of inequalities, participatory budgeting, community engagement and community assets but there were concerns around financial challenges and support for activity.

Barriers and challenges

Barriers and challenges that limit effective CPP participation include: problems inherent in engaging meaningfully with multiple, complex structures; the wider economic and social context; and changes in service demand. Challenges exist around: capacity issues; defining and agreeing priorities; CPPs deemed too heavily tied to local authorities; vested interests opposed to public health; the lack of maturity of structures; and limited resources, preventing joint planning and pooling of resources.

Integrated Joint Boards

Activity and expertise

Public health and health improvement staff are contributing to various activities under the auspices of IJBs including: mental health; data and health intelligence work; horizon scanning; epidemiological evidence; strategic planning and assessment; capacity building; skills development; needs assessment; and quality improvement. Respondents stated that public health or health improvement expertise has been utilised by local IJBs in IJB-led service re-design or development, but not fully.

Engagement and influence
Most respondents felt that IJBs provided an opportunity for engagement and influence, with support from IJB Chief Officers identified. For most respondents this was not to the same extent as local CPPs. The degree to which the agenda might be shaped was variable, with significant barriers identified including heavy IJB focus on finance, crisis management and downstream crises.

Prevention, health inequalities and population health improvement
There is evidence that prevention, tackling health inequalities and population health improvement have been taken on board by some IJBs. How far this agenda can be supported and prioritised given competing demands placed on IJBs and limited resources is less clear.

Barriers and challenges
Challenges and barriers limiting effective IJB participation include: IJB focus on finance and crisis management; resource issues such as lack of capacity, and the competing demands on staff time to contribute to differing combinations of IJBs, CPPs, the Local Authority and the NHS Board. The failure of NHS and Local Authority cultures to be sufficiently integrated and that IJBs, and CPPs may also be viewed as being at the mercy of political considerations and changes wrought by local elections are further challenges.

Need for National Support

ScotPHN / Public Health Scotland
Interviewees were asked to identify how ScotPHN and – in due course – Public Health Scotland could support their CPP or IJB activity. They were keen to see connections, and clarity, between local and national working, evidence to support key topics, best practice, the national public health priorities, training provision and the reduction of unnecessary duplication of effort. There was some support for further opportunities for interviewees to share their experiences of working with CPPs and IJBs.

Conclusion

This study further contributes to our understanding of public health and health improvement staff engagement with CPPs and IJBs and we can make a number of broad statements based on the findings. Interviewees and wider teams are clearly a key source of expertise for CPPs, and they continue to be successful in influencing CPP agendas. How far this is leading to action and activity, amid the wider context of retrenchment and limited capacity is less clear. The focus on prevention and inequalities is variable and limited, dedicated resource might be acting as a brake on upstream working to address these issues.

Interviewees and wider teams are also clearly involved in activities to support IJBs although shaping IJB agendas to include a focus on prevention, inequality reduction and population health improvement is not straightforward. This may not be surprising given IJB

responsibilities associated with service provision and funding challenges. How the agenda may be influenced to push activity upstream was not necessarily clear to interviewees.

The findings of this report, our third, indicate that as CPPs and IJBs have evolved, interviewee and wider team support for these structures has also evolved, with continued variation in how the structures work and the nature of the public health input. There is a greater degree of understanding in how public health can best engage locally within CPPs and IJBs and interviewees and wider teams have become more able to use their experiences to exert local influence and effect change although barriers and challenges remain.

1 Introduction

The public service reform landscape and the nature of local and regional partnership working and collaboration in Scotland continues to evolve and new legislation, most recently the *Community Empowerment Act* (Scotland), is changing what is demanded of the public sector. To understand how these changes are affecting local public health delivery, ScotPHN has undertaken repeated surveys with the specific aim of teasing out public health engagement and alignment with Community Planning Partnerships (CPPs), and latterly, Integrated Joint Boards (IJBs). This work was published as:

R. Walton & P. Mackie. (2015) *New Ways of Working for Public Health: Providing Specialist Public Health input to Community Planning Partnerships and Integrated Health and Social Care Arrangements.*[1]

McCann & P. Mackie. (2017) *New Ways of Working for Public Health: Providing Specialist Public Health Input to Integrated Joint Boards for Health and Social Care and Community Planning Partnerships: An Update.*[2]

The formal evidence base in Scotland, related both to CPPs and IJBs is slight, but it is developing. This is beginning to better frame our understanding of how these structures work, as well as emerging challenges and potential solutions.[3] [4]

CPPs are at the centre of Scottish Government aspirations for public service delivery in local communities. The *Community Empowerment Act* (2015) expects CPP participation across a range of partners, the development of local outcome improvement plans (LOIPs), replacing Single Outcome Agreements, to set out agreed outcomes to be prioritised for improvement particularly around inequalities, and improved outcomes for the most disadvantaged, as well as 'locality plans' for smaller areas with the poorest outcomes, with partners taking account of these and contributing appropriate resources. LOIP and locality plan priorities might differ, but they must be reviewed and progress reported.[5] [6]

---

[1] Walton R & Mackie P (2015). *New Ways of Working for Public Health: Providing Specialist Public Health input to Community Planning Partnerships and Integrated Health and Social Care Arrangements Available from:https://www.scotphn.net/wp-content/uploads/2018/09/2015_01_16_CPPs_Consolidated_Report_Final.pdf*

[2] McCann A & Mackie P (2017). *New Ways of Working for Public Health: Providing Specialist Public Health Input to Integrated Joint Boards for Health and Social Care and Community Planning Partnerships: An Update.* Available from: https://www.scotphn.net/wp-content/uploads/2015/10/2017_07_25-NWW-IJB-CPP-Update-Report_Final.pdf[3] Baylis A and Trimble A. (2018) *Leading across health and social care in Scotland. Learning from chief officers' experiences, planning next steps*. London: The Kings Fund. Available from: https://www.kingsfund.org.uk/sites/default/files/2018-07/Scottish_officers_full_final.pdf

[4] Audit Scotland. (2018) *Community planning: an update. Impact report*. Available from: http://www.audit-scotland.gov.uk/uploads/docs/report/2018/ir_180824_community_planning.pdf

[5] Scottish Government. *Community Empowerment (Scotland) Act: summary*. Available from: https://beta.gov.scot/publications/community-empowerment-scotland-act-summary/

[6] NHS Health Scotland, Audit Scotland, Improvement Service. (2018) *Local Outcomes Improvement Plans Stock-take. Emerging Themes*. Livingston: Improvement Service. Available from:

CPPs face challenges in delivering change, improving outcomes and evaluating impact, in an increasingly complex and crowded reform landscape. Audit Scotland reports some progress in delivering services but not yet to the extent envisaged in terms of, "*sharing, aligning, or redeploying their resources in significantly different ways and on a larger scale*" and in involving communities in the planning and delivery of local services."[7]

Progress towards the expectations set out by the *Community Empowerment Act* appears patchy, with recent research indicating that CPPs should improve levels of community participation and representation, and lower current barriers to community participation[8] although there appear to be 'genuine attempts' to do so.[9] Moreover, LOIPs, highly variable in focus and scope, are making some headway in terms of stating their ambitions to reduce inequalities but require greater clarity around how the biggest impact may be achieved.[10]

Interwoven with this activity is the emergence and development of IJBs. Recent research by The Kings Fund suggests that IJBs can provide some evidence of service transformation and improvements in joint working to achieve this but progress to integration is a work in progress and activity uneven. Integration is deemed easier where commitment to this is reciprocated across IJB partners, considerably more problematic where, "*historical boundaries of hierarchy and sectoral interests prevail*".[11] Audit Scotland's recent update on integration points to some improvements in collaboration and developments in activity but within a wider context characterised by financial pressures that make it difficult for integration authorities to achieve meaningful change.[12] To add further complexity, the models adopted by each CPP and IJB will diverge and each structure will be at a differing stage of development and maturity; discussion, processes and practice will be guided and managed in multiple, different ways.

