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Improving Health Commission

Deliverable 3: Customer requirements of the improving health function

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Introduction

The purpose of this document is to describe the customer requirements for the future *improving health* function within Public Health Scotland. This includes an outline of potential products and services which would address customers' needs.

Project overview

The Integrated Joint Board (IJB) Chief Officers' Group and NHS Health Scotland (HS) in partnership with others, have been asked to describe and deliver options for strengthening the health improvement domain at national level within the new public health body; and in turn, describe how this will support and enable activities at the regional and local level across the wider Scottish public health system.

Thus far, as part of the Improving Health Commission work:

- The project group has summarised their ambitions for the new improving health function in the paper: Our Challenge: Improving the Health of Scotland's People.

- The group has produced a document describing the Current Health Improvement Landscape.

- The group has worked with the Scottish Health Promotion Managers Group to produce a detailed description of the health improvement function in health boards and health and social care partnerships.

- Stakeholder engagement has been a key focus for the project group. A survey was widely distributed and face-to-face engagements were carried out.

This paper is based on the work detailed above.

More detailed information on the work of the Improving Health Commission can be found in the Project Brief.

Customer requirements of the future improving health function

For the purpose of this paper, the term 'customer' describes those people (or organisations) who are best placed to improve the health of people in Scotland and who will receive products and services from the future improving health function of Public Health Scotland.

The customer groups outlined in this paper were taken from the Current Health Improvement Landscape paper, which contains more detailed information about each group that we have not repeated here. The customer groups are:

- Scottish Government
- Local authorities
- Integration Joint Boards (IJBs)
- Community Planning Partnerships (CPPs)
- Community and Voluntary Sector
- Housing organisations
- NHS boards
- Employers
- Global corporations
- The public

Stakeholder survey findings

The aim of the stakeholder survey was to gain a better understanding of what stakeholders need to work together to improve health and achieve better health gains for the people and communities of Scotland. This included asking stakeholders to provide feedback on the suggestions detailed within the paper *Our Challenge: Improving the health of Scotland's People* and share ideas about how to make the changes happen.

The survey was hosted on the Public Health Reform website and remained open from 6-23 November 2018. People and organisations with an interest in health improvement and the reduction of inequalities were alerted to the survey through the Improving Health Commission members. Stakeholders were also encouraged to distribute the survey through their local networks. In addition, NHS Health Scotland encouraged staff to disseminate the survey through their managed networks.

Survey response breakdown

Sector	**Total responses**
Public sector (broken down as):	64
NHS	34
Local authorities	11
Health and Social Care Partnership	4
University	1
Not revealed	7
Other	7
Third sector	22
Private sector	3
Members of the public	14
Total	**91**

The stakeholder survey included four qualitative questions:

1. How do you affect health in your context?
2. What do you think is required for all organisations to give priority to their effects on people's health?
3. What do you think is required to support the ‘health in all policies' approach? This means ensuring the impact of health is considered in all decisions; including in areas, which are not specifically about health but which affect it (like housing, education, employment, social support, family income, our communities and childhood?
4. What do you think is needed to ensure that actions to keep people healthy are prioritised over services that treat people once they are already ill?

Survey results have been analysed and grouped into themes, which are shown below. It should be noted that some responses could be categorised under more than one theme.

Themes

An overwhelming majority of responses support the proposals outlined within the paper *Our Challenge: Improving the Health of Scotland’s People*. There are no significant difference of themes identified between responses by sectors. Responses offered feedback on what survey respondents feel is required to achieve success.

Better communication

- Improve understanding about the underlying social determinants of poor health, together with a much greater political will to invest in tackling these.
- Increase awareness of the impact on health and health inequalities from policies which are seen as being outside the ‘traditional’ health field.
- A shared understanding and language is needed across different policy areas, sectors and settings which can support better communication and collaborative working, for example around what is meant by health, health improvement, inequalities, and wellbeing.

Culture change

- An increased understanding and culture shift is needed to challenge entrenched and outdated attitudes about the contribution of different sectors, settings and organisations to undertaking primary prevention and their ability to influence the social and environmental determinants of health and wellbeing.
- This should result in achieving a greater parity of esteem among all stakeholders, particularly the third sector and challenging the imbalance of weight and influence which some sectors command.
- The function and purpose of national organisations within the statutory and public sectors should include supporting health improvement/ health inequalities agenda.
- Call for spending/ resource allocation to shift from treatment/ clinical care to prevention more quickly as recommended by the Christie Commission with responses expressing concern around the lack of progress, lack of leadership and accountability.

- Evidence for the economic benefits of adopting a prevention approach to focus on the social and environmental determinants of health should be made clearer and widely publicised.
- Recognition that many of the actions that keep people healthy happen outside the NHS.

Resource allocation

- Greater parity of esteem should be used to address a significant 'imbalance' of resource allocation which currently exists. Stakeholders across the policy spectrum need sufficient resources and capacity to increase their prevention/proactive activity rather than focusing on reactive approaches (fire-fighting).
- Greater trust and understanding is needed around the third sector how they can support prevention activity – particularly from the health sector.
- Any saving that local authorities can create for the NHS by creating vibrant resilient places needs to result in some diversion of funding from the health budget to local authorities particularly in the spatial planning arena.
- A clear decision-making framework is required which can support 'win-win' situations and trade-offs between health gains and other gains.

Advocating for prevention approaches

- There is a need to raise awareness around economic benefits of a holistic/ prevention approach both in terms of the impact of preventative spend on improved health outcomes as well as reducing demand on NHS services.
- It was suggested that prevention approaches and actions are not particularly valued at the moment by some stakeholders, particularly those with a clinical remit within the NHS.
- To support evidence informed advocacy, use of evidence-based actions which are known to work for 'upstream interventions' are imperative, not least to reassure sceptical stakeholders that prevention activity will work around improving health and reduce demand on health services.
- The responses were clear that the aim should be to redress the significant imbalance which exists around resource allocation in favour of services and that action around prevention is equally important as care and treatment.

Strong national leadership

- The ambition requires strong leadership, commitment, & advocacy from Scottish Government and the new body Public Health Scotland

- Clear leadership is needed from Scottish Government that the delivery and progression of the public health priorities in Scotland is an integral part of service delivery with public health viewed as a shared responsibility by all.

