IHC - Future State Final 1.0 071218

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Date Published: 21 August 2019
Version: 0.1
Status: Draft

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Document control sheet

Key Information:

Title:	IHC - Future State Final 1.0 071218
Date Published/Issued:	21 August 2019
Date Effective From:	
Version/Issue Number:	0.2
Document Type:	Project Document
Document Status:	Draft
Authors:	Cath Denholm
Owner:	Cath Denholm and Patricia Cassidy
Approver:	PHR Programme Board
Approved by and Date:	
Contact:	
File Location:	

Revision History:

Version:	Date:	Summary of Changes:	Name:	Changes Marked:
0.2	21 August 2019	Initial draft	Cath Denholm	No

Approvals: This document requires the following signed approvals.

Name:	Signature:	Title:	Date:	Version:

Distribution: This document has been distributed to

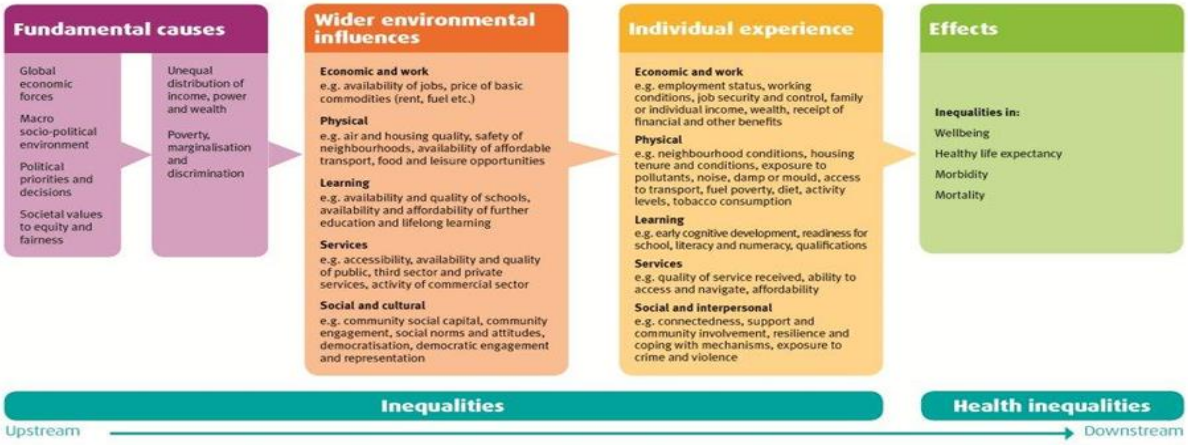
Name:	Title/Division:	Date of Issue:	Version:

Linked Documentation:

Document Title:	Document File Path:
Current Health Improvement Landscape 1.0	http://extranet.healthscotland.com/sites/phr/Programme/ProjectsCommissions/Deliverable%204%20Current%20Health%20Improvement%20Landscape_1.0%20(Final).pdf
Improving Health Commission Customer Requirements 1.0	http://thesource.healthscotland.com/collaboration/teams/hed/mads/CST/IHC/20181130%20IHC%20-%20Customer%20Requirements%201.0.pdf
Our Challenge – Improving the Health of Scotland's People	http://thesource.healthscotland.com/collaboration/teams/hed/mads/CST/IHC/Our%20Challenge%20-%20Improving%20the%20Health%20of%20Scotlands%20People%20FINAL.pdf

1. The Future State of Improving Health: Summary Proposal

Our proposal is that the purpose of the Improving Health domain of Public Health Scotland (PHS) should be to influence the Social, Economic and Environmental (SEE) determinants of health. This domain should operate at the middle and upper ends of the fundamental causes of poor health outcomes and health inequalities.



The new Improving Health domain of PHS should continue to build on NHS Health Scotland's progress in becoming more purposeful and skilled in influencing policy on the SEE determinants of health at a national level and international level, **but it must bring an entirely new level of focus and effort to achieving similar success in influencing policy and practice and building capacity across the whole system and at all levels (local, regional and national)**.

By focusing on the SEE determinants, the Improving Health domain will make a critically important contribution to the six Public Health Priorities (PHPs). However, we are clear that this is a contribution only. For example, the contribution that the Improving Health domain could make to a Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs may be around environmental placemaking, planning and licensing policy for alcohol and food outlets. Other actions will be required around the public health domains.

The Improving Health domain of PHS must be outward focused and aimed at 'shining a light on the connections of what is done locally and nationally with the determinants of health'.

To do this, the Improving Health domain of PHS must excel in two activities:

- Influencing the policy decisions and then practice of others with regards to the SEE determinants of health
- Through collaborative leadership effort and practical support, create the conditions across the system whereby all partners at various levels of practice are in a position to take and implement those decisions, in their own right and on a shared basis.