In parallel with this, work towards reforming the public health landscape is progressing and this also places greater emphasis on collaboration and partnership working. Seeing if, or how, this reform is generating any appreciable change in public health's relationship with CPPs and IJBs is therefore, of interest. Against this background, it was felt that this was a useful time to revisit the work around CPPs and IJBs. In line with pre-existing ScotPHN activity, this document applies a primarily qualitative approach in order to:

---

http://www.improvementservice.org.uk/documents/community_planning/loip-stocktake-emerging-findings-may2018.pdf

[7] Audit Scotland, *op. cit*.

[8] Weakley S and Escobar O. (2018) *Community Planning after the Community Empowerment Act: The Second Survey of Community Planning Officials in Scotland*. What Works Scotland. Available from: http://whatworksscotland.ac.uk/wp-content/uploads/2018/11/WWSCPOsSurvey2018CommunityPlanningAftertheCEA.pdf

[9] NHS Health Scotland, Audit Scotland, Improvement Service, *op. cit*.

[10] *Ibid*.

[11] Baylis and Trimble, *op. cit*.

[12] Audit Scotland. (2018) *Health and social care integration: Update on progress*. Available from: http://www.audit-scotland.gov.uk/uploads/docs/report/2018/nr_181115_health_socialcare_update.pdf

- provide an update on the current alignment of public health and health improvement teams to CPPs and IJBs; and
- consider what, if any, specific additional support needs Scottish Directors of Public Health have identified from ScotPHN and Health Scotland / Public Health Scotland that might support their activity with CPPs and IJBs.

2 Approach to Data Collection

This report asked Scottish Directors of Public Health (SDsPH), or a nominated representative (Deputy DPH, health improvement manager, Consultant in Public Health Medicine, senior researcher) a short number of questions (six) delivered in an online format (using LIME Survey tool) during September 2018 and sent to all SDsPH. The questions (see Appendix 1) sought to gain a brief overview of:

- the number of CPP and IJB structures in local health board areas;
- health representation across local IJBs and CPPs;
- public health direct involvement or input to IJBs and CPPs;
- other non-public health department sources of public health advice used by IJBs and CPPs; and;
- any perceived change in activity in relation to drawing on public health expertise across CPPs & IJBs as a consequence of moves towards public health reform.

Ten online responses were received and these were supplemented by a more extensive range of telephone interview based questions. Twelve semi-structured interviews were conducted with SDsPH or a nominated representative. One DPH did not take part in the telephone interview but provided some information via the online questionnaire. The interview guide is available in Appendix 2. The approach was iterative, and as data was gathered from interviewees this further shaped understanding and context, although all respondents were asked the same set of questions, with additional questions posed, where appropriate. NVIVO (v12)[13] was used to manage and code interview data. Codes were generated before and after collecting interview data and so deductive and inductive codes were generated.

A number of the questions used are in line with those asked by Walton and Mackie (2015), with the aim of generating comparison in activity between that reported in 2015 and the current position. Walton and Mackie did not ask SDsPH about IJBs, given their very limited development at that time. The current interview-based questions sought specifically to elicit responses around CPP and IJB engagement, influence and activity, barriers and challenges

[13] For further information about NVIVO (v12) see QSR International: https://www.qsrinternational.com/nvivo/support-overview/downloads

to this and CPP and IJB focus on prevention, tackling health inequalities and population health improvement. Further questions centred on how ScotPHN, and Public Health Scotland might support the SDsPH in current and future CPP and IJB activity.

Question responses, as will be shown below, provide evidence of variation in experience but some common themes arise too. The interviewees are to some extent working out the lie of the land, this is unsurprising given ongoing change and it must be noted that not all of those who participated in interviews were able to provide full first-hand accounts of work with all CPPs or IJBs within their NHS Board area. This was a consequence of their engagement being primarily with one CPP and or IJB, with considerably less engagement with the remaining CPPs or IJBs. However all interviewees were able to provide a response to most or all of the questions.

3 The General Context

3.1 Local Approaches to Integration

There are 32 CPPs and 31 IJBs (most IJBs operate using a Body Corporate model, with the remaining one a Lead Agency model). The landscape is not uniform, each apply divergent approaches, within as well as between local Board areas. Public health and health improvement staff engagement with these structures reflect this. It's not possible within the scope of this work to provide a comprehensive overview of public health and health improvement representation, engagement and activity across all CPPs and IJBs. However we know that there is variability in representation across these structures in terms of staff seniority and capacity to meet the competing demands of multiple, complex structures, working across a diversity of themes.

Public Health input to CPPs is not a requirement, though most DsPH sit on at least one CPP Board. Where there are multiple CPPs, there are significant challenges in being able to dedicate the necessary time and capacity for one DPH to participate comprehensively in all CPPs. As a result not all CPP Boards have a DPH as a member, but most include senior public health or health improvement representation. One CPP Board is currently without DPH or other public health or health improvement representation as a matter of local policy. Consequently the DPH in question was currently exploring the barriers to this, calling for:

"*Some directive that says public health needs to be involved around these tables*".

Most interviewees were able to provide information around further public health or health improvement staff engagement. These included: CPP management groups; lead officers groups; across topic or theme specific partnership and delivery groups/ sub-groups; community partnerships; LOIP work-streams; and locality partnership groups.

Most DsPH sit on at least one IJB. One sits as a proxy substituting for absent members, several attend as advisers or expert practitioners. Several DsPH, but not all, sit on all IJBs within their local Board area. Another sits on a strategic planning group. Alternatively consultants, or other staff, fulfil this role or attend IJB Strategic Planning Groups, or a health and social care committee overseeing integration, depending on local arrangements. In terms of the relationship between IJBs and the CPPs, several participants (three) stressed that irrespective of the name of structure (CPP or IJB), there could be significant overlap in those attending. This was particularly so for small boards, leading to a sense of duplication. As one pointed out, this resulted in a reliance on a limited core of individuals and where posts are unfilled this places pressure on other parts of the system.

Most could identify an IJB / Health and Social Care Partnership (HSCP) presence at the CPP. From the information provided, it is not clear if a formal role for the IJB actually exist for all CPPs. Where it does, IJB / HSCP engagement takes place across varying levels of the CPP structure, or at Board level. These were variously described as: IJB Chair; the Chief Officer; the joint director of the HSCP; NHS Board Chief Executive; chief accountable officer of the HSCP; or non-executive directors. The nature of that relationship tended not to be explored, but one participant did comment that in their experience there wasn't a "*good formal relationship*" between the IJBs and CPPs and while in their opinion IJBs had initially been characterised as part of community planning, there had been a tendency by IJB chief officers to create IJBs, "*in their own image*" and very distinct from CPPs.

3.2 Providing Public Health Expertise

Irrespective of the complexity of local working arrangements with CPPs or IJBs, interviewees were reasonably confident that they, or their wider team, were a key source of public health or health improvement advice and expertise, where sought by CPP and IJB partners. Other providers were thought to include the Local Intelligence Support Team (LIST), NHS Health Scotland, Scottish Government, the Glasgow Centre for Population Health (GCPH), ScotPHN, Third sector, What Works Scotland, HSCP health improvement teams and work commissioned from academia. One interviewee observed, from undefined sources, that public health had been bypassed altogether by the CPPs, though less so by IJBs. Moreover, a coherent approach to the management of information sources that might benefit both IJBs and CPPs was generally thought absent by this participant, but potentially worthwhile.

There was some concern expressed by several DsPH that organisations including Health Scotland and GCPH had offered, or been approached to provide information or support, but this had not necessarily been communicated to local public health or health improvement staff. The conclusion drawn was that awareness of this by local public health teams might have generated collaborative working and a consistent and coordinated input. It was, however, also pointed out that Health Scotland's input had been useful where local resources were not sufficient to respond to demands.

3.3 Impact of Public Health Reform

The extent to which wider public health reform might be driving a change in the nature of how public health or health improvement staff engage with CPPs or IJBs was explored. Responses tended to indicate that most interviewees thought that there had been a positive change in engagement, even if variable, in the form of greater demand for public health involvement, a change in the nature of discussions, an appetite for information about the public health priorities, increased requests for information and support, local discussion about the wider and specialist workforces, and where activities should sit.