- Health outcomes should be embedded across the policy spectrum.

- Local service providers need to be commissioned on a minimum of three year Service Level Agreements and evaluated on these outcomes. The focus should be on outcomes, not outputs.
- There is a real need to outline how stakeholders across the policy spectrum can help and support each other to meet the outcomes within the National Performance Framework.

Tools, approaches and processes

- The health sector should be involved in the development of policy in all areas that impact on health.
- Health Impact Assessment (HIA) should be set within statutory legislation, providing a duty for all policy makers to undertake HIAs for all national policy and ensure clear accountability and monitoring.
- There should be a specific section within all policies which outlines how the policy relates to and influences health and health inequalities.

Innovation Ideas

In addition to the themes above, a number of innovative suggestions were made in the responses to the survey, including:

- Ensuring planning authorities request evidence of health being considered at the planning application stage of new developments in the community.

- Developing a hub system to support health sector professionals to understand what third sector services are on offer in their area and enable all service providers to work better together.

- Using wellbeing as the standard basis for measuring impact, including in the planning and implementation of all public policy.

- Adapt workforce planning and job profiles to reflect the importance of health improvement across a broad range of roles.

- Commission a Health Rights Commission by and for the people, which will be responsible for undertaking a health and health inequalities impact assessment for all governmental policy decisions liable to impact on health, gender and other socioeconomic inequalities and other social determinants of health.

- Include health improvement and health inequalities in the school curriculum.

- Provide more support for third sector and community organisations to evidence what they are doing.

Stakeholder engagement

Stakeholder engagement has been a key focus for the project group. Building on the landscape paper, the stakeholder engagement plan identified groups with which the Commission wanted to engage and assigned each group to a commission member as the engagement contact. The table below provides a summary of engagement outcomes for a selection of stakeholders.

Stakeholder	Summary of engagement outcomes
Improvement Service	Regular updates have been provided to IS and meetings have taken place with all staff working on public health commissions. The outcome of this was: • Better understanding of the impact of health improvement across all commissions the Improvement Service is involved in. • Recognition that the whole public sector system has a role to play in improving health, with a need to look beyond the health profession to make this work. • Agreement around the need to promote the use of existing community planning structures (e.g., the development of Local Outcomes Improvement Plans and Locality Plans) as the methods for recording and measuring progress against health improvement. • Recognition of the need to understand what not only the data, but crucially what people and communities, are telling us about their public health needs (and the services as a result). • It highlighted the need to realise the benefit of improved public health on a number of reactive demand driven services.
Members of the Faculty of Public Health in Scotland	The Committee of the Faculty Public Health in Scotland was asked to disseminate the survey link to members in Scotland. The link was also sent to Public Health Specialty Registrars, which generated an additional more in-depth discussion. The outcome of this was: • It was agreed that cross sector working is effective for big wins at policy level e.g. ACEs work, Minimum Unit Pricing, Smoking ban. • It is important that we don’t just work with the same third sector organisations, but rather obtain a more sophisticated understanding of which third sector organisations to work with and how on which aspects and then to target that approach.

	• It is important to roll out pilot programmes when they evaluate well, instead of forgetting about them. • We need to prioritise and encourage partners to think 'prevention'. • We need to think about ways we can support services by reducing demand instead of supplying more services? • We need support from national bodies to achieve this goal • We need to truly engage in community empowerment. • It is important to move away from short term funded projects which do not allow meaningful changes to be made. • We need a 'supportive' approach not 'directive' for multi-disciplinary work to be taken forward. • We need to map organisations that are involved in various sectors so that we can appreciate their contribution and involve them more.
Directors of Public Health (DsPH)	Engagement took place at the August meeting of the DsPH. The DsPH agreed with the thinking set out in the Challenge paper. Specific points include: • At local level there has been a loss of public health capacity – examples were given of posts devolved to HSCPs that have disappeared. • Public health should play an important role to support HiAP in Local Authorities and all DsPH should identify resource to support HiAP. • There is a key opportunity just now with implementation of the Fairer Scotland Duty as HiAP approaches can help to meet the Duty. • There was discussion about targets as an incentive mechanism for the use of HiAP and the suggestion that the Commission could operationalise HiAP by demonstrating how it can help address the public health priorities. • It was suggested that the public health reform team could write to all the other Cabinet Secretaries and ask how they will support delivery of the priorities. • There was discussion about the proportion of local authority level policies and plans that would require public health support to adopt HiAP – some could be led by Local Authority officers.
Academics	Several academics who are interested in health improvement contributed to the Challenge document. There was strong support for: • The overall aim to re-focus work 'upstream' to address health determinants.

	• Recognition of a need for system wide, multi-level approaches to public health priorities • Advocacy to support shared ownership of health • The Health in All Policies approach. Academics were also encouraged to contribute to the survey.
NHS Health Scotland Staff	NHS Health Scotland staff took part in two staff engagement sessions across its two sites (Edinburgh and Glasgow) and there were also a number of specific discussions with, for example, the Corporate Management Team, Heads of Service and Directorates. The following is a summary: • All public sector organisations should be encouraged to take responsibility for undertaking action resulting from health impact assessments. • We need to identify the levers that shape professional practice and quality improvement processes to see how they could be reframed e.g. quality improvement in social work via Chief Social Work Officers. • Staff health and wellbeing should be a core objective for all organisations. • We need to ensure all key agencies are involved in policy development – public and third sector. • We need better interactive user engagement to understand how we can influence stakeholder actions and build them into our service approach. • We need to improve understanding/ knowledge of what health improvement is. • It is important to prevent the slide towards individual behaviour change interventions. • We need to improve the relationship between public health and the third sector to prevent it being an ad hoc case of who knows who. • We must make sure that as a new organisation PHS does not lose sight of important public health issues that do not sit neatly under the six Public Health Priorities. • We need to make sure that the Public Health Priorities do not become defacto PHS's health improvement priorities. Health improvement should be seen as making a contribution to the PHPs, but not owning them. • We need to promote a more positive view of public health. • We must ensure autonomy of voice and authority to influence at an international level (which would include recognised authority to influence at UK as well as Scottish Government level).

