ScotPHN report

New Ways of Working for Public Health:

Providing Specialist Public Health input to Community Planning Partnerships and Integrated Health and Social Care Arrangements

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January 2015

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1 Introduction

In 2010 ScotPHN and NHS Health Scotland undertook a programme of work in support of the Review of the Public Health Function which had been commissioned from Gina Radford, the then Director of Public Health in Fife. This work covered a number of the roles and functions of specialist public health services, one of which was the input to the newly formed Community Planning Partnerships (CPPs) and to the existing Community Health (and Social) Partnerships (CHPs / CHSPs).

More recently, NHS Boards and their local authority partners have been directed to achieve greater integration through the CPP mechanism and were required to detail their contribution to Community Planning Partnerships CPP(s) as part of their Local Delivery Plan 2013-14. Work is also underway to develop new Integrated Adult Health and Social Care Boards, replacing the existing CHP structures.

Against this background it seemed opportune to revisit the findings of the 2010 work and to update them in the light of the how local Public Health Functions have developed their engagement with, and support to their local CPPs and explore what additional support Directors of Public Health (DsPH) and local teams would like to be provided from ScotPHN and national bodies in ensuring public health delivery.

In this report we:

- summarise the key findings from the work undertaken in 2010 as they relate to CPPs and CHPs;
- provide an update on the current alignment of specialist Public Health teams to CPPs and the support being provided; and
- consider what specific additional support needs Directors of Public Health have identified.

In publishing this report we also hope that highlighting these issues in the context of public sector reform, they may help to inform the context for, and development of, the potential role(s) of specialist public health functions in the Integrated Adult Health and Social Care Boards.

2 Findings from the 2010 Report

2.1 Background

The 2010 report was based on field work undertaken in September 2009 and which aimed to obtain information about the role of the DPH, specialist public health capacity, and models of engagement used in relation to CPPs and CHPS in every health board area. Fuller details of the methods are set out in the report, but in summary piloted, self-completion questionnaires were sent to all DsPH and telephone surveys were undertaken using a piloted survey instrument in a sample of general managers of 18 of the 40 CHPs then in operation, and the coordinators of the 18 corresponding CPPs. The final sample was stratified to reflect the complex relationships between Health Boards and their CPP/CHPs. The response rates from the DPH survey was 100%. For the CPP and CHP surveys the response rate was 100%, though local circumstances had to be taken into account. As a result for one CHP, two Local Health Partnership managers were interviewed as no CHP respondent was available. The CPP interviewees were usually community planning or corporate policy managers or co-ordinators with responsibility for their CPP's arrangements. Data was collected during the period of time when pandemic Influenza A(H1N1) outbreak was underway. This may have affected the results.

2.2 Specialist Public Health input to CPPs

Both DsPH and the CHP and CPP responders were asked about the nature and scope of specialist public health input to the work of the CPPs. They reported that:

- specialist public health representation on the CPP Board (or its sub-committees) was complex. Representatives on the CPP included DsPH, consultants in public health, or health promotion managers;

- DsPH indicated that specialist public health input to CPPs was more often about health improvement than either health protection or health and social care services; however, the scope of public health issues presented to the CPPs varied considerably from area to area;

- six DsPH and 15 of the CHP and CPP responders cited some form of involvement with the development and implementation of SOAs. Ensuring HEAT targets were reflected in local outcomes was a common area, though areas also mentioned included:
    - priority setting, including for resource allocation;
    - strategy development;
    - partnership working at various levels;
    - collaboration on training and employment initiatives; and
    - health inequalities reduction initiatives;

- the relatively limited availability of the specialist public health resource was noted by all responders and several commented on the need for greater resources being made available, especially embedded within the CPP; and

- resource limitations aside, satisfaction with the specialist public health input was good with 75% or more of the CHP and CPP respondents indicating they were fairly or very satisfied with specialist public health input to the CPP. Interestingly this may be compared with 57% of the DsPH who were fairly or very satisfied with inputs.