One interviewee described demands for support as '*inordinate*', impacting on staff capacity to respond. Another commented that the ability of CCP/IJBs to act on requested advice may prove to be particularly problematic. Several deemed it too early to gauge progress at this stage; though one was unsure if this was a result of it being difficult to gauge the current position, or there was insufficient clarity on which to base a judgement, or simply that they felt engaged and influential anyway. Another interviewee pointed out that public health, and more broadly, wider public sector reform is not a new experience for CPP partners, given the considerable overhaul in their approaches to enable improved working with public sector partners (e.g. the Police and Fire Service reforms).

Discussion around the national public health priorities emerged through several of the interviews, although a direct question was not included in the interview schedule. These tended to be viewed as aligning to a greater or lesser extent with pre-existing priorities and also as a mechanism to influence CPP agendas. They were also seen to enhance activity, to allow conversations to start, to develop opportunities and engagement, to mirror and support already developed local priorities. One interviewee mentioned being involved in a mapping exercise across the CPPs and HSCPs to identify gaps in activities and to better position themselves to respond to the national public health priorities.

The priorities were viewed by one participant as giving, "*even more of an opportunity to link up the public health, CPP and HSCP work*", by providing a, "'*useful backdrop of areas to focus on*". Another stated that the priorities provide more legitimacy and impetus to take discussions to a "*range of places*". One was keen to gain greater influence around these, allowing them to push partners to think about them beyond having importance for 'health' only. For another, the priorities were yet to have an influence; although there was significant overlap with the priorities of the LOIPs. While for another interviewee the priorities hadn't been met by a particularly '*proactive response*' by partners.

Some saw the priorities as broad, "*they are so wide that you can capture pretty much anything and badge it against the public health priorities*", which was seen as beneficial. However, they also required narrowing to identify activity, and, more usefully, to identify activities that cannot be addressed without the collective input of partners.

Several viewed the priorities as too wide, "*themes*" rather than priorities, encompassing a range of potential activity with questions around what the key priorities within the main priorities could be, and that could make a significant difference and might allow CPP partners to collectively agree on and support. In contrast, one interviewee commented that in their view, the high level nature of the priorities was useful, allowing for adaptation across Scotland, thus requiring activity to take place around translation at the local level to enable this.

4 Public Health Input to Community Planning Partnerships

4.1 Activity

Public Health and health improvement staff are contributing to various CPP core and priority work areas. These include the development of activity at locality level, LOIP and locality plans, leading or participating on locality, partnership and thematic groups, the development and delivery of local and national priorities, delivering needs assessments and evidence reviews, support for the *Community Empowerment Act* as well as current or planned activity. This activity varies to a lesser or greater extent from CPP to CPP, and reflecting capacity to pursue multiple topic areas and around the wider determinants of health (poverty, welfare, housing, employment, economy, regeneration).

In terms of further activity, key joint planning or strategic commissioning arrangements with local authorities that might sit outwith CPPs, interviewee responses were mixed. The picture is clearly complex, with differing local arrangements around what may be outwith or within the sphere of the CPP. One interviewee was keen to stress that they were "*really focusing in on driving things through the CPP or...making connections to the CP*" but "*in reality, depending on the maturity of the CPP there is lots of joint work and planning going on with some or all of community planning partners that may not be badged as CPP.*"

Another interviewee thought that the majority of the key commissioning was happening at IJB and CPP level, but most interviewees identify a handful of joint planning or strategic commissioning arrangements and several of these activities emerge on a number of occasions. Interviewees identified various combinations of the following: health protection planning; community justice partnerships; alcohol and drug partnerships; civil contingency planning; local or regional resilience planning; children's services planning; early years; commissioning of third sector organisations by public health; engagement around poverty issues with a local authority and a joint executive management team for older persons' health improvement. In one local authority area, joint health protection planning is situated within the CPP and this might not necessarily be the experience elsewhere. Children's services planning sits within the CPP in another local authority area, as well as community justice, which appears to sit outwith community planning elsewhere.

One DPH was critical of the positioning of the local community justice partnerships outwith the structure of the CPPs. These were viewed as creating, "*duplication and extra work",*

given that, *"it is just the same people around the table who would be at any community planning meeting"* excluding several participants from the justice sector, who want to keep the partnership as a '*distinct entity*'. However, the DPH felt that such an approach to the partnership had the effect of isolating the issues around imprisonment and justice from the wider community planning arrangement that are heavily connected to justice outcomes. All of this was deemed to be taking place within the broader context of local authority staff turnover problems and stretched resources, including for the interviewee and the wider team.

4.2 Alignment, Engagement and Influence

Public health or health improvement team priorities were thought by interviewees, in the main, to align well with those of the CPP and to wider national priorities (even if not expressed in quite the same way). The national public health priorities were viewed as one means by which priorities might be more successfully aligned. However, one interviewee commented that while their priorities were well aligned, there remained a significant disconnect between the CPP priorities and national programme priorities (e.g. screening).
Most interviewees pointed to existing opportunities to engage with CPPs and to shape, lead and influence the agenda. In terms of influence, several characterised this as primarily one-way, in the sense that they had brought influence to bear on CPP aims and ambitions, rather than vice versa. Influence was noted as having been built on engagement over many years, on being embedded across the structure of the CPP, or as a consequence of making and fulfilling a commitment to align and influence the CPP and bring coherence to activity across CPPs amid a wider recognition of the *Community Empowerment Act* and public service reform. Most experienced little or no difficulty in influencing and shaping the agenda.

"It's very easy to get things on the agenda. You are pretty much pushing at an open door….. You are seen as a core partner."

"I think you are pushing at an open door. They are keen to look at public health and population health … I think there are lots of opportunities and I think we do take those opportunities and I think we do push the agenda a bit… There is no shortage of opportunities. It's about being in the right place at the right time."

"Yes, we can put public health issues on the agenda, we can bring a public health perspective to the discussions, yes absolutely."

"I would say we set their agenda. We work very closely together. We are very influential in the three local authorities. I don't think the local authorities would even dream to set their plans without our local public health team and health promotion team."

"I have to say it has been a bit of an open door, which is good."

The picture is complex however and so as one interviewee commented, "*We don't have any difficulty in getting what we want around the table*", but pushing partners to, "*think about how they play in to the CPP and what they should be putting forward*" was the challenge. This was in addition to ensuring that partners maintain a focus on improving the wider economic environment to positively impact on health, as well as sufficiently prioritising the inequalities agenda.

Engagement and influence, as a number of interviewees pointed out, is variable across local CPPs. This is not happening solely at CPP board level but also where the strategic and operational activity was deemed to be shaped. Clearly a range of factors might contribute to this, linked to differing structures as well as personnel related. As one interviewee pointed out, their ability to influence the agenda was in their view dependent on having gained access to the most appropriate forum within the structure of the CPP to be able to do so. For this interviewee, membership of a CPP strategic management group was deemed absolutely crucial in making connections and building relationships: in other words, "*joining the dots*" across the NHS, HSCPs, CPPs and locality groups. Other local CPPs not offering an equivalent opportunity, given differing structures, were viewed as undermining the potential to gain traction for health improvement staff at this level, although there had been an effort to ensure senior staff participation across all local CPPs. Activity at locality partnership level, as a lead officer, for the same participant, was another means by which significant influence and connection building could take place, as a real, "*go to partner*".

Some frustration was expressed that although the agenda might be influenced to incorporate and discuss public health and health improvement this does not necessarily lead to action or activity, or leads to variable levels of activity across CPPs. As one DPH working with multiple CPPs stated:

"[People are] supportive and there is no disagreement that this is important and we need to change things… nobody is disagreeing with our conversations… but we are struggling to get action out of it. I think that none of them [CPPs] would put up barriers to adding issues onto the agenda. They would all be very open to that. I suppose the variability is what do they do with that discussion and some are better at saying we'll take forward some action from that and with others it can feel that it has been a pleasant discussion with no ongoing action."