Scottish Health Promotion Managers (SHPM) group	Engagement took place at the August meeting of the SHPM group. The SHPMs agreed with the thinking set out in the Challenge paper. They also provided detailed feedback in response to the four questions in the survey, which was included in the analysis above. Specific points to highlight include: Q1. What is currently working in relation to health improvement in Scotland? • The strong local presence supports partnership working across CPPs, ADPs etc. • Local health improvement provides effective leadership for health; bridging the gap between strategic and operational work and getting evidence into practice. • Local teams understand local needs and profiles. • NHS Health Scotland provides good resources around health inequalities. Q2. What needs to change at local and at national level in order to meet the health improvement challenge? • Strong national leadership with a collective narrative for delivering public health priorities. • Clarity on contributions between local, regional and national roles; with governance arrangements in balance with local partnerships. • Health improvement needs to be more integrated across the system with collective planning processes (at local, regional and national level). • Public Health Scotland needs to provide a clear offer of products and services for local use. • Community planning for health improvement is currently not effective in practice. • Retention of workforce capacity with a stronger recognition of core health promotion workforce. Q3. What do you need from a national public health body? • Autonomy of new body to advise and influence Scottish Government especially from the ground up, holistic and non-medical perspective. • Support on data and evidence. • Provide a key link for us at local partnership level into Scottish Government – policy, workforce development and planning – resource commitment.

	• Breadth of skills aligned to the public health priorities, e.g. mental health, so that local system can influence and draw on this, e.g. intelligence. Drawing on local expertise and knowledge e.g. through task groups / special interest groups (SIGs) • Recognition and leadership of practitioner workforce – with a clear system for workforce planning, support for national and local system planning; career framework. • Lead and coordinate actions for the PHPs. • The new body needs to be set up and operate in a way that everyone across the whole public health system feels a part of it. Q4. What will be different about Public Health Scotland, and how will that support/enable stakeholders to achieve change? • A common public health narrative with recognition of inter-relationships across the wider system. • Ensure sustainability of workforce. • Recognition of the contribution of local workforce. • Increasing joint up working should facilitate planning, action and support for joint priorities. • Different leadership and governance will be an opportunity; particularly closer alignment (and accountability) to COSLA. • Public Health Scotland should provide more direct support to localities. • A role around funding and prioritisation of funding, with effective decision making frameworks to support local system work with partners.

Summary

In summary, stakeholders in general agreed with the thinking in the Challenge paper and were supportive of actions listed in it.

Factors relating to health improvement which were felt to be working well included:

- whole system working
- identifying local priorities
- partnership working
- capacity-building across the wider public health workforce
- the move towards public health registration (practitioner and specialist).

Aspects requiring change at local and national level were identified as:

- a shared understanding of health improvement and the public health function

- better co-ordination and integration of local systems
- collective planning around the public health priorities
- ensuring that SG policy leads closely co-ordinate their ask of local systems
- using existing community planning structures (development of Local Outcomes Improvement Plans/ Locality Plans as the methods for recording and measuring progress against health improvement.

Stakeholders said that the new public health body should have increased autonomy to advise and influence partners, especially the Scottish Government. It should have a clearly understood package of products/services which it can provide to local and national partners, provide leadership and governance of the health improvement workforce, operationalise how it will support the PHPs and hold Health and Social Care Partnerships to account for the national health and wellbeing outcome around health inequality.

The feedback aligns well with that received via the stakeholder survey.

Analysis of customer requirements

The commission group undertook a workshop to discuss what had been learnt through stakeholder engagement in order to identify customer requirements. For each customer group, the commission group developed a brief description of:

- The customer group's role and remit
- Key opportunities and barriers for the customer to improving health and reducing inequalities
- An outline of potential future products and services which can address identified problems and opportunities
- The changes required to enable delivery

Scottish Government

Scottish Government's role and remit
The Scottish Government is responsible for implementing laws and policy on matters that are devolved to Scotland including health and health improvement. It has a number of civil servants responsible for 'core' health improvement policy covering topics such as physical activity, food and obesity, and substance misuse. In addition to the core health improvement policies, Scottish Government also has responsibility for policy areas that are not directly badged as health improvement but which impact on health improvement. The Scottish Government involves stakeholders in policy matters through public consultations and by talking directly to key stakeholders.

Opportunities and barriers for the Scottish Government in improving health and reducing health inequalities
Opportunities: • Many of the key drivers of health and health inequalities sit with SG policy including housing, environment and local government. • SG policy has direct impact on social, environmental and economic determinants. • The culture, discourse and expectations set by SG influence other public sector organisations. Barriers: • Some of the policy areas with the most significant impact on health are outwith Health Directorates and therefore their primary focus is not on the impact on health. • Some of the most significant policy areas for health are reserved to Westminster, including benefits and social security, and employment. • Credibility of Public Health Scotland (with regards to quality of evidence, quality of relationships and political acuity) is critically important to build and maintain in order to have the policy influence relationship needed.
How the improving health function can support and enable the Scottish Government
• Adopt and invest in Health in All Policies approach with priority SG policy areas – need to identify staff with relevant skills to do this • Use of health impact assessments and similar approaches • Development of data and evidence that demonstrate links with health outcomes • Research and evaluation of health outcomes from policy across all sectors • Advocacy for shared ownership of health outcomes • Keeping health on the agenda – advocate for Right to Health and show links with policy decisions
What needs to change to deliver that
• Recognition that ‘health’ is not just about the NHS • Acceptance of Health in All Policies approach • Increased joint working • Time spent on building relationships • Re-focusing of data and evidence towards social determinants rather than healthcare/ health programme performance • Willingness to prioritise health outcomes over economic and other outcomes.

Local Government

<table>
<tr><td>Local Government's role and remit</td></tr>
<tr><td>There are 32 local authorities in Scotland. Each has responsibility for a range of services that can support local health improvement. Examples include housing, education, sport and recreation, environment, spatial and urban planning.