2.3 Specialist Public Health input to CHPs

For CHPs, the DsPH and CHP respondents were asked about specialist public health input in the three domains of public health: health improvement; health protection; and health and social care service quality and effectiveness. The key findings were:

- fewer than half of the DsPH said they were satisfied with the level of specialist public health input available to CHPs, particularly for health and social care services where only about a third were satisfied;

- the majority of DsPH commented that they simply did not have the capacity overall to meet all the demand for specialist public health input at both Board and CHP levels;

- most CHP respondents reported they were satisfied or very satisfied with the level and quality of specialist public health input they received across all the three domains of public health. Indeed, their satisfaction levels appeared somewhat higher than those of the DsPH;

- several CHP respondents commented that it would be better to have more specialist public health resources in the CHP. Gaps specifically mentioned were:
    - to help with planning;
    - to provide specialist health intelligence – linking health status profiles with deprivation data, support more responsive local planning to meet the needs of different localities within the CHP;
    - insufficient presence from specialist public health at CHP meetings, giving rise to the lack of an epidemiological perspective in planning for health improvement; and
    - the lack of specialist public health 'clout' to get things done at the NHS Board; and

- shortfalls in locally based health improvement staff were noted as resulting in a lack of capacity to deliver national agendas on inequalities and HEAT targets, and for developing and delivering local health improvement solutions for local priorities.

3 The 2013/14 Survey

3.1 Background

In the light of the renewed Scottish Government focus on CPPs as the major delivery mechanism for health inequalities reduction and other public health initiatives, and the move towards greater integration of health and social care, with the establishment of Integrated Health and Social Care Boards, it was decided to undertake a further stocktake of DPH involvement with CPPs and other local planning arrangements.

The DPH (or their nominated responder) for each NHS Board completed a questionnaire in August 2013 (Annex 1). The purpose of this was to establish the 'local landscape'. ScotPHN followed up on the returned questionnaires with a structured telephone interview in November 2013 (Annex 2). This was designed to 'unpack' the local detail and explore what additional support ScotPHN, or other national agencies could provide.

A summary of the data from both these collection exercises have been subjected to thematic analysis, highlighting where possible consistent themes and those where diverge was clear. This is presented in the next section. A fuller analysis of the data is available on request from ScotPHN.

3.2 Community Planning and Public Health

3.2.1 Community Planning Structures

At the time of analysis (January 2014) there were thirty-two Community Planning Partnerships (CPP), focussing on each Local Authority area. It was clear from the interviews that each CPP operated in a different way and at a range of different organisational levels to suit local circumstances. Only six of the NHS Boards were co-terminus with their local CPP, the remaining eight NHS Boards worked with between two and six CPPs each.

The Public Health input from NHS Boards was provided via two main approaches. These can be described as:

- devolved Community Health (and Care) Partnership-based Public Health Team; or
- using public health 'experts' to provide 'topic-based' input to CPPs.

Five Public Health Departments had devolved (CHP-based) teams that provided a large proportion of the public health input to a total of nineteen CPPs. The CHP-based teams involved a range of people including Public Health Practitioners, Public Health Leads, Health Promotion staff, Public Health Co-ordinators and Health Improvement Staff. The Boards using this model were Ayrshire and Arran NHS Board, Grampian NHS Board, Greater Glasgow and Clyde NHS Board, Forth Valley NHS Board, Lanarkshire NHS Board. One Health Board, Highland used this model where it supported the Argyll and Bute CPP. More detail on the specific approaches outlined here is available on request from ScotPHN.

Two of the NHS Boards with multiple CPPs used a topic-based approach, with an individual leading the public health input on specific areas, such as for children or inequalities. However, it was also noted that topic-based input was also used where there was a devolved CHP-based Public Health Team.

The co-ordination of Public Health input to CPPs used a range of mechanisms. These included NHS Board Community Planning Groups (some of which focused on inequalities), Public Health Steering Groups, Health Improvement and Inequalities Groups, line management arrangements with individuals reporting to the DPH or Topic Leads and also the use of Public Health Department Business Plans.

Specific partnership planning and delivery happened through an array of thematic and locality based groups which came under the umbrella of the CPP. For many NHS Boards a number of partnership groups were in existence prior to CPPs. For some NHS Boards interviewees explained that partnership groups could feed into report to groups outside community planning partnership structures to fulfil other responsibilities. So one Early Years Collaborative was re-configured as a CPP subgroup. The structures had been established so that this one group does the work but may report/feed in a number of different directions.

Similarly it was reported that there may be multi-agency groups and partnership working outside CPP structures that need mechanisms to enable them to interact

with CPP groups. For example, one Inequalities Group identified that there was a huge amount of work going on, and they were trying to make the connections with all the relevant groups and agencies. Other partnership groups mentioned included Alcohol and Drug Partnerships and the Community Justice arrangements.