For another interviewee, their input into the CPP had been supported by partners and the opportunities to influence were there in varying degrees across CPPs. Discussions were taking place with one local authority chief executive around further reinforcing this by attaching a member of staff to the CPP and not simply attending committees. This was in addition to seeking better use of public health evidence with the aim of moving from a '*transactional*' to a '*transformational*' approach. The challenge, however, was perceived to be around the weight and volume of activity so, "*maintaining the momentum*" was viewed as problematic when other initiatives, such as those championed by government, arrive on a frequent basis:

"It's not that there isn't commitment, it's the pace we are able to deliver and take forward the change that I think is the problematic element."

Another interviewee commented that while public health is placed on the agenda, CPP partners were too wedded to their own organisational difficulties to take on board those highlighted by others. Pursuing public health and health improvement activity with council partners was problematic, evidenced by what they viewed as an inadequate level of support around alcohol, tobacco and healthy working lives:

"The CPP vehicle is maybe not quite as effective as it could be. So they listen to the DPH report, they listen to children and families and plans, they listen to the ADP plans, they listen to inequalities, but it's like all of these things, the individuals come with their own organisational problems and they don't want to take on anyone else's."

More generally this was thought to be attributable to financial issues, leading to a, "*pulling up the drawbridge*" rather than a lack of (improved) co-operation. Nevertheless, even if the CPP was not a generator of, *"grand strategic plans*" and was "*pretty ineffectual*", they thought that there were still some benefits attached to CPP participation. These were expressed variously as: building relationships; sharing views; and in supporting and ironing out problems across several agendas. As such, the CPP may not be the engine, but it is, "*the oil in the machine that lubricates change.*"

In terms of how interviewees perceived their engagement and influence across the wider social and economic determinants of health, one interviewee indicated that they were working with local CPPs around the health and homelessness, welfare reform, poverty and inequality agendas, which they had, "*really tried to push"* with CPPs. They were keen however, to develop further understanding around how CPP partners might influence the (national) public health priorities. However, the influence that could be exercised was noted to be variable. As one DPH pointed out, while they had been able to influence CPP committees, the level of influence was deemed more robust across some issues (e.g. health improvement), but less so for others including housing, education, employment, economy, or what they termed the, "*real public health inequalities agenda*". They felt the reason for this was that the "*council probably consider those as 'theirs' more than 'ours' and they maybe don't look to us for help*". The DPH noted that that council also viewed the *Community Empowerment Act* as having shifted Community Planning away from simply being a local authority function, drawing on health staff to provide, "*support*", to a function based on joint working. As a consequence:

"Council attitudes are starting to change off the back of that and we are genuinely seeing the CPPs as partnerships where we have an equal role and I think that does give us some opportunity to be more involved in… the real underlying causes of inequalities rather than the health items, the items that might traditionally be seen as NHS."

4.3 Prevention, Health Inequalities and Population Health Improvement

Across the prevention, health inequalities and population health improvement agenda, responses indicate that there are varying degrees of focus from CPP to CPP, as evidenced in the LOIPs.

Partner understanding was considered to be variable and public health and health improvement interpretations of inequality and deprivation were not necessarily aligned to those of CPP partners. One interviewee commented, in relation to one CPP, that recognition of the need for public health and collaborative working was perceived to be weak, as was a shared understanding of inequalities and deprivation. This was attributed to differing perceptions of inequality in that the CPP was based across affluent communities and saw rurality and gaining access to services as a form of deprivation.

Where an understanding of prevention, health inequalities and population health improvement was likely to be stronger, this was felt to reflect long-standing public health and health improvement staff input. One participant mentioned using tools to ensure that activity with partners incorporated a prevention and inequalities focus, which resulted in a greater emphasis on inequalities in discussions, as well as a focus on this in the context of the Community Empowerment Act.

In terms of the wider context, one interviewee was of the opinion that the inequalities agenda is likely to have been forced along to some extent by local CPP partners keen to get the best from dwindling resources. Furthermore, a desire to push these issues, as the same participant pointed out, might also be predicated on the ability of those leading and chairing CPPs to do so. Moreover, the overall effectiveness of these structures was viewed as:

"O*nly as good as and only as influential as whoever is chairing and who is the chief executive*."

One interviewee highlighted that, over and above the LOIPs, a CPP inequalities specific strategy had been in place in one of the local CPPs. This strategy was set to run across a period of 15 years and aimed at reducing inequalities across various themes (children, employment, environment, food, health). This was deemed as providing the, "*backdrop to really push forward with the public health agenda*", and that the, "*local authority is really signed up to addressing inequalities, they really get it. So it is a really rewarding place to be working in public health*."

Another interviewee mentioned that their local approach had been to avoid, as part of outcomes improvement activity, a focus on lifestyle and behaviour. Rather they had focussed on shaping policy and priorities around the wider determinants, reflecting longstanding public health, inequalities and poverty agendas that all partners could sign up to and support. They thought however, that there was less clarity around activity at local

level and how this work 'plays out' at local level. Other responses tended to be considerably less optimistic and were thoughtful about how a focus on prevention and inequalities might translate into activity and the necessary resources to provide that activity. One DPH commented that CPPs are good at talking about those issues and developing plans but are not good at, "*holding people [to] account to deliver those plans*", and all of this was made more problematic by complex structures and, for example, local IJB activity aimed at purloining health promotion staff and a hollowing out of local authority staff. Nevertheless the DPH felt confident that there was a clear vision and set of priorities agreed locally that health board senior staff supported.

Another DPH saw the need to ring fence resources to support prevention and health inequalities work so that, "*people have to spend it in that way*". They felt that until, "*it comes with a label and dedicated funding stream*", then in their view, resources would remain insufficiently targeted at upstream prevention. In terms of translating the ambition around these themes into any appreciable action, one DPH suggested that what could be useful were, "*solid examples*" of inequalities related activities, appropriate to the local rural and remote, context, and how these might impact locally. Nevertheless, as one DPH commented, in spite of not viewing sufficient progress to have been made against tackling health inequalities, the CPP had provided, "*us with an opportunity we wouldn't normally have*" to push this issue.

It's also worth pointing out that useful comments were raised by two participants about the difficulties attached to identifying and measuring deprivation and inequality in rural and remote areas. The Scottish Index of Multiple Deprivation was not necessarily viewed as helpful, the Hutton Institute's Socio-Economic Performance Index[14] was seen as more appropriate. Moreover one participant viewed applying the latter methodology as having helped CPP partners better understand the scale and nature of deprivation and had generated discussion. One expressed interest in working with partners (Public Health Scotland, academia) to further explore and develop understanding around the use of such tools.

4.4 The Community Empowerment Act

The extent to which the Community Empowerment Act is changing the nature of how specialist Public Health staff, or the wider public health and health improvement team, interacts with CPPs is variable. The responses pick up on various aspects of the Act. One interviewee hadn't observed any change, but was currently engaged in activity to increase involvement with multiple CPPs at senior and local level. This wasn't necessarily tied to the Community Empowerment Act but to a recognition of a lack of sufficient involvement. Further respondents indicated that change was expected to flow from this; one noted that, for example, participatory budgeting was now on the agenda; and another felt there was

[14] For further information about the Hutton Institute's Socio-Economic Performance Index see: https://www.hutton.ac.uk/news/socio-economic-performance-rural-scotland-highlighted-new-research

now a greater focus on addressing how community engagement might be improved. One interviewee pointed to more conversations taking place at a local level, with more awareness and engagement around the transfer of assets; but they also viewed the cultural shift required for true engagement and empowerment, rather than just consultation a long-term aspiration. While the benefits of the Community Empowerment Act are observable for several interviewees, the question of resources to support activity remains.