The role of local authorities includes:
Being a major employers (see Employers/work section)
Licensing, including around food, alcohol, gambling and landlords
Providing resilience/ civil contingency, via their planning role and incident response
Being a community planning partner
Providing infrastructure e.g. roads, transport, housing, master planning, building developments
Providing universal services including. education, emergency services, and social care
Facilitating economic development – business/ corporate connections (chamber of commerce), regional and local economy
Providing facilities for sports, leisure and culture, and provide services including childcare services, housing and financial inclusion services and citizens advice</td></tr>
<tr><td>Opportunities and barriers for Local Government in improving health and reducing health inequalities</td></tr>
<tr><td>Opportunities
Providing opportunities for 'good work' through employment and procurement practices
Set local policies/ duty of wellbeing (statutory)
Steer connections for the wider good – public, community, business
Direct resources to priority areas
Shape the agenda for others; provide a narrative and strategic direction
Significant weight/influence enables critical advocacy role, lobbying and influence
Strong/ adaptive leadership as a means of effecting change and delivering on commitments
Community asset transfer as a means of empowering or reinvigorating people, groups and areas
Barriers
Complicated voting system and local government structure
Efficiencies and loss of staff leads to resource constraints
Loss of prevention services – not seen as statutory
Impact of transformation priorities, i.e. investment heavily focused on ways of doing business (e.g. digital) and becoming less so on front line delivery
Influence of business interest and global economy – e.g. market forces' influence on planning, licensing</td></tr>
</table>

- Political will/ ideology is difficult to plan for, changes every five years, conflict between national and local politics.
- Relationship between national and local government – national and local government do not always agree on issues
- Variations in approaches across 32 councils
- Relationship of each authority to COSLA and differing levels of influence
- Silo visions and limited ability to grasp opportunities
- Structures may be a barrier to effective planning and implementation

How the improving health function can support and enable Local Government

- Create the environment for movement of the workforce across spheres – CPP manager, health improvement practitioner, middle ground operators
- Local Authorities, in most cases, provide the resources to facilitate Community Planning Partnerships, where a substantial range of work around public health takes place. Therefore this is where the improving health function can input across a range of services and agencies.
- Vocational focus on practitioner development (skills not just knowledge)
- Share/ highlight good practice, e.g. award scheme. There needs to be a collaboration across a range of improvement agencies who have the responsibility and resources to enable the sharing of good and innovative practice. This will vary from community to community.
- Provide evidence and resources and illustrate the links between the local authority's work and health
- Promote knowledge into action approach and provide knowledge brokerage/ translation function
- Develop and share tools, including Health Impact Assessments and other needs assessments
- Develop skills around advocacy and influence, horizon scanning and adaptive leadership
- Develop community skills – including assisting with developing capacity in areas experiencing inequality.
- Support and evaluation/ evaluability assessment
- Capability support – training, mentorship/ coaching, leadership, management development for health
- Improvement skills usage across systems

What needs to change to deliver that

The Local Authority provides a range of services that have a major impact on public health, e.g.: Economic development, Housing, Children's Services, Adult Social Care, Culture and Leisure. The improving health function of Public Health Scotland will need to acknowledge this and provide support tailored to local government. Investment of time, resources and expertise will be needed around early intervention and prevention.

Consideration could be given to providing local government with a central role in delivering health-improving activity (accompanied by the rebalancing of resources that would need to come with that).

Local authorities are leaders of place, and although they are no longer the lead community planning partner in legislation, they should be seen as central to coordinating and giving democratic accountability to the planning and delivery of public health services in their broadest sense.

Integration Joint Boards

Integration Joint Boards' role and remit
Integration Joint Boards (IJBs) bring together local and health and social care services. The National Health and Wellbeing Outcomes apply across all integrated health and social care services and are intended to provide a strategic framework for the planning and delivery of health and social care services. One of these outcomes specifically requires IJBs to contribute to a local reduction in health inequalities. The role of an IJB includes: • Bringing together health and social care services under the Public Bodies (Joint Working) (Scotland) Act 2014 and managing delegated services • Delivery of national outcomes and development and implementation of local strategic plans and delivery plans • Being a community planning partner • Addressing/ reducing inequalities • Leading on strategic commissioning of health and social care services • Locality planning, including Joint Strategic Needs Assessment • Improving health, either with a dedicated health improvement team or in partnership with the health board health improvement team • Promoting self-management and wellbeing • Community focus, including community based health services • The funding of care at home services • Partnership working with the third and independent sectors and with primary and secondary care, and social care • Community justice outcomes • Innovation and transformation • Strategic planning of acute care service (Mental health, some secondary care), from the front end of provision
Opportunities and barriers for IJBs in improving health and reducing health inequalities
Opportunities: • Supporting primary care to be impactful around reducing health inequalities and improving health • Taking a whole system approach, working with partners to ensure better integration and alignment of activities and outcomes • Influencing opportunities (including the IJB Chief Officer's position with the health board and the local authority, the strategic commissioning role, the

strategic planning operational Board membership and the community planning role) can be used to encourage a population approach is taken with a focus on prevention and the reduction of inequality
- Supporting the adoption of a social model approach to health (as opposed to the medical model), being person-led and collaborative
- Promoting the use of Self-Directed Support and a person-led approach to social care SDS

Barriers:

- IJBs are still relative new bodies and ways of working are still being developed
- The “delayed discharge” agenda dominates, draws work downstream and away from the social determinants of health and can make it difficult to secure investment in prevention
- The effectiveness of links with the public health team/ DPH in the health board varies from area to area
- Some IJBs do not feel empowered, in part a legacy of the previous attempts at health and social care integration (Community Health Partnerships)
- There are cultural differences between the health service and local government
- Professional protectionism can hamper effective collaboration
- Working in siloes can prevent a whole system approach being taken

How the improving health function can support and enable IJBs

- Improve understanding of the IJB’s place in the whole system, including connections, blocks and interdependencies
- Develop modelling tools for use in decision-making at a local level
- Provide segmentation data
- Provide examples of good practice and build up an evidence base of what works to reduce inequalities
- Undertake capacity building for community development
- Capacity building to support IJBs to work upstream around prevention

What needs to change to deliver that

There needs to be a greater understanding of the role of IJBs and the potential IJBs have to improve health and reduce inequalities.

The national drivers need to support work around prevention so as to refocus staffing and resources away from downstream work around delayed discharge.

The improving health function of Public Health Scotland will need to have a closer relationship with IJBs and tailor products and services specifically for IJBs. These products and services must be developed by people with a detailed understanding of the operating context of IJBs and should be developed with the involvement of the people who will be using them.

