Public Health Reform Commission

Leadership for Public Health Research, Innovation and Applied Evidence

Stakeholder Engagement August Engagement Event

Capturing Emerging Stakeholder Views

Background

At the first of the Leadership for Public Health Research, Innovation and Applied Evidence (LPHRIAE) Commission's Stakeholder Engagement Events, the participants (see Appendix 1) were invited to consider a number of related questions that were designed to help identify the scope of the leadership that was needed.

The questions were posed in three, facilitated workshops that sequentially looked at:

1. the 'research, innovation and applied evidence' vision for Public Health Scotland?
2. research and innovation in Public Health Scotland? and
3. applied evidence' and innovation in Public Health Scotland?

In each of the workshops, the questions posed related to the operation of the new agency. These questions were kept fairly open and sought to understand participants' thoughts on:

- what should Public Health Scotland be doing as part of its own work?
- how should Public Health Scotland work to support others in the wider public health landscape? and
- how should Public Health Scotland use its position to influence external agencies and functions that have an impact of public health in Scotland?

The outputs from each of the three workshops have been analysed to identify emerging themes identified by participants and the underlying characteristics which formed the theme. Because of the open way in which the workshops were facilitated, it quickly became apparent that these themes needed to be captured across all the workshops. These emerging themes were then further refined to help clarify which of the workshops best reflected the theme's underlying characteristics. This is the format in which the workshop outputs are presented in this report.

Workshop 1: What is the 'research, innovation and applied evidence' vision for the new Public Health Scotland?

In workshop 1, the participants were asked to consider the following questions:

- what should Public Health Scotland be doing as part of its own work?
- how should Public Health Scotland work to support others in the wider public health landscape? and
- how should Public Health Scotland use its position to influence external agencies and functions that have an impact of public health in Scotland?

PHS should be a source, translator, identifier of, and commissioner of research / applied evidence:

- enabling all partners to be involved in research in order to be evidence-informed and performance driven;
- it would be disappointing if PHS is ONLY a research commissioner. Needs to be able to lead and collaborate in research; and
- developing a programme of research – longer term focus and ambitions

PHS should be a builder of relationships, collaboration, co-ordination of a wide range of organisations and stakeholders (beyond 'health'):

- providing the 'glue' that brings range of searchers and users of research (practitioners and the community) to the table to define questions, establish research priorities and identify gaps for the benefit of practice and policy;
- developing collaborative approaches – find out who has experience on an issue, build working groups around this, drawn from a range of organisations, not just the same old, same old people who are tried and tested;
- developing a wide sense of what public health means (housing, health, fuel poverty, etc.) and find means and ways to collaborate and develop evidence of relevance to all sectors;
- developing the wide consortium of stakeholders/partners – multi-disciplinary perspectives/pool of expertise. Collaborators must include universities to ensure coordination/ joined up approach rather than on an ad-hoc basis, engagement with PHE & PHW, wider social sciences, as well as NHS boards and community level players;
- recognising the value there is in diversity in different organisations doing different thigs – PHS the new org needs to have flexibility to work with others; and
- creating the 'place to go' to support those who wish to collaborate, to exchange data, share and work together. Establish common ground aspirations;
- taking barriers away within stakeholder organisations to focus on what matters.

PHS should be a shaper and sustainer of transformational research:

- helping to shape the research needs/questions that we want answered, offering 'pathway to impact';
- involving the users of research early on to shape research priorities;
- connecting the right people to the right research – who wants to be involved?
- aligning research and practice side by side – practitioners need to meet researchers;
- creating and supporting dialogue between front-line end user and the researcher – helping frame the questions that should be asked – bottom up / not just top down;
- facilitating engagement for real co-production and helping to manage the tensions co-production can create;
- learning from those interesting networks that already exist and which could be used as models – Drug Research Network set up in Scotland, Scottish PHEN, ScotPHN have worked well – good examples for collaboration; and
- providing mechanisms to break into England dominated UK discussions – representation NIHR etc.

PHS should be a champion of practitioner generated evidence / data / research:

- helping to reconcile the differing research agenda between those who deliver services and those who do not (made more complex by multiple funders) – need better alignment of research agendas;
- promoting practitioner generated evidence, and for this to form part of the evidence that is gathered and shared by PHS;
- providing information in real-time from existing data collecting systems – e.g. from GP systems; and
- making research and innovation accessible – groups should include practitioners to make research more applicable.

PHS should be a skills and capacity builder and opportunity provider:

- supporting evidence use;
- encouraging and helping to develop existing skills;
- helping to capacity and skills development in a range of ways;
- providing a source of expertise around critical appraisal / association and causation / evaluation / interpreting data and statistics;
- working to fill the gap between the evidence and having the confidence to use it;
- influencing training and development in academic circles to ensure that there are more people with academic skills working in a policy and practice environment;
- support practitioner/ frontline staff to undertake research;
- helping people understand data and statistics – to help people understand where the gaps in the statistics are – what is and what is not available;

- engaging policy makers/politicians to enhance their skills in understanding and using evidence, and to understand what they would need from evidence to make it influential. Policy makers/politicians differ hugely in terms of their understanding of evidence;
- supporting the development of front-line staff in research – mentoring and capacity building and helping to keep skills up to date;
- organising networking and/or local events – using technology (webinars) for networking and connections; and
- promoting research collaboration by a range of employment approaches - have people employed by both academia and PHS, create short secondments to foster interaction, institute policy fellowships.