Resources were seen as an important factor. For one interviewee, the benefits were located in the generation of greater cohesion, a shift away from local authority responsibility to a broader range of partners, viewed as a good backdrop to place more of a focus on public health, as well as activity around participatory budgeting leading to local bids for funding, but, "*the money has not followed through.*" For a second interviewee, the lack of resource to support activity was also identified, but the Act was viewed as having generated a radical partnership overhaul and a focussing down on a handful of key priorities. It was seen as providing a real opportunity to build engagement across CPP partners, not solely the local authority. Additionally, the interviewee perceived a change in the use of terminology around inequalities, and an extension in the range of CPP participants who might now be routinely referring to and applying these (e.g. the Police, the Fire and Rescue Service). This had been accompanied by considerably greater partnership working around community development and asset mapping and the development of community engagement by local partnerships. Where working well this was thought to be generating community engagement by community partnerships around new initiatives and services; examples noted included: testing social prescribing; fuel poverty projects (in a heavily rural / remote Board); asset mapping; identifying key community priorities; and local partnership working around influencing the wider determinants, including work and transport.

In contrast, for another interviewee, the Act had provided a, "*nudge*" and a rationale for the DPH and health improvement team to push on issues surrounding community assets, their use and transfer from a health perspective. This had been met with what was viewed as, "*lip service*". This inability to embrace the ethos of the Act was felt to have resulted in a missed opportunity to fully make the links between community assets and positive impacts on health, although clearly there are barriers around the practical and financial challenges that asset transfer entails.

More positively, another felt that they now had a better lever, as the CPP now includes inequalities as a work-stream with which to champion the Health In All Policies approach. With the local authority now signed up to this, it was possible to challenge cuts in services, such as to benefits advice officers, undertaken without any form of assessment, and to push inequalities further up the agenda. However there was also a sense that some of the provisions of the Community Empowerment Act might simply increase the danger of empowering already empowered communities, particularly those most able to articulate their demands living in more affluent communities who are more likely to benefit from engaging in participatory budgeting.

4.5 Barriers and challenges

Interviewees identified a range of barriers and challenges that might limit effective CPP participation. These include the wider economic and social context, principally austerity, funding cuts, changes in the demand for services, and an ageing population. Challenges exist around time, staff and capacity issues (particularly in supporting CPPs and IJBs), local NHS Board engagement, and further CPP or non-CPP related strategy and planning groups. This was, perhaps even more pronounced where interviewees work with multiple CPPs and IJBs, public health teams are small, and further responsibilities have been absorbed. Differing locality priorities might also undermine the extent to which staff can pull together to work on the same thing. Further challenges exist around engaging meaningfully with multiple and inherently complex structures, with an overriding sense for one interviewee of these having generated further layers of bureaucracy. Having clarity around what is trying to be achieved, what the contribution might look like, whether resources and skills are available to support such contributions were also noted, as was linking evidence with practice and ensuring that the CPP was not the sole preserve of, or a specialist activity for, a very limited pool of the most senior staff.

Several interviewees, in spite of the Community Empowerment Act, viewed CPPs as too heavily tied to local authorities. It was noted, that the local authority continued to be viewed as the lead partner ("*because they have always done that*") or were taking the burden and absorbing CPP costs as, "*everyone is strapped for cash at the moment. You are around the table but with no money.*" As one stated:

"It is time for us to think a bit more broadly about who the lead partner is I don't think it has to be the local authority."

This emerges elsewhere, and for another interviewee, the long standing nature of council-led community planning characterised by their, "*own way of doing things*" and, "*to a degree councillor sort of surveillance isn't necessarily helpful.*" Council officers were also viewed as requiring support amid what should be a transition in those staff letting go of the reins and other partners taking the reins, but there was lack of clarity currently around what that entails.

For one interviewee, the lack of maturity of structures and limited resources, "*too strapped for cash ourselves in each agency*" limits the ability of CPPs to effectively engage and to "*share that power and trust*" in joint planning and pooling of resources:

"We are not truly sharing resources yet. We are a long way away from that… few CPPs are acting as they envisaged... we are a long way from pooling our resources to tackle a public health issue, that's not happening and what we are trying to do is influence individual budgets or strategies beyond just rhetoric."

Moreover, as another interviewee pointed out, while there were discussions in one local CPP about pooling resources, this was likely to be '*in kind*' but these "*conversations are incredibly difficult when everyone is worried about cuts*".

Further barriers and challenges were identified around: defining and agreeing priorities and, "*seeing them through and not suddenly shifting onto new priorities*"; differing NHS and local authority cultures; vested interests not keen on public health involvement and not opening things up to partners; elected members who are concerned with issues that may not be aligned to those pursued by public health and who prefer approaches that relate to council committee structures. Furthermore, as one participant commented, community planning may be seen as being on top of the day job not being the day job and there is reliance therefore on the "*organisations and the officers that are nominated by each of those organisations to take forward the work and that is always a problem and it always has been*."

Another interviewee characterised the challenge as one associated with the, "*complexity of the systems*" they are working with and having a better understanding around how best use may be made of the public health resource delivered to CPPs. Therefore in their view, this needs better co-ordination and capacity issues identified. A lack of capacity was deemed to have undermined opportunities to engage further for this interviewee, and this might be assuaged by having the ability to draw on capacity from other organisations to help fill gaps and, "*regardless of what the outcome is around Public Health Scotland we need to be smarter about how we takes a systems approach to public health support.*"

4.6 Summary

Public health and health improvement staff are a key source of expertise and advice to CPPs. This will continue as the work of CPPs is extended and shaped by the wider public health reform agenda. The national public health priorities are also important in shaping this work, although there is some divergence in opinion in terms of how useful they may in developing and targeting, effective local activity. Public health and health improvement teams continue to be successful in influencing CPP agendas, recognising that this is variable from CPP to CPP, and by theme. How far this is truly leading to action and activity, amid the wider context of retrenchment, resourcing, limited capacity, the volume of activity and a perception for several interviewees of CPPs as a local authority construct, is less clear. In terms of prevention and inequalities, the focus on these issues also appears to be variable. The wider context (in terms of available resources) might be sharpening engagement around this issue but limited, dedicated resource might also be acting as a brake on upstream working to address social and economic determinants of health and health inequalities.

5 Public Health Input to Integrated Joint Boards

5.1 Activity and Expertise

Public health and health improvement staff are contributing to a wide range of activities under the auspices of IJBs. Contributions to the development of mental health strategies were noted. One interviewee felt that public health involvement had been highly influential in shaping the mental health transformation programme. Another interviewee pointed to contributions not only to the local mental health strategy, but also service reviews and models of care strategies. However, they also commented that the heavy emphasis on service delivery across IJBs had pulled them further into that work, with considerably less capacity for consideration of the wider determinants of health.

Several interviewees alluded to data and health intelligence related work and horizon scanning, taking the form of frequent health intelligence related discussion and engagement involving representatives of local IJBs, local public health, local NHS Board business unit staff, academia and LIST staff members and activity in relation to housing need and modelling housing provision. The latter was described as welcome and useful but the IJB was deemed not necessarily ready to engage with upstream issues because of other pressures. A further interviewee also provided an epidemiological footing for IJB activity and horizon scanning delivered via the DPH, a team member working directly with the IJB and the wider health intelligence team, as well as heavy involvement in mental health services redesign, work around sustainable economy, population and workforce and modelling work around maintaining the latter. They also planned to engage in children's services, not fully within the IJB with the exception of health visiting and CAMHS, and so there was an expectation that this would be a "*bit of a delicate piece of work"*.

Further activity mentioned by interviewees included: strategic planning and assessment; health and social care staff capacity building (e.g. to support asset-based conversations to address the wider determinants of health); workforce skill and competencies; modelling of elective and unscheduled care; housing contribution statements; needs assessment; health promotion activity (e.g. link workers, welfare rights, older people); quality improvement activity; improving service take up (e.g. vaccination); community health services; primary care transformation; a minor injuries unit review; ADPs, drugs, alcohol and licencing; and absorption into public health of services previously provided by primary care.