Community Planning Partnerships

CPPs' role and remit
Community Planning Partnerships (CPPs) plan and provide public services in a local area. Each CPP focuses on where partners' collective efforts and resources can add the most value to their local communities, with particular emphasis on reducing inequality. Health improvement is one of the issues covered by CPPs. It is envisaged that CPPs will play a key role in realising the new national Public Health Priorities. The role of a CPP includes: • Producing a Local Outcomes Improvement Plan (LOIP), which sets out their local priorities and planned improvements, covering the whole council area • Producing Locality Plans, which cover smaller areas within the CPP area, usually focusing on areas that will benefit most from improvement. • Delivering outcomes agreed under each LOIP with a focus on reducing inequality and disadvantage • Empowering communities and enabling effective participation, in line with the Community Empowerment Act 2015 • Co-ordinating partner groups and resources • Improve the economic footprint of the council area.
Opportunities and barriers for CPPs in improving health and reducing health inequalities
Opportunities: • Allocate resources to prevention activities • Evidence the need in the local areas and describe the issues and what can be done by partner organisations • Work across a wide range of stakeholders on a statutory footing • Be the lynchpin of local/national working, ensuring that national bodies learn from CPPs • Uniquely placed to deliver on the Public Health Priorities and contribute to national strategies (public health should not become another "local" plan) • Focus on health and wellbeing • Drive forward improvement through national divers such as the Fairer Scotland Action Plan, the public sector equality duty, and the Child Poverty Strategy. • Using commissioning and procurement to reduce inequality • Providing Financial Inclusion Services to maximise people's incomes • Raising the profile of CPPs as the key vehicle for improving health and reducing inequalities Barriers: • Comparatively low level of 'moveable' partner resources, therefore limited capacity to shift resources

- Competing interests among partners, linking activity to a public health intervention e.g. community police officer
- Lack of good data and data analysis providing real-time and predictive information
- Leadership and vision can be variable from area to area.

How the improving health function can support and enable CPPs

- Develop person-centred evidence/ data based interventions – linked to localities
- Support the CPP to act as one public service, using the LOIPs
- Facilitate all partners sharing data and helping them understand how to use it
- Provide analyst support at a local level
- Support the CPP to be brave about shifting resources to prevention, ensuring that CPPs use the LOIPs and don't create another public health planning construct
- Provide capacity building for taking a Health in All Policies approach – networking between CPP teams, sharing experiences, training, best practice, and evidence resources.

What needs to change to deliver that

CPPs are focused on delivering the outcomes in their LOIPs and Locality Plans. Given the focus on reducing disadvantage and inequality in these plans, improving health will be central to that. These plans already provide the basis from which to deliver improved public health outcomes. The following points focus on areas we need to focus on:

- Current community planning governance arrangements provide a vehicle through which community planning partners should seek to plan, collaborate and deliver on local priorities in order to tackle inequalities, including health. The accountability for the local delivery of improving health should lie with relevant community planning partners (e.g. local authority, NHS, Police, Fire etc.) rather than with the community planning partnership itself.
- Given the current community planning landscape, it is not necessary or desirable to focus on a structural solution or create new layers of partnerships to deliver this.
- Community planning is one of many processes which individual partners may choose to utilise in delivering improved health in each locality. Therefore improving health and other supporting activity may appear within LOIPs and local reporting; however, this will be by local agreement and should not be considered the totality of partners' contributions.
- Local contribution to should be influenced by local evidence, local assets / needs and community participation.

The intention for Public Health Scotland to be a statutory community planning partner is welcomed and would have a significant impact on maximising the opportunities and minimising the barriers.

Community and voluntary sector

The community and voluntary sector's role and remit
The community and voluntary sector makes a significant contribution to improving health outcomes for people in Scotland. This customer group includes larger umbrella organisations such as the Scottish Council for Voluntary Organisations and the Health and Social Care Alliance, as well as topic-specific groups such as Alcohol Focus Scotland and Obesity Action Scotland. A full mapping of community and voluntary sector organisations and groups, including a description of their specific remits, can be found in the commission's current health improvement functions paper. The community and voluntary sector's role includes: • Providing services including mental health, physical activity, healthy eating and self-management • Responding to community needs and issues • An advocacy role to raise and address community concerns and issues • Reducing isolation and improving connectedness for individuals and communities • Campaigning/lobbying both at a policy-level and at a community-level • Offering opportunities for volunteering • Providing opportunities for bottom-up growth, including through social enterprises • Taking part in community planning and enabling community engagement.
Opportunities and barriers for the community and voluntary sector in improving health and reducing health inequalities
Opportunities • Support the upscaling of Participatory Budgeting to expand community participation in mainstream budget allocation • Utilise the sector's expertise in community engagement, taking a holistic approach and using a social model of health • Work with the sector as a catalyst for community action on health issues • Expertise in formal and informal partnership working across sectors • Making the most of the sector's trusted relationship with local communities and ability to focus on people experiencing the poorest health and social outcomes • Make the most of the sector's ability to be flexible and able to adapt services to meet expressed needs • Utilise the sector's creativity, entrepreneurship, lack of risk aversion, and freedom from market-led goals to drive forward innovation • As employers, the sector can be exemplar of best practice by being driven by social improvement goals rather than by profit and taking a holistic approach. Barriers • Short-term funding is a barrier to achieving long-term outcomes and moving of more upstream

- Lack of understanding and recognition of the contribution made by the sector to improving health and reducing inequalities
- The difference in scale between the resources and capacity of the sector compared to the public sector
- Capacity to engage with public sector procurement processes
- Top-down approaches dominate over the sector's more bottom-up approach
- The creation of small, local community-led organisations can be stifled by a demand-driven approach
- Financial constraints, including the prevalence of short-term funding.

How the improving health function can support and enable the third and community sector

- Work with the sector to support improved awareness and understanding of the social model of health within mainstream agencies/partners. This includes how their work/impact is located within the social model and how they can adopt this model in their approach.
- Support the sector to provide more hands-on support for people and communities to shape their own actions to improve health, influence health spend and determine priorities so that communities are supported to deliver on public health outcomes.
- Improved sharing of health improving data and intelligence across all sectors.
- Help address the need for fire-fighting: existing resource issues are inhibiting change across sectors, strong leadership and guidance is required to look at how we all use our resources in a different way
- Provide expertise and assistance with translating and using evidence that is appropriate to community/voluntary sector approaches. This could also include undertaking longitudinal research into community led approaches and/or social interventions that improve health.
- Reframe how we talk about health in Scotland so that the focus is on good health and wellbeing, not just about providing health services, statistics and treatment of diseases/conditions.