One NHS Board had taken the opportunity to review the existing groups to ensure that there was appropriate NHS representation and to agree the remit, role and responsibilities of individuals representing the NHS Board. It was hoped that this would help ensure that the right people were available to make decisions.

One DPH noted that community planning takes up a lot of public health resource. There are complex structures of local community groups but these have not been in place long enough to evaluate how well it is working. They commented that there are a lot of groups and if Public Health were on all of these *'…we would do nothing else'*. Working with multiple CPPs was described as challenging but given that it is not going to change, *'…we just have to work with it'*.

3.2.2 Partnership Working

There was almost universal agreement that community planning offers opportunities for delivery of the public health agenda, with the formal arrangements within CPP structures getting the right people around the table. Most interviewees said that partnership working was functioning well. One DPH said:

'We do partnership working and we capture the elements of that which fit into The Community Plan... Community Planning sits at the top but the strength is the partnerships underneath the Community Planning Board'.

There are strong engagement processes with a range of partners around key national and local priorities and The Community Plan was seen as pulling these together. In general the CPP guidance had not required any new work, and had been used to strengthen existing work and the arrangements already in place.

However, some interviewees commented that their partnership working was outside CPP arrangements. For example, one DPH said that community planning was not the main approach to their local partnership working. It was seen as an important part

but they were not totally reliant on it as a way of getting the work done. A large proportion of the work took place with the knowledge and support of community planning but independent of the formal community planning structures. The work of community planning is valued but was not the driving force behind a lot of the work, neither was it an obstacle to getting things done: '*We see community planning as a key part of getting commitment to the public health agenda and getting our recommendations implemented*'.

A DPH representative suggested that Community Planning should be the all encompassing, over-arching way that public sector business is conducted, instead of which it is perceived as a 'bolt-on'. Partnerships were working well before community planning, and continued to do so, but much of it is outside the community planning structures.

Partnership working within CPPs was described as challenging by many of the interviewees. Organisations have separate priorities, targets, budgets and responsibilities. Tight timescales may also make collaborative working a challenge. It was noted that sometimes shared priorities may need to be identified. For example, teenage pregnancy was seen as a sexual health issue, but local authorities became more engaged once it was recognised as an educational attainment issue as well.

One DPH suggested that their CPP was very Council dominated, with a slightly old-fashioned approach to some issues. They felt that there needed to be discussion about how to better engage other partners and shape the agenda.

Another DPH commented that their community planning partnerships worked well, but that there was a perception that it did not have much authority, operating on goodwill and commitment.

3.2.3 Governance Arrangements

One DPH expressed concern about the ownership and leadership of some issues, which appeared to be falling between the formal partnership structures and the Health Board or the Councils. This was not felt to be exclusive to the public health agenda. Examples were given for Getting it Right for Every Child, the Early Years Collaborative, as well as health inequalities.

Another DPH identified that there was still work to be done to improve the governance arrangements of some bodies within their community planning structures. Examples were given for the Alcohol and Drug Partnership that had a traditional line of accountability to the old Community Health and Care Partnership. There was discussion about whether the governance would be better through the CPP. Similarly with a well-connected, effective independent Children's and Young People's Planning Partnership, there was discussion about its governance arrangements, as opposed to the governance arrangements and management of specific projects it undertook.

A third DPH was finding that whilst there were very good Community Planning Partnership arrangements, they generated their own bureaucracy which was burdensome and made them less efficient and productive. It was felt that in some ways the bureaucracy was generated because of the success of community planning and the need for proper structures and accountability. Another DPH commented that the community planning partnerships can get somewhat bogged down in the Single Outcome Agreements (SOA) and performance management.

3.2.4 Joint Posts

A number of NHS Boards had joint posts with Local Authorities. The interaction of these with community planning was not explored in detail but included Joint DPH posts, Joint Head of Health Improvement and Joint Health Improvement Teams. Where these exist, they were considered to work well.

3.2.5 Development

The arrangements with CPPs were at different stages of development for each of the Public Health Teams. Some, such as NHS Borders were well established, with one CPP and many joint posts between the NHS Board and the Council. The Borders Community Planning Partnership has been subject to audit by Audit Scotland and its SOA was assessed as Highly Commended by the National Quality Assurance Process. Other Public Health Teams were at an earlier stage of engagement. One team used the survey to explore their team's understanding of CPPs, finding that most of the awareness and involvement was provided by the devolved CHP-based teams.