Most interviewees could state that public health or health improvement expertise had certainly been utilised by local IJBs in any IJB-led service re-design or development. However they did not feel they had been involved fully. Limited capacity and to a lesser extent lack of understanding of what public health may have to offer, or lack of awareness of IJB activities by public health teams, might act as a brake on continuing provision of expertise. For example, several interviewees indicated that while expertise had been used, capacity was an issue preventing further engagement and as one commented, "*I think the challenge is that we could do so much more if we had more capacity*." Another stated that

provision had been "*patchy*", and while they had been able to influence in some areas (notably in relation to frequent service attenders and services for people with long term conditions), their perception was that:

"*There is a whole host of stuff that we haven't got near and there are areas, where yes there has been a recognisable contribution and then there are other areas we haven't got near*."

5.2 Engagement and Influence

Interviewees were asked if IJBs offered sufficient opportunities for public health and health improvement staff engagement and if they felt able to adequately lead, shape or influence the agenda to include sufficient consideration of public health. One participant felt less able to comment on specifics but, in general, viewed the local IJBs as providing more scope for public health involvement by comparison with local CPPs. This is matched by the experience of another interviewee, a DPH, currently not a member of a CPP board.

Despite the view that IJBs did offer opportunity for involvement, the degree to which the agenda might be shaped was variable, with significant barriers identified. Capacity was an issue for one DPH, sitting as a non-executive director of one IJB. This was impacting on the ability to have a presence on all local IJBs. Their perception was that while IJB agendas could be influenced, this was hard to achieve within the context of the pressures on finances and services. Limited capacity meant that gaining traction with several IJBs had been via non-executive Board members, which was viewed as problematic, even though they are briefed by public health staff. Where the DPH sits on the IJB, the agenda may be more easily influenced and where not (i.e. non-DPH Board members attend) this was thought harder to achieve. The response has been to aim to place NHS Executive Directors on the IJBs but this is also dependent on places becoming available.

One participant viewed IJBs as not necessarily providing significant opportunities for public health, and fewer than for their local CPPs. The heavy emphasis on service improvement, finance and crisis management and downstream crises meant that, "*it's almost like you are pushing a boulder up a hill."* Another, sitting on the IJB as an adviser, pointed out that whilst, in theory, the IJB provided opportunities to public health, and that they certainly felt able to place items on the agenda for discussion; in practice, the current heavy focus on delayed discharge and financial challenges would most likely curb this.

More positively, another interviewee contributing as a member of a Senior Management Team, perceived IJBs as having responded well to the need for a public health and health improvement presence:

"*Public health is seen as being important to their agendas and they want to have us around the table*."

Moreover IJB Chief Officers were perceived as having been supportive, of having provided strong leadership, and crucially of having "*bought into*'" the public health agenda. Such leadership was felt could, "*make or break*" public health input. Others were also able to identify a good level of interest in public health or health improvement contributions from IJBs but the challenges identified were perceived to dampen this. One DPH, sitting as a non-voting expert practitioner on the IJB, identified the IJB Chair as enthusiastic around the prevention and health inequalities agenda. As a result opportunities to contribute to the agenda were perceived to be developing. Whilst these were grasped wherever possible, the prevention agenda was deemed difficult to pursue given the heavy focus on service provision and a need to shift resources in favour of the prevention agenda. Likewise, another DPH identified a high level of interest from the IJB Chief Officer in encouraging public health involvement, and in developing a focus on prevention. However wider financial and governance related issues, were deemed to be absorbing senior management time, and while prevention was on the agenda, management time and effort wasn't necessarily able to support this. The same interviewee, however, was critical of the wider context in terms of IJB governance, inability to hold budgets, fully take decisions, confusion around accountability (e.g. for adult drug and alcohol services but not those working with children/ families) as well as issues around partnership working and having been bypassed by the IJB around a key area of public health activity.

One DPH (sitting on an IJB) went as far as questioning why public health or health improvement staff should have a presence on IJBs or seek to influence the agenda around the wider determinants that might be, or are, more usefully pursued via other forums (i.e. Health Board, CPPs). A preferential situation in their view would be for a better demarcation of responsibilities including between CPPs and IJBs. They felt that CPPs, working with COSLA and public health could collaborate more effectively to influence the wider determinants of health and health inequalities. Furthermore, they viewed IJBs as a complex and flawed model which had been unable to deliver positive change. They were of the view that there should be considerable scepticism around the appropriateness of promoting public health via IJBs:

"Our IJBs have delivered very little….so why would we further complicate things by taking what's a very good public health structure with a very clear strategic focus and delivery and throw it to the lions in that way?"

5.3 Variation in IJB Responsibilities

As a consequence of the variation in responsibilities and approach across IJBs, interviewees were asked to comment on how far they thought that this could lead to inequity, specifically in the extent to which public health and health improvement expertise is influential in shaping decisions.

The variation in public health and health improvement input was acknowledged by interviewees and several factors, potentially contributing to inequity, were identified including:

- stretched or limited capacity and skills mix of public health and health improvement staff;
- the ability of public health staff to adequately lead and influence the agenda, and this might vary based on differing interpretations of the role;
- the need for staff to service multiple overlapping structures and supporting strategy development for each;
- the presence, or lack of, HSCP joint directors who understand the rationale for the presence of public health expertise and for a preventative approach; and
- IJB understanding of the role of public health, ability to work with public health, ask questions and have an understanding on how they might act on the answers.

How variation may be addressed or if it is worth addressing, given that nationally generated legislation and guidance will be translated at a local level, was not formally explored. However, the need to strengthen the public health voice within IJBs is alluded to by one interviewee. Another mentioned that a requirement be placed on IJBs to access public health advice. One DPH, as a means of limiting variation, highlighted that potential for channelling public health team work through HSCP health improvement teams, working under the banner of public health, could influence multiple IJBs. Although it was acknowledged that local teams might vary in capacity to do so.

5.4 IJB Chief Officers and Partners

The involvement of IJB Chief Officers in local public health committee meetings and in public health meetings with them as a group was also noted as a possible solution. Another DPH alluded to close working relationships with IJB Chief Officers around what might be expected of the specialist workforce across an agreed set of priorities as well as sign-up by key IJB executives to this work across all local IJBs.

In terms of how others, specifically IJB Chief Officers, may influence the public health agenda, a question was asked around if there had been sufficient IJB Chief Officer-led activity that had sought to influence public health policy at a national stakeholder level. Most interviewees thought it not likely that Chief Officers would seek to do so, or as one participant pointed out it's not always clear what Chief Officers are invited to contribute to around the public health agenda, undermining the extent to which a broader awareness might be developed around who is championing public health, building relationships and where. Further comments ranged from feeling "*lucky*" to get public health on the agenda at local level given pressures on the Chief Officer, to another where the Chief Officer was viewed as not overly supportive of public health anyway, and the perceptions from a third that leadership was "*being less than adequate*" and lacking a, "*high level of energy of commitment.*" One participant did have a positive perception of the Chief Officer's abilities, and who therefore, could, potentially, champion issues at a national level.

Several thought that national influence was significantly more likely to take place around service related policy not public health, given the priorities of IJBs and how they are held to account. As one pointed out, even though some Chief Officers are likely to have particular public health interests, which may not necessarily correspond with public health or health improvement specialist interpretations of how public health should be pursued, as a group they were thought not in a good position to champion and influence public health policy. In contrast, one interviewee thought that Chief Officers do try to influence public health, citing, for example, their endorsement of the NHS Health Scotland generated inequalities statement for HSCPs.

Interviewees were also asked to consider if there is a need to widen the pool of partners within local IJBs in order to effectively make changes that influence public health. Most were confident that the pool of partners was acceptable; although as one DPH commented, gaining membership of the local IJB would be helpful. Another indicated that the inclusion of the DPH on one IJB, but not another, reduced public health influence. Several other comments indicate a preference for avoiding an extension in IJB partners, as CPPs already draw on a wide group of representatives and are, "*the public health partnership of the future*". As IJBs are a key partner in CPPs, widening the pool of IJB partners was not necessary. Likewise, another didn't want to risk replicating and duplicating the work of local CPPs by widening the agenda further.