What needs to change to deliver that

- Change our over-reliance on the medical model of health and shift resources and activity towards other models that support prevention and self-empowerment.
- Develop actions/interventions that achieve outcomes that are people driven/led, not just high-level outcomes that are solely top-down and/or medically driven.
- Recognise the importance of using different types of evidence – open up the system to acknowledge the relevance of lived experience and self-reported improvements in health via participation in social interventions.
- Better empower and enable community-led organisations (of geography and identity) to work with individuals and families to access information, identify options and make choices for their health and wellbeing.
- Develop and/or strengthen accessible structures that support local inequalities work and activity across partners – not all CPP locality structures/processes support meaningful engagement, particularly for identity or issue-based organisations.

- Support and assistance for better policy implementation – supportive policy for empowering people and communities exists but its implementation can be patchy and under-resourced.
- Apply collective leadership models to involve all stakeholders in decision-making and implementation (local and national).
- Training public agency staff in the social model of health, preferably in a multi-disciplinary and/or cross sectoral setting.

Housing organisations

Housing organisation's role and remit
Housing has an important influence on health outcomes for the people of Scotland. The Chartered Institute for Housing, Scottish Federation of Housing Associations, Royal Town Planning Institute and Shelter are examples of organisations which are included in this customer group, as well as local government, housing associations, letting and estate agents, housebuilders and facilities management companies. A mapping of housing organisations, including a description of their specific remits, can be found in the commission's current health improvement landscape paper. The role of housing organisations includes: • Providing sufficient housing stock both in the public and private sector • Providing quality housing to meet or exceed building standards requirements • Supporting tenancies • Managing repairs and maintenance to achieve the requisite standards • Achieving the relevant safety standards • Provision of neighbourhood management and essential services • Supporting community connections and amenities • Providing an accessible environment including for vulnerable people • Supporting independent living and other needs of the household • Collaborating with partners to tackle homelessness • Reducing demand in other sectors, e.g. delayed discharges in hospital • Contributing to statements for health and social care strategic plans • Providing advice and information • Wellbeing: one of the Government's national indicators for housing is around wellbeing • Strategy: joining up Local Housing Strategy, Strategic Investment Plan with Strategic Commissioning Plans through the Housing Contribution Statement • Prevention and place making: creating places that are sustainable and promote wellbeing • Housing organisations also employ significant numbers of people.

Opportunities and barriers for housing associations in improving health and reducing health inequalities
Opportunities: • Contributing to the realisation of national strategies including mental health, dementia, loneliness and social isolation, and children and people. • Improvement of building standards around wellbeing principles to provide quality housing and integrated communities • Holistic design with health and social outcome focus, rather than profitability • Technological improvements including smart homes, with the potential for targeted development • Improving access to housing for vulnerable groups, including homeless people • Long-term planning and development strategies to ensure a sustainable housing stock • Co-production between health and housing partners • Increasing use of health impact assessment for housing • Employment opportunities including sector growth • Doing more around the prevention of health-harming factors in communities and more to promote the benefit of creating places that are sustainable and promote wellbeing. Barriers: • Resource limitations including staff and financial backing • There are multiple suppliers across the industry, which can make engagement and communication difficult • Economic diversity across Scotland leads to huge variability in investment and metrics • There has been a reduction in housing staff working to support independent living and promote wellbeing and early intervention • Affordability of housing, access to affordable housing • Private sector investment is dependent on returns, which draws the emphasis away from quality • There are challenges in developing sufficient community amenities in addition to housing stock, such as road layouts, schools, and parks • There are fewer investors in geographically remote or poorer areas • There is variable in the quality, size and amount of housing stock in different areas • It is difficult to ensure quality, affordability in housing provided by private landlords • There are variations due to the tenure of leases • Health impacts caused by cold, damp and overcrowded housing.

How the improving health function can support and enable housing organisations
• Provide up to date evidence about the relationship between housing and health • Provide data linking health outcomes with housing i.e. how fuel poverty impacts on health outcomes • Offer training and support for housing staff to recognise people at specific risk (e.g. dementia, mental health, domestic abuse, substance misuse) and signpost to services • Offer opportunities to bring health professionals together with housing professionals to facilitate cross sector learning and understanding • Facilitate networking and the sharing of good practice • Provide guidance and support around integrating health outcomes into local housing policy/strategy • Conducting health impact assessments on local housing policy/strategy.
What needs to change to deliver that
NHS Health Scotland supplies some of these services already and potentially could supply them all but the main issue is capacity. Public Health Scotland would need a greater level of resourcing in this area to be able to offer all of these services all across the country consistently and simultaneously. Further changes required include: • Greater recognition and understanding of housing's contribution to improving health and reducing health inequalities • Increased collaborative working across partners involved in place making • Appropriate protocols in place relating to data sharing, policy and services development and consultation.

NHS boards

NHS boards' role and remit
NHSScotland includes 14 local health boards which are responsible for the protection and the improvement of their population's health and for the delivery of healthcare services. Health boards have a health improvement team (some under the auspices of the H&SCP) which vary in shape and size. However health improvement work is not restricted to the health improvement team, which has a role in supporting other parts of the NHS and wider system to improve health and reduce health inequalities. There are also seven national boards and one public health body that support the regional NHS Boards by providing a range of important specialist and national services. The role of the NHS includes: • Providing patient-facing services across the lifespan including primary care, acute care and community care

- Providing high quality services and achieving continuous improvement of services, working with IJBs
- Transformational change – delivering services locally in communities in line with the 2020 Vision
- Providing services covering prevention, health improvement, and public health
- Meeting national and local delivery plan targets
- Maintaining and developing suitable infrastructure and building stock as a property/asset owner
- Being a significant employer and providing high quality employment including progression/development
- Having a substantial economic footprint.