It was noted that the development of the Integrated Health and Social Care Boards is likely to have an impact on CPP. Early indications were that the Boards are likely to be as diverse as the CPPs themselves. How Public Health plays into these Boards will be subject to the local interpretation of the statutory Regulations set out by the Scottish Government. Once this has been agreed by the Cabinet Secretary, the impact in each local CPP may be assessed.

4 Developing Support for DsPH and Local Public Health Functions

As part of the data collection, interviewees were asked to consider what ScotPHN and other national agencies could do to develop support for Health Board Public Health Teams, both at a strategic and operational level. Interviewees were asked what work had been useful and where additional input could be focussed to help public health contribute to the community planning agenda.

On the basis of this information, the following areas for national development were identified.

4.1 Develop a Coherent Approach to Community Planning

A number of respondents highlighted the need for public health to develop a coherent, Scotland-wide approach to community planning and public sector reform. It was suggested that this needs to consider how public health is engaged with, and positioned within, public sector reform: both in relation to community planning and health and social care integration. As one DPH noted:

'…Where we want to take public health and what the options might be at the various stages in the pathway as it might emerge…facilitating a common consensus of what it is we are trying to do with public health and community planning processes and social care integration'.

4.2 The Role of ScotPHN

The role of ScotPHN in helping position public health within this agenda was noted by some. For example, it was suggested that there should be a view on how DsPH should contribute to work at a national level so that they were:

'…being clear with Local Government, COSLA, Scottish Government and the Improvement Service about what we see as the community planning priorities and how partnership working might facilitate delivery of these'.

One request was for help in developing the role public health has to play in creating Joint Strategy Needs Assessments and the Strategic Commissioning Plans for Health and Social Care Boards Respondents suggested the need to develop an understanding of current public health practice in relation to community planning across Scotland: specifically; to identify common systems and common priorities.

4.3 Develop guidance to inform Community Planning Partnerships

One respondent highlighted the recommendations from the Review of Health Inequalities in Scotland, (Audit Scotland (2012)) and requested that consideration be given to developing national approaches to key recommendations:

- to include in the SOAs clear outcome measures for reducing health inequalities which demonstrate impact; and
- to ensure that robust evaluation, using all available data and including outcome measures and associated costs, are an integral part of local initiatives aimed at reducing health inequalities and that staff have the skills to carry out evaluations.

(See: http://www.auditscotland.gov.uk/docs/health/2012/nr_121213_health_inequalities.pdf)

Similarly, a request was made for ScotPHN to consider developing generic guidance to inform the Prevention Plan for Community Planning Partnerships.

4.4 Topic Specific Support

Respondents suggested a number of specific, topic areas that could benefit from a national focus. These are summarised below. It was also suggested that existing ScotPHN work could be better signposted, perhaps under the Single Outcome Agreement headings, to increase accessibility. A further suggestion was to adapt work to make it more directly relevant to community planning, adult health and social care boards etc. A number of respondents commented that the Impact of Welfare Reform work and various needs assessments had made a valuable contribution to community planning.

- Children and Young People

A request was made for assistance around the Early Years Collaboratives. Whether this was in form of maximising the public health contribution to this work across partnerships or more practical areas such as in localising the national logic model/driver diagrams for each work area in terms of evidence underpinning these and possible indicators of progress towards the national aims.

Another interviewee noted that work focussing on Looked-after Children has been brought into community planning, so further work in this area may be helpful.

Youth unemployment was identified as a priority area for one CPP, could ScotPHN consider work around mental health and resilience?

- Older People

One DPH commented that the Older People's Health and Social Care Needs Assessment should really influence community planning but it had not yet done so in their area. They suggested that some of the existing reports might need adapting so that they are written in a community planning friendly way, making them very easily applied to the local area, perhaps written in a way that local data could be inserted or analysed for use in Joint Strategic Need Assessments .

Another DPH commented that there is a need to make sure that the *'"the older people's work continues"*.

- Other Topics

Alcohol – is there more that can be done around alcohol? Changing the culture, alcohol free events, advertising and sponsorship and the role of local groups around advocacy.