PHS should be a specific provider of skills and expertise, and builder of capacity, where necessary:

Health Economics:

- building health economics experience and expertise across the system;
- strengthening the existing, multi-agency collaborative network – HENS; and
- recognising the gap in HE at local level and providing a support service.

Evaluation:

- providing a source of expertise around evaluation;
- building capacity for more locally generated evaluation and enhancing locally relevant data for the purpose;
- providing advice and support for service evaluations; policy evaluation; and practice evaluation; and
- encouraging shared learning from local initiatives across local government – providing effective collaboration with wider evaluation capacity – WWS, IRRIS etc.

PHS should be a challenging advocate:

- providing an independent research position – especially where politically sensitive issues;
- developing the advocacy role of PHS, especially around challenging commercial interests and the social determinants of health;
- creating mechanism to influence political priorities; and
- using a strong, independent voice, be brave, be visible and not be risk adverse.

PHS should be a horizon scanner:

- ensuring that it avoids being behind the curve in terms of setting up structures and processes for using evidence in a time when society and technology are changing so rapidly;
- developing a research agenda suited to demographic change, changes in work and the labour market, formalising composition;
- helping to plan ahead – anticipating the problems of tomorrow; and
- ensuring its applied evidence function is flexible and adaptive with a futures focus and a commitment to sustaining its own learning.

Workshop 2: Research and Innovation

In workshop 2, the participants were asked to consider the following questions:

- what should the research function of PHS be?
- how can PHS support research more widely in Scotland? What research should be undertaken nationally and locally?
- what innovation may support this function?
- who should PHS collaborate with and how?
- who should PHS seek to influence?

In addition to the themes and characteristics already explored, the following seemed to be more specifically associated with workshop 2 on research and innovation.

PHS's research and innovation function should:

- generate an explicit research agenda;
- identify research gaps – and focus resources;
- share a strong mix of data and evidence – data & statistics, qualitative data, health economics, etc.;
- translate and synthesise evidence from UK and international contexts – to the right people, to generate innovation, for practitioners; ;
- map and audit the evidence base for the 6 PH priorities;
- align applied questions and the research interests of those carrying out research
- provide and support data linkage
- ensure lack of duplication of effort in research;
- ensure evaluation and research are put in place early in the policy cycle and enable baselines to be measured;
- show how evidence has been used to inform policy; and
- address data governance, ownership, technology, arrangements

PHS should be involved in shaping funding / resources:

- influencing funding decisions in terms of what research is done, or how it could be done, and to support innovation for health – CSO, Research Council, NHIR, as well as wider public and charitable sector research funders;
- facilitating effective use of pooled resources that can be currently fragmented across the system;
- facilitating imaginative approaches to funding for collaborative working;
- facilitating the coordination of academic work given the competitive market for academic funding; and
- supporting accessing to funding from different sectors, especially where currently 'siloed'.

PHS should be able to reflect the local picture in terms of research / evidence / innovation and in turn local activity needs to influence the research / innovation agenda:

- creating the environment where the research and innovation agenda can be influenced from bottom-up, understanding from local to national level as well as an understanding at national level around how well innovation actually impacts on the ground;
- helping communicate a greater understanding of what need exists at local level and how policy and intervention play out at ground level;
- using local feedback to influence national policy and a better sense of how outcomes and outputs can be measured at local level to measure success;
- avoiding duplication of local research effort; and
- capturing innovation at local level – scale up and share and use to influence wider agenda.

Workshop 3: Applied Evidence and Innovation

In workshop 3, the participants were asked to consider the following questions:

- what should the applied evidence function of PHS be?
- how can PHS support applied evidence more widely in Scotland? What should be undertaken nationally and locally?
- what innovation may support this function?
- who should PHS collaborate with and how?
- who should PHS seek to influence?

In addition to the themes and characteristics already explored, the following seemed to be more specifically associated with workshop 3 on applied evidence and innovation.

PHS's applied evidence and innovation function should:

- generate evidence and briefings – focusing on making what works 'actionable';
- help determine weight and strength of the evidence – not cherry pick;
- identify and share evidence about local and national activity – and just that which is formally published;
- map and audit the evidence base for the 6 PH priorities in practice;
- translate evidence into policy;
- link evidence and research to decision making
- share a wide mix of evidence about what works;
- translate what is known in order to solve problems;
- PHS must present evidence in ways meaningful and impactful on local decision makers – tailor evidence for different audiences;
- actively link individuals / organisations with research / evidence
- challenge misunderstanding, misrepresentation, and evidential error; ensure that interventions / programmes can be adapted to local contexts
- help users avoid making the same mistakes of the present or the past
- identify and share evidence about innovation and experimental working at local level; and
- adopt a model for knowledge into action to guide the structure and practice of the new body and those with whom it works;
- addressing the disconnect between evidence and how it is applied – helping to influence decision making at local level; and
- developing the capacity to support the use of applied evidence locally.