Opportunities and barriers for the NHS in improving health and reducing health inequalities

Opportunities:

- Delivering inequality-sensitive services/ practice
- Offering opportunities for workforce training to improve knowledge and skills
- Promoting staff wellbeing through employment terms and conditions and workplace practices, including ensuring the principles of 'good work' are incorporated into the monitoring of the Staff Governance Standard and promoting active travel
- Mitigating and preventing the impact of inequality through commissioning and procurement policy and practice
- Advocating to reduce health inequalities: Leaders, Board Members and other senior managers can actively advocate for action on inequalities in partnership with local authorities, IJBs, the third sector and others in their community
- Proportionate universalism: focussing resources to those with poorest health outcomes
- Taking a human rights based approach and embedding the PANEL principles into all work (participation, accountability, non-discrimination and equality, empowerment and legality)
- Quality of service provision and continual improvement, including taking opportunities to utilise resources more effectively
- Move upstream and focus more on prevention, while also maintaining work around mitigation
- Promoting self-management
- Community asset transfer as a means of investing in communities and outcomes
- Potential to capitalise on emerging technologies including such as e-health, to drive efficiencies
- Potential to use green space more effectively to improve wellbeing
- Ensure public health considerations are highlighted through involvement in community planning as a consultee in the development of local social infrastructure
- Prioritise preventative services, including early years and early intervention.

- Work with partner organisations to advocate the Health in All Policies approach.

Barriers

- Budgets: Limited financial resources and the focus of funding is heavily geared towards acute care rather than upstream prevention
- National procurement rules and processes can be a barrier to local innovation
- It is challenging to change the public's view of what the NHS is for and how it should be used – overuse, misuse and dependency is an issue, as is the culture of seeing the NHS as an ill-health/illness service rather than holistic healthcare
- Linked to the point above, political views at a national and local level do not always support the necessary change
- The workforce is ageing with increasing ill-health
- Workforce capability: outdated approaches may curtail innovative and more effective solutions to new and complex problems
- Brexit and the risk of losing skilled workers
- Targets such as the four hour waiting time target in A&E drive focus and funding into solving downstream issues and can distract from upstream prevention work which would be more likely to reduce demand on A&E
- The service is demand-led and demand is rising with an ageing population and an increase in co-morbidity
- Modernity: the influence of big industry (e.g. pharmaceutical); consumerism, expectations, and the effectiveness of medicine

How the improving health function can support and enable NHS boards

The public is part of the solution – the improving health function could support a public conversation about the barriers listed above and what the public values.

Data, evidence, and resources are needed. The improving health function could share best practice about what works in reducing health inequalities and what the specific role of the NHS is. Local tests of change could be supported, with effective innovations shared across the other boards.

Capacity building for Health in All Policies: The improving health function could support the NHS to work with partners to embed a Health in All Policies approach. Building capacity amongst NHS representatives on boards and committees of Community Planning Partnerships could help build critical mass at a local level. This includes supporting boards to help evaluate the impact of policies and services in order to continuously improve the evidence.

The improving health function could also provide national Health Impact Assessments to support local Health Impact Assessments.

The national function could support more focus on the NHS role in the wider economy and not just the delivery of cost effective clinical services.

As large employers, the customer requirements listed in the ‘Employers’ section are also relevant here.

What needs to change to deliver that

In order to change public attitudes towards the NHS, the national body would need to engage the public in a way that the current bodies do not. Engagement with politicians would also be needed.

In order to achieve more focus on the NHS role in the wider economy permission may be needed to use other criteria for decisions (e.g. to support community benefits in procurement or land use decisions).

Re-direction of focus upstream and building support for Health in All Policies needs dedicated time to build relationships. Public Health Scotland should encourage and support that change in local Boards.

Employers

Employer’s role and remit

The availability and nature of work is an important determinant of health and health inequalities within society. Employment matters because having an adequate income can help protect health and contribute to reducing inequalities. Conversely, having no job or poor quality employment can be detrimental to health.

The role of employers includes:

- Recruiting and retaining staff
- Maintaining a competent workforce by means of education, training and staff development
- In the private sector, ensuring financial viability and competitiveness
- In the public and third sectors (including social enterprise), basing their approach on public value
- Selling products, and/or delivering services
- Offering career progression and personal development
- Ensuring compliance with employment and health and safety legislation and regulation.

Opportunities and barriers for employers in improving health and reducing health inequalities

Opportunities:

- Ethical procurement, contracting, and commissioning
- Supply chain/ business pledge – Public Procurement Footprint
- Provide a sense of purpose and contribution to the employee and wider community, perhaps even the nation

- Fair contract conditions including security of tenure and hours, adequate wages, pension contributions, sick pay, annual leave and other policies
- Positive working environment including wellbeing principles and safety
- All aspects of fair work/good work
- Community benefit brought by local employment – indirect investment into local areas

Barriers

- Improving health is not (necessarily) the priority of employers
- Actions to improve health may conflict with jobs or aims of employers, such as increasing pressure on profits versus wages/ contracts
- Inflexible social security systems, for example difficulty accessing training whilst receiving job seekers allowance
- Labour market issues, such as lack of adequately educated and trained people in the right places
- Job opportunities limited by geographical location
- Austerity agenda and underinvestment in key sectors or training
- Abundance of opportunity in industry specific job markets (e.g. oil industry) drives the local market and economy
- Over reliance on particular parts of the economy when it can fluctuate and thus affects the local economy and wider job market

How the improving health function can support and enable employers

There are a number of products and services that could be provided through the improving health function, although not directly delivered to employers. These include providing data and evidence, and influencing policy and legislation in order to:

- increase the availability of good work
- promote trade union organisation
- increase the wages of low-paid workers
- support people with health and social issues into work
- increase the quality of available work by increasing worker autonomy and investing in in-work training
- improving the quality of work, including:
    - job security
    - the physical work environment
    - the demands of the job and job control
    - the design of the job (including shift work)
    - the balance of power between workers and the employee

What needs to change to deliver that

Increased capacity around the good work agenda at all stages in the Knowledge into Action cycle.