5.5 Prevention, Health Inequalities and Population Health Improvement

As already indicated there is evidence that prevention, tackling health inequalities and population health improvement have been taken on board by some IJBs but how far this agenda can be supported and prioritised given competing, significant demands placed on IJBs and limited resources is less clear. As one CPHM commented:

"In fairness to the IJBs, their plans certainly seems to take that stuff into account very well. Whether that manifests as an actual change in circumstances over the next few years then I'm slightly less confident about."

Most participants could identify some focus on prevention and inequalities but what is less clear however is how those issues might be addressed. One DPH felt that resources had been committed to supporting specific groups and those most distant from services, even if the language around this wasn't inequalities focused. Another felt that the issues were recognised, but not prioritised, and while they were trying to move the conversation upstream and were shaping the rhetoric, the heavy focus on service delivery, day to day needs and huge financial challenges limits the extent to which the agenda can be truly influenced. Moreover, the point was raised about scoping out an appropriate role for public health at IJB level and widening discussions around upstream determinants while avoiding the, "*classic public health approach* [of] *telling people what to do*".

Likewise, another viewed the focus as insufficient. They felt that this situation should change and as consequence were seeking to influence change at local board level which would filter that through to the IJBs. They also perceived the wider situation as:

"Harder than its felt for many years because of the pressure on services and the increased demand and the pressure on acute waiting times or finances and it's very hard to get public health taken seriously on the agendas."

A number of participants pointed to the recognition that more must be achieved around these issues, but that rhetoric had not been backed by action in terms of resources and commissioning. For one interviewee the challenge around the heavy focus of the IJBs on acute, treatment and care was to consider how, in the next commissioning plan, expenditure might be shifted upstream and long term indicators identified and applied. Early intervention, prevention and health improvement was already a feature of the commissioning plans but this was yet to be followed, "*by some money and real commitment now around a shift in resource*." For another, discussions were taking place, but without a commensurate shift in resource to the point where the IJB can:

"U*tilise more of their core funding to do good at scale*'. This was deemed a '*massive challenge given the financial status of the IJB but also their parent bodies. So it is about looking at a financial model that is different than the one we have at the moment*."

One DPH commented that the focus on inequalities and deprivation was strong, leading to some prioritisation of service provision in areas of deprivation. Even so significant questions remained around how these issues might be tackled in the longer term and how partners may be best made use of to achieve this. One DPH viewed IJBs as having progressed in terms of moving beyond, to some extent, challenges associated with setting up governance structures. However, the barriers associated with pursuing prevention and inequalities focused issues via IJBs led one participant to comment that the preference was to do so via community planning because:

"I think the energy you would need to put in to get IJBs to the point where they would be embracing some of the public health and population health work would be disproportionate. I just don't think that they are there yet."

For another interviewee, referring to one local IJB, prevention and inequalities had been sufficiently prioritised and this was a reflection of additional funding provided by a local authority, in recognition of the heavy focus of the IJB around service provision, to support a greater focus on prevention and intervention. This was viewed as having provided the opportunity to develop projects aimed at shifting some of the current activity to consider upstream, wider determinants.

5.6 Barriers and Challenges

The multiple barriers and challenges identified above mean that for several interviewees there is a need for stability and funding for IJBs to allow movement away from activities centred on funding challenges. In addition, there is a need for IJBs to be equally focused on, and held to account for, delivering public health policy and practice alongside service provision issues.

Further challenges that limit effective IJB participation exist around resources in the form of people, money, workload, timescales for delivery, and the consequences of variation in local structures that can lead to variable demand on the levels of engagement in terms of staff numbers. The competing demands of the combination of IJBs, CPPs, the Local Authority and the NHS Board can be onerous and risk, as several participants observed, heavy repetition of activity around some themes. This is especially so where there is a significant overlap in the membership of those structures. The practical day to day challenges for staff of HSCP partner organisations (NHS, LA) with differing cultures, systems, governance and terms and conditions were also identified.

Other barriers and challenges were described in terms of the failure of NHS and Local Authority cultures to be sufficiently integrated. The IJBs, as well as CPPs, may be viewed as being at the mercy of political considerations, the pattern of local elections, and the change in personnel brought about by this. Furthermore, IJBs might be viewed as heaping yet further complexity into what is an already complex web of connections.

5.7 Summary

Interviewees and wider teams have been involved across a range of activities to support the work of IJBs and most felt that their expertise had, to some extent, been tapped into. Shaping IJB agendas to include a focus on prevention, inequality reduction and population health improvement was not straightforward however. This may not be surprising given the specific IJB responsibilities associated with service provision, as well as funding challenges and a range of other barriers identified by interviewees, even where there is a significant IJB interest in a public health and health improvement contribution. How the agenda may be influenced to push activity upstream, which is clearly not taking place to the extent that interviewees hoped or envisaged, and how funding might be harnessed to support this, was not necessarily clear to interviewees.

6 Need for National Support

6.1 ScotPHN / Public Health Scotland Support

Interviewees were asked to identify how ScotPHN or existing national agencies / Public Health Scotland could support their work with CPPs or IJBs via the provision of advice, data or knowledge. Future support and activity might be predicated on the role of Public Health Scotland and as one DPH commented, the positioning of Public Health Scotland (PHS) as a body that seeks to develop policy and actively draws on the input of wider public health expertise, is preferable to one that implements policy determined and sanctioned by government.

Participants were keen to see connections, and clarity, between local and national working and evidence to support understanding of key topics, best practice, delivering the national public health priorities, and to reduce unnecessary duplication of effort.

Suggestions were provided across several themes:

- Local, regional and national working:
  - making connections between the strategic, national direction provided by PHS and local agencies, and the how those interact and inform one another; and
  - establishing and maintaining clarity around local, regional and national responsibilities for action across the decluttered public health landscape.

- National public health priorities:
  - providing evidence about the national public health priorities at CPP level: where the biggest gains might be achieved; how activity might be monitored and evaluated; reducing duplication of effort across all boards by providing one set of evidence; and
  - communicating what is expected of local systems, especially when the public health priorities can be viewed as something that can generate 'buy in'.

- Evidence / health intelligence support:
  - additional capacity around evidence reviews and business intelligence functions;
  - Public Health intelligence that could add "*huge value"* to the work of colleagues, particularly for smaller boards that might lack capacity around data and research;
  - continued ScotPHN support for evidence around best practice deemed useful in supporting IJBs in the delivery of services that are better aligned to national standards and in understanding evidence around how those services be best configured to reduce local variations in activity and outcomes;
  - providing evidence aimed at key issues where "*we are all struggling",* on a once-for-Scotland basis;
  - PHS / ScotPHN support focused on young people's mental health and on drug misuse;

- supporting DPH annual reports, by helping them share resources, to reduce duplication of effort, (e.g. use of common chapters, providing local data);
- support around identifying commonalities, (e.g. across the LOIPs) and considering how public health can influence common themes.

- Collaboration with PHS:
  - ensuring collaboration and support from PHS is sensitive to local arrangements and avoids a top down approach. Input into local IJBs and CPPs that fails to recognise local expertise or facilitate local public health and health improvement staff in helping build and develop local relationships within these structures, is likely to be unhelpful; and
  - PHS will need to recognise the intricacies of relationships at local level; collaborations must seek to improve public health capacity at a local level.

- Training and skills development:
  - provision of training or re-fresher training, as public health teams become smaller and thinner on the ground, and training (e.g. a mini-MPH) for those in partner agencies who have a public health role but not necessarily a public health background; and
  - skills development around working within health improvement and health in the community (e.g. community development, engagement and participation, and working with communities in practice).

- Inequalities:
  - support around measuring inequalities in remote and rural areas, including academic support, and input to support remote and rural activities in general; and
  - ScotPHN support in driving a focus on inequalities and prevention, with some level of consistency across Scotland, given the variation in local activity.