Food policy – a number of local authorities in one area are interested in food policy, not just healthy weight and obesity, but local produce and sustainability.

Work in these areas need to be nationally driven, but then tailored in such a way as to make them useful for local application in a variety of community planning and joint commissioning arenas.

5 Wider Public Sector Reform

5.1 Community Empowerment Agenda

Two interviewees selected community empowerment as an area for additional work. One suggested reviewing the proposals laid out in The Community Empowerment Bill currently passing through the Scottish Parliament. This outlines new duties to strengthen community planning, so that public sector agencies work as one to deliver better outcomes with and for communities.

A second interviewee suggested that there may be opportunities for ScotPHN to support a longer-term, wider strategic vision about community empowerment and the approaches to public sector reform.

5.2 Sustainability

Several respondents included 'sustainability' issues in their requests. One said that the work of the Scottish (Managed) Sustainable Health Network (SMaSH) is potentially helpful in working with colleagues in NHS Estates, CPPs, and local commissioning partners to improve sustainability, as well as health and equity.

Another asked "*What is Community Planning's role and approach to sustainability of public services?"* There may be a need to consider linking social enterprise developments and bringing in other organisations like First Port and Scottish Health-related Social Enterprise Network to look at the fundamental social inequality, income and employment.

It was noted that there is a need to ensure that clinical strategy, in terms of NHS contributions to adult health and social care integration, has more of a whole system focus, not just taking account of social services. Creating sustainable care services, and sustainable prevention for that matter, needs to include the differing voluntary sectors and communities themselves in co-productive ways.

5.3 Support for Smaller NHS and Adult Health and Social Care Boards

It was noted that some of the Public Health Teams from larger NHS Boards have access to additional resources such as Universities, and the Glasgow Centre for Population Health. In a world of small public sector arrangements, those with existing links to these resources are likely to maintain contacts (at least for a while).

However, could the NHS Boards, serving more rural and remote populations benefit from additional support from ScotPHN?

In an age where greater work at the very local level is being envisaged, what is the role for ScotPHN in helping and supporting such ways of working?

6 Conclusions

This document has sought to capture the views of DsPH (and others) in relation to Community Planning Partnerships and more local commissioning arrangements. As these structures have evolved over time, so have their views. However, the core message has remained the same.

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.

This is an important message to understand as Public Health is developed to meet the challenges of a reformed public sector, with its competing principles and challenges.

Annex 1: New Ways of Working - CPP Development - Questionnaire

NHS Board: ……
Completed by ……
Contact Tel .....
Date: ……

1	Please describe the local CPP "landscape" within your Health Board area? (How many are there? What are their main areas of operation? How does the NHS relate to them?)
2	Please describe your own *direct* involvement / input to the local CPP(s) (if any).
3	Please describe any *direct* involvement / input to the local CPP from members of your local Public Health Directorate (if any).
4	Does the local CPP(s) have access to other public health advice / resources which is not from within your Public Health Directorate team?

5	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.)
6	Please describe your own *direct* involvement / input to these arrangements (if any).
7	Please describe any *direct* involvement / input to these arrangements of your local Public Health Directorate (if any).
8	Does the local CPP(s) have access to other public health advice / resources which is not from within your Public Health Directorate team?

Please return to ScotPHN (nhs.healthscotland-scotphn@nhs.net) by 19 August 2013.

Many thanks.

Annex 2: New Ways Of Working - Community Planning Partnership - Interview Schedule

I am trying to understand how Public Health Departments engage with the Community Planning Partnership agenda. I would like to be able to describe the landscape, and identify any key documents which outline the structures and accountability arrangements.
From your survey response...I see that ...

2. Are these structures established or in a process of development?

3. a) What are the main areas of CPP work that your department contributes to?

b) What other joint planning or strategic commissioning arrangements are NOT covered by CPP?

4. Are there barriers that limit effective participation (of your public health department) in the Community Planning Process?

5. Are these 'challenges' improving?

6 Does the Community Planning Partnership agenda offer opportunities for public health?

7. ScotPHN is exploring options to develop support for Public Health Departments, both at strategic and operational levels.

What support has been useful so far?

8. Are there areas where you would like support (from ScotPHN) to make more of a contribution to the CPP agenda?

9. How would PH departments like to be able to influence the ScotPHN work plan/support for CPP work in the future?

ScotPHN report

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