Global corporations

Global corporations' role and remit
Global corporations ("big business") are multinational entities that employ approximately 45% of the workforce in Scotland[1]. The role of global corporations includes: • Delivering products/services that fulfil the needs of their customers and are at a level of price and quality that is competitive in the marketplace • Complying with legislation and regulations including employment and taxation • Adapting their businesses to meet the changing demands of their customers • Meeting corporate targets including financial (profit, turnover) and growth targets • Attracting and retaining skilled staff that boost competitiveness • Attracting, maintaining and growing a customer base • Building and maintain a positive public relations image
Opportunities and barriers for global corporations in improving health and reducing health inequalities
Opportunities: • Global corporations produce products and services with a direct impact on health. These products and services can be health-promoting or health-damaging – there is an opportunity for corporations to produce more of the former and less of the latter • Organisations may be driven by the "triple bottom line" – financial, social, environmental. There are clear links to health impacts with all three and an opportunity to place more of a value in positive health benefits • They are big employers – 45% of the workforce is employed by "large" organisations. Wages and working conditions have a direct impact on the health of their workforce so there is an opportunity here to promote good work/fair work • Global corporations can influence consumer behaviour through marketing and "nudging" – greater emphasis could be placed on marketing of healthy products and services • They can influence policy through lobbying activities • They can provide a wider impact on the local economy/communities by means of development investment, direct employment, community schemes, and third sector investment. Barriers: • Businesses are largely driven by market demand and may be less driven by ethics and social conscience

[1] https://www2.gov.scot/Topics/Statistics/Browse/Business/Corporate/KeyFacts

- A perceived negative impact on profit may be an obstacle to investment in the local market
- Some organisations may prioritise short-term employment flexibility over longer-term contracts with the risk of increasing in-work poverty
- Corporate strength may overpower local labour markets, i.e. “too competitive” for local providers to survive
- Products and services may be harmful to health
- Global corporations drive the global economy and culture of consumerism
- Marketing power can be used to promote unhealthy goods and services
- The is the potential for jobless growth by means of automation and technology
- Businesses may be driven by their bottom line, which could negatively impact on opportunities for work-based training/ progression.

How the improving health function can support and enable global corporations

The improving health function could providing businesses with the evidence that shows they can achieve their aims and outcomes at the same time as contributing to health and wellbeing.

Data and intelligence could be provided that shows businesses that by using their expertise, reach and customer loyalty, they can positively influence behaviour while also meeting their corporate objectives. This could include providing a ‘health endorsement’ which may help them sell their products.

PHS can help ensure there is a clear and well managed approach to public health working with industry, especially where industry’s primary interests are not necessarily consistent with public health interests.

As large employers, the customer requirements listed in the ‘Employers’ section are also relevant here.

What needs to change to deliver that

The public health sector does not routinely engage with big business and therefore does not have a strategy or plan for how it could influence.

The Public

The public's priorities
Approximately 5,373,000 people live in Scotland. The Scottish Government undertook public engagement in 2015/16 to hear from the public about what matters to them around health and wellbeing. The most common themes in the Creating a Healthier Scotland national conversation[2] were: • The need for a far greater focus on preventing illness – through education and support to help us make healthy lifestyle choices • The importance of mental health and wellbeing – and the role of connected communities and good support networks as part of that • The themes of person-centred care, support to self-manage health and the importance of a holistic approach • Increased awareness of the full range of social care services and how it benefits different people, along with recognising and valuing the important role of unpaid carers • The need for more accessible and flexible services, better partnership working and joined up care, and an easier way of signposting people to what's available • Recognition of the challenges ahead and the need to set clear priorities for the future In addition, the commission project team identified the following priorities at the customer requirements workshop: • Achieve a good quality of life • Maintaining family and friends – social connections and network • Having a sense of purpose • Being able to follow interests and be happy • Safety and security in one's own environment • Sense of status and recognition in wider society, including a feeling of contribution • To be loved/ valued • To have a home • Freedom of expression and ability to build an identity • Having the means to keep/live well • Having the option to have children/build a family
Opportunities and barriers for the public in improving health and reducing health inequalities
Opportunities: • Increased empowerment and ability to contribute to civil society, including through the Community Empowerment Act and changes to local democracy • Greater engagement in the right to health

[2] https://www2.gov.scot/Topics/Health/Policy/Healthier-Scotland-Conversation

- Improve personal behaviour and be a good role model of positive health behaviours, including with children
- Engage with democracy, i.e. voting and linking with local councillor/ MSP/ MP
- Contribute to petitions or other movements for change
- Participating in local and national conversations about health and the social determinants of health
- Discussing things with others including groups or organisations
- Help establish a social economy/social capital to influence both tangible and intangible assets
- Utilise time banking as a means of collaborating with others to effect positive changes

Barriers

- The environment we live in e.g. fast food, pubs etc. and resulting impact on health behaviour
- Disempowerment: a sense that you are only one person and that wider changes can be difficult to effect
- Balancing life and work and finding time to contribute to the community and take part in health-promoting activities
- Power inequalities and status in society can be a barrier to being heard / making a meaningful change
- Apathy and disillusionment if progress is difficult to achieve or see
- understanding the social mechanisms/ structures/ processes in order to effect change
- Financial barriers to achieving goals
- Going against norms/ ingrained cultural norms may be socially risky and elicit negative responses from others, or result in alienation
- Confusion and muddied waters caused by “fake news” and not having a real sense of who to trust and what the truth is
- Implicit limitations due to personal history/ background/ upbringing e.g. adverse childhood experiences, mental health, long-term conditions
- Lack of knowledge or skills to question and probe a situation
- Powerful influencers e.g. global corporations, wealth, social status
- Inequality in access to opportunities to engage with empowering and health-promoting actities.

How the improving health function can support and enable the public

- Support for community development, including sharing best practice and advocacy for taking a community development approach
- Be a source of credible, accessible information
- Bring people together to be an exemplar of engaging with people e.g. citizens juries
- Facilitate local and national conversations about what we value, increasing awareness of the right to health and the impact of inequalities across the population – building momentum for change at a grass roots level

- Utilising innovations in digital technology to develop digital assets for health improvement that are user-led, targeted and support people to make healthy choices.

What needs to change to deliver that

NHS Health Scotland does not usually engage directly with members of the public. PHS would need to develop a public engagement strategy that:

- Engaged the public through digital channels including social media
- Prioritised effective engagement with those with the worst health outcomes
- Takes a human rights based approach
- Was developed with partners in the third and community sectors and people working in public health locally

As well as its own work in public engagement, PHS could have a role in supporting other organisations to engage with the public. This could include advocating and supporting community development approaches.