6.2 Ongoing Support Regarding Working with IJBs / CPPs

Interviewees were asked to comment on whether there was sufficient opportunity to discuss their experiences of CPPs and IJBs. Responses indicated that most already had forums (regional public health networks and collaboratives, SDsPH, health promotion managers' networks, cross-health board activity, intra-health board activity) within which these could be discussed and learning shared. Several participants thought that these were sufficient and that further activity might duplicate existing discussions and engagement.

Six participants were interested in building on these existing structures around the public health involvement and contribution, to share examples of good practice and successful activity deemed to have improved health and to share experience at strategic level. One participant was less keen on the generation of further opportunities to bounce problems

around given the existence of other forums, but thought that the provision of opportunities for engagement for public health specialists and the wider workforce across IJBs and CPPs could be more useful. One participant, a DPH, expressed some frustration around what they viewed as the repetition of past mistakes, especially where there was limited understanding and experience of public health. The development of a wider network to support understanding, including a focus on, for example, asset-based approaches and community development was deemed potentially useful.

7 Reflections

As with the previous versions of this review of public health working within CPPs and IJBs, it is hard to draw firm conclusions. Rather, it is a snapshot at one specific moment in time from which some reflections may be drawn.

The 2014 review[1] noted in its conclusion that:

"Specialist Public Health teams are already working within and for such local planning arrangements. They are seeking to improve and protect health and improve the quality and effectiveness of delivered services in such structures as they are required to operate."

"As structures change, so will the support provided by Public Health Directorates. But this needs to be done in a thoughtful fashion. Whichever structures to which such teams are aligned, there is a need to ensure that the other parts of the overall system – those that also affect and mediate the health of local populations – are not differentially disadvantaged and new health inequalities and social injustices created."

It is clear, in this 2018 review, that the structures have continued to evolve and that public health and health improvement team support for these structures have evolved with them. The variation observed previously in how the structures work and the nature of the public health input has continued to be an issue in seeking to delivery population health outcomes.

Public health and health improvement staff remain a key source of influence, expertise and advice to CPPs, perhaps reflecting a greater degree of structural maturity. It is clear that the national public health priorities are becoming more important in shaping the work of CPPs, although it may be too early to see what impact they will have on local activity in the longer term. As yet, the impact of the Community Empowerment Act – noted in the 2014 review as being an area for potential public health interest – has yet to gain significant traction in CPPs. The focus of CPPs in prevention and reducing inequality – on the social and economic determinants of health – remains variable. There are some signs it is improving, but the availability, and flexibility of dedicated resource is seen as a barrier to further local action.
Work with IJBs is more variable, perhaps reflecting more on the local pressures and concerns which the structures are seeking to address. Public health activities are

increasingly focussed on needs assessment and service improvement related work, with a very strong implication that this is associated with seeking to achieve greater financial sustainability. Shaping IJB agendas to include a focus on prevention, inequality reduction and population health improvement is not straightforward, and even questioned by some to be inappropriate for IJBs. Whilst there is clear interest in some IJBs around prevention, how the agenda may be influenced to push activity upstream remains a question asked rather than answered.

Overall, the picture is one which suggests that there is a greater degree of understanding in how public health can best engage locally within CPPs and IJBs. There is a sense that they have become more able to operate in these complex landscapes and use their experiences to exert local influence and effect change. Barriers and challenges clearly remain, though this seems to have created a greater degree of realism or pragmatism amongst interviewees.

As with previous reviews, navigating the local landscape of integration is not straight-forward. Further support is felt to be needed, though these are increasingly more focussed on how a new, more integrated public health system across Scotland operates rather than simply on supporting local capacity. Perhaps this, more than anything else, is what is new in this review. It is not just that collaboration is sought, but that such collaboration and support is undertaken in a way that builds local, regional and national capacity so that public health can be more effective in meeting local needs.

Appendix 1: Online Questionnaire

The following questions were sent (online) to the Scottish Directors of Public Health on X, via the use of LIME Survey. The questions were as follows:

1. Please briefly describe the current CPP and IJB structures within your Health Board area. (e.g. number of CPP(s) and IJB(s), health representation within local CPP(s) and IJB(s));
2. Please briefly describe your own or wider public health / health improvement department direct involvement or input into the local CPP(s) (if any);
3. Please briefly describe your own or wider public health / health improvement department direct involvement or input into the local IJB(s) (if any);
4. Are you aware of other sources of public health advice, not from within your Public Health / health improvement department, that local CPP(s) or IJB(s) use?
5. Are you able to gauge, as a consequence of moves towards wider public health reform, a change in the nature of activity in relation to drawing on public health / health improvement expertise across CPP(s) or IJB(s) within your Health Board area?

Appendix II: Interview Question Schedule

<u>IJBs and CPPs</u>

1. Could you outline the relationship between the IJB and the CPP(s) in your area?

<u>Other planning / strategic commissioning</u>

2. Please describe any other, key joint planning or strategic commissioning arrangements with your local authority/local authorities which are not covered by your CPP(s). (e.g. Joint Health Protection Planning, Single Outcome Agreements for health improvement, CJA, ADPs, infrastructure planning, Civil Contingency planning, etc.)

<u>Community Planning Partnerships</u>

3. Do local CPP agenda(s) currently offer opportunities for public health / health improvement engagement or partnership working?
4. If so, do you or the wider public health / health improvement department feel that you are able to adequately lead, shape or influence CPP agenda(s) to include sufficient consideration of public health?
5. What areas of CPP(s) work do you or the wider public health / health improvement department contribute to currently? What CPP(s) priority areas do you think you could contribute to but are currently not?
6. What are the barriers or challenges that limit effective CPP(s) participation? How can these be overcome? Are any previous challenges diminishing? Are new challenges emerging?

7. In your view, are local CPP(s) sufficiently focused on, or resourced, to improve health outcomes based on prevention, tackling health inequalities and population health improvement? If so, are the desired outcomes ambitious enough or sufficiently targeted on health?
8. How do the ambitions and aims of the CPP(s) align with, or influence, public health / health improvement department activities?
9. Given what should be a shift in emphasis for CPP(s) due to the Community Empowerment Act to partnership working and community engagement with a specific focus on tackling inequalities, do you get a sense of whether this is changing the nature of how you or the wider public health / health improvement department interacts with CPP(s)?
10. Are there any other aspects of your involvement with CPP(s) that you would like to comment on?

Integrated Joint Boards

11. Does the IJB(s) agenda offer opportunities for public health / health improvement involvement and influence?
12. If so, do you or the wider public health / health improvement department feel that you are able to adequately lead, shape or influence the IJB agenda and objectives towards integration to include sufficient consideration of public health?
13. What main areas of IJB(s) work have you or the wider public health / health improvement department contributed to? What could you contribute to but are currently not?
14. What are the barriers or challenges that limit effective IJB participation? How can these be overcome? Are any previous challenges diminishing? Are new challenges emerging?
15. In your view, has public health / health improvement expertise been adequately utilised by local IJB(s) in any IJB-led service re-design or development?
16. In your view, has the need for prevention, tackling health inequalities and population health improvement been sufficiently prioritised within local IJB(s)? Is there a need to widen the pool of partners within your local IJB(s) in order to effectively make changes that influence public health?
17. Are variations in approach across IJBs leading, in your view, to inequity in terms of how far public health expertise is influential in shaping decisions from IJB to IJB?
18. In your view, has there been sufficient IJB chief officer-led activity that has sought to influence public health policy at national stakeholder level?
19. Are there any other aspects of your involvement with IJB(s) that you would like to comment on?

ScotPHN / Public Health Scotland support

20. Going forward, are there particular areas of activity in relation to your work with CPP(s) or IJB(s) that you particularly feel that ScotPHN, or Public Health Scotland, could provide support via the provision of advice, data or knowledge?
21. Given differing approaches to integration and community planning, is there sufficient opportunity for cross-IJB / CPP public health representative engagement and discussion?

ScotPHN report

For further information contact:

ScotPHN
c/o NHS Health Scotland
Meridian Court
5 Cadogan Street
Glasgow
G2 6QE

Email: nhs.healthscotland-scotphn@nhs.net

Web: www.scotphn.net

Twitter: @NHS_ScotPHN