These are the **pre-conditions** that the Commission has identified as being key to the success of the Improving Health domain of PHS:

- The tension and pull between upstream influence and work related to the mitigation of the effects of poor health or to supporting individuals with negative health behaviours must be relieved by these functions being understood as related but discrete, at a national and local level. Directly mitigating the effects of negative health behaviours must not be a function of the Improving Health domain.

- Structural barriers to achieving sufficient upstream working must be addressed. In local health improvement teams in particular there is significant variation in operation. The strategic intent to work upstream is hampered by a number of factors, including national drivers such as funding models and strategies, capacity in other disciplines and services. At the local level, the public health workforce needs to be able to act as change agents and influencers in the middle ground between strategy development and implementation.

- The quality, level and nature of how influence and capacity building are currently delivered must be stepped up, at national and local level. This must involve the substantial development of skills in listening, influencing, challenging and collaborating across complex systems and credibility and recognition to support a Health in all Policies (HiaP) approach. It must also involve a new authorising environment to be able to operate and apply more influence at a number of levels – including at local, UK government and international levels.

- The data and evidence that underpins our understanding of the SEE determinants of health and multi-level interventions must be improved and developed. This will require a material shift in focus of some of the data and evidence analytical capability of what is currently based in the Information Services Division (ISD). The approach to knowledge generation also needs to develop. For example, research needs to be conducted in a way that local partners own the findings. It needs to include a focus on creating a shared understanding of what needs to be done by respective partners, including the community and voluntary sector.

- Public Health Scotland must have the authority and mechanisms to support partners across the whole system to hold each other to account for the effective implementation of policy that works to tackle the determinants of health and the disinvestment from what does not work. It must be able to galvanise strong, collective and ambitious leadership at all levels and all sectors. We have a specific suggestion around how this could be supported (see p.14 and 22).

- Public Health Scotland must be an organisation with a strong voice, ensuring that stakeholders and customers at national and local level are clear about their call to action. It must also build a strong cohort of advocates for the public's health to ensure sustained and effective support for health and the reduction of health inequalities. These advocates should come from all sectors including the community and voluntary sector, the public sector and academia. They should

retain an unerring focus on people with the poorest health and effective primary prevention.

2. The Commission

The Integration Joint Board (IJB) Chief Officers' Group and Health Scotland (HS), in partnership with others, were 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.

3. Background

The vision for the Public Health Reform (PHR) Programme is "a Scotland where everybody thrives" and where Scotland is seen as a world leader in improving the public's health. To achieve this ambition, we need to address the nation's current health challenges and how our health and social care services can best respond to the needs of a population with more complex needs.

Improving Health has been commissioned as part of the PHR programme because, despite concerted efforts, our public health approach to date has not delivered significant and major improvement gains to bring the health of the people of Scotland in line with that of people in other Western European countries. Scotland's current health challenges are complex and go far beyond the control of the NHS. Major issues include an ageing population, enduring health inequalities, deprivation, poverty, changes in the pattern of disease and increasing pressures on health and social care services.

With this in mind, work was required to set out how the health improvement domain or health improvement activities could be organised in Public Health Scotland, to meet the needs of national and local partners and customers working across the whole system in a collective endeavour to improve health.

4. The Commission's Work to Date

4.1 The Questions we are Trying to Answer

The Improving Health Commission has been asked to address the following questions:

a) "The new body will be, and be seen to be, upstream of and separate from the NHS, while retaining important operational links." How should the arrangements for the improving health function support this ambition?

b) What is working well in terms of supporting effective policy development and delivery at national and local level to improve health outcomes and reduce health inequalities (proposed benefits and benchmarks)?

c) How should the advocacy and independence of the health improvement function be maintained and improved?

d) How can best use be made of public sector data, initially starting with health and local government data, and will this be used to support public health improvement?

e) What new functional arrangements will better support national and local policy development (proposed benefits and benchmarks)?

f) How will the new functional arrangements support Community Planning Partners (CPPs) and local systems in meeting their communities' needs (proposed benefits and benchmarks)?

g) How will the new functional arrangements better identify areas for health gain and support related activity at national and local level (proposed benefits and benchmarks)?

h) Which current arrangements may be working less well and which mitigating actions that should be taken e.g. further improvement work or closing down of an existing offering?

i) How will the new body provide capacity and capability to ensure national and local decisions and interventions are intelligence and evidence led, and that local professionals (in Local Authorities, Community Planning Partnerships, Integration Authorities and NHS Boards and in the Community and Voluntary sector) are supported in areas such as service change, efficiencies, economic impact, equality of prosperity and inclusive growth?

j) How will the new national body provide the best opportunity for some functions to be delivered nationally on a 'once for Scotland' basis?

k) How will the new national arrangements support a multi-agency approach to public health both nationally and locally?