PHS should be a trusted source of evidence that recognises, and doesn't perpetuate, failure:

- helping to develop a broader interpretation of what constitutes the available evidence for application, from research, through experiential evidence, to evidence from the lived experience or people and communities and how these evidence types could be aggregated;
- helping to foster trust - to be able to share information/research about what has gone well and what has gone badly;
- providing ways of communication what has been less successful without compromising funding regimes;
- developing and encouraging a culture where we understand failure, tolerates it, and leans from it; and
- accepting that meaningful innovation and change will involve failure and creating the safe space to explore this?

PHS should be an enabler in the use of technology:

- helping to developed better use of technology to harness understanding of what already exists out there;

- providing an accessible hub for applied evidence / research that make it easier to pull together and review – in a Scottish context;
- supporting better interpretation of the evidence – data dashboards can be unhelpful if you lack an understanding of what lies beneath the headline statistics;
- developing the types of national data repository and institutional evidence repository that can sustain digital innovation and delivery;
- navigating the types of UK and international portals that connect public health practice and research – e.g. PHINDER is UK wide can we use this in Scotland?

Preliminary Conclusions

A wide range of views have been shared and captured and drawing firm conclusions from these themes and characteristics is not necessarily straightforward. However it is clear that we that Public Health Scotland (PHS) is being expected to support a number of functions as a research provider, collaborator, supporter, facilitator, and interpreter.

These include being a:

- source of high quality data for Public Health research;
- conduit through which research can be crafted for application;
- trusted source for evidence for application into policy and practice:
  - champion for, and provider of, practice-based evidence as a source of knowledge in its own right; and
  - evidence form the lived experience of people and communities;
- facilitator / supporter for implementing the evidence, moving beyond the process of converting evidence into actionable products into actual practice;
- facilitator for change and innovation; enabler, and builder of skills and capacity;
- learning organisation that is self-reflective, open to sharing, and able to sustain a culture of learning about not just “what works”, but “how to make it work” locally; and a
- reporter/ identifier of pressing Public Health research questions / priorities.

The nature of what will be demanded of PHS is help co-create a transformational approach to public health in Scotland. This means successfully generating and translating research and evidence to influence practice and policy; and in turn, enabling the translation of practice based evidence and experience to inform research and evidence creation activities. Essential to this process will be PHS engagement and collaboration with both local and national policy-makers and practitioners across the NHS, local government and the third sector to strengthen the understanding, adoption, uptake, and the application and use of research and evidence. This will require a need, as the workshop has identified, for PHS to gauge and fill the gaps in capacity and skills-mix among the wider workforce.

How we achieve this will be the focus of our debate and discussion during the coming months, but the output of the workshop indicates that it is anticipated that PHS will take a

strong leadership role in this. It will also need to be sufficiently independent to 'speak truth to power' if it is to be successful in fulfilling a role as a robust, evidence-informed advocate.

The range of views shared at the workshop raises questions about PHS and its research function and going forward it would be useful to tease out what model(s) would best serve the needs of the NHS, local government and third sector organisations and workforces. Would PHS better achieve its aims by seeking to commission, undertake and generate research and evidence or by seeking to shape and influence the research agendas and priorities of major funding bodies, or a combination of both? What elements within this function are desirable, achievable, compatible, and would avoid over-stretching capacity and resources?

The workshop has highlighted a need for PHS to build partnerships and facilitate discussion among key actors and stakeholders to make better use of what research and evidence already exists, thereby avoiding possible duplication of effort. How can we make better use of existing evidence and research and avoid simply stockpiling evidence that is not used? What are the best means whereby research and evidence can be signposted to and accessed? How can the results of research be communicated effectively and the key messages identified and shared in new and engaging ways with a focus on problem-solving? How can PHS successfully and usefully add value to the research and evidence base to increase the likelihood of getting evidence into practice?

These are just some of the key questions that ***must*** be addressed in the coming months, as well as the recognition of the challenge for PHS of bringing together a range of partners to provide the means for horizontal and vertical engagement at all levels across those organisations, to act not solely as a national body but one that also links to and engages with national, regional and local stakeholders.

In this regard, it was noted that a greater representation from end-users and academics in the event would have been welcomed. This is an area which needs to be further considered by the SLWG. It will be essential for Public Health Scotland to be able engage academia in the transformational process effectively, especially in helping others to understand how the academic system, and its behaviours, works as a means of provide the navigator role identified. For end users, creating an agency that is accessible, trusted, and able to fulfil their expectations to deliver actionable knowledge will be a central marker of success. In other words, how Public Health Scotland leads and sustains the transformational role which is clearly required.