l) "The new body will be staffed by a 21st Century public sector workforce, continuously seeking to improve efficiency across the public sector; encouraging the application of generic skills as well as international expertise; grounded in agreed ethics and values; and fostering leadership at all levels." What are the particular implications for staff focused on improving health work?

m) Public Health Scotland will take a Digital First and data-led approach. What are the particular implications for the improving health work of the new body?

n) "Support for local public health activity in order to contribute to delivery of the public health priorities is strengthened. The offer of support will include the third and independent sectors where that is appropriate." What new is needed to do that?

o) "The successful establishment of a credible, effective new public health body which is responsive to local strategic planning needs is key to building momentum and support for stronger local partnerships." What is the role of improving health in this aspect?

4.2 The Challenge for Health Improvement

The Commission has come to this by drawing on its own collective experience and engaging through the range of stakeholder groups identified. The group focused on understanding what the key challenges for health improvement are; what needs to be different and what the opportunities are to use the creation of Public Health Scotland to innovate and take us one step further towards Scotland's national public health body being a world class organisation. The detail of these are in the documents referenced on p.4. However, in summary:

Within the overall vision for the Public Health Reform Programme – "A Scotland where everybody thrives" - we have defined the specific ambition for health improvement as a Scotland where:

- We all prioritise health as a human right
- We take a Health in All national and local policies approach
- We prioritise prevention and build local capacity to take effective preventive action

4.3 Stakeholder Groups Considered

The Commission identified the following stakeholder groups as most crucial in influencing the new Improving Health domain:

- Scottish Government
- Local authorities
- Integration Joint Boards (IJBs)
- Community Planning Partnerships (CPPs)
- Community and Voluntary Sector
- Housing organisations
- NHS boards
- Employers & Employment Organisations
- Businesses
- The Public

4.4 Summary of Change Needs from Stakeholders' Perspective

Detail of customer needs, as described by the stakeholders with which the Commission engaged, have been reported in detail Deliverable 3, Customer Requirements. This section offers a summary:

The biggest ask of stakeholders was to bring as much focus, effort and new skill development to supporting the whole (local) system as to working at a national influence level. This requires a fundamental shift in mindset, skill and focus in how the new body will work with local systems.

The greatest challenges that local systems face in tackling health challenges appear to be a lack of evidence of what works in terms of prevention and the constraints (both in system and in skill) in working collaboratively in order to focus efforts to achieve that prevention.

The following examples of customer need are taken from the Customer Requirements document. They are chosen to highlight the types of innovation that the proposals in this paper aim to achieve.

- **National Government:** We need data and evidence that supports policy makers across Scottish Government to see the value of and work towards health in all policies.
- We also need an authorising environment to influence **beyond Scottish Government**, recognising that many of the drivers behind the challenges are UK or global.
- **Local Government:** We need redirection of resource and expertise, particularly in prevention & early intervention. For example, for new planning developments, planning authorities should request evidence of health being considered at the planning application stage. "Well-being" should become the standard basis for measuring impact and using this in the planning and implementation of all public policy.
- **IJBs:** We need to provide IJBs with modelling tools and data for decision making, which will help re-focus national drivers from down to upstream work and provide tailored products and services.
- **CPPs:** We need to support CPPs by developing locally-linked interventions and analysts that support data-sharing.and ways of demonstrating impact on local outcomes?
- **Housing and other Public Services:** We need to promote different use of resource and translate evidence into better practice and collaboration across services.
- **NHS (general):** We need to provide leadership in the NHS to help change policy focus and culture towards prevention. We need to use practical opportunities such as procurement decisions to effect change.
- **NHS (local public health/health improvement teams):** We need a sustained and recognised health improvement workforce at practitioner and specialist level to lead and support this work across local, regional and national levels, with governance for public health across our systems.

- **Employers:** We need to provide employers and others concerned with employment and income with data and evidence to influence policy in order to create more fair work and influence the determinants of income and employment.
- **Businesses:** We need to engage with businesses at all levels, including global corporations, to develop a stronger understanding of how business aims can be met while also improving health and wellbeing.
- **Community and Voluntary Sector:** There needs to be a new level of relationship with the community and voluntary sector, that takes in both strategic and delivery partnership. The community and voluntary sector should be understood as a partner across all the domains of public health. With regard to improving health in particular, there is huge potential for example to promote and support community and peer-led approaches that use the opportunity of local democracy initiatives to take independent action on issues that affect their health and wellbeing. There is also potential, for example, to work differently and better with national third sector bodies on policy leadership and influence.
- **The Public:** We need to fully engage with the public in a new dialogue about how health and related rights and responsibilities are met at societal, community and individual level. We need to develop an approach that allows people to engage in meaningful 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. We also need to engage much more effectively with the public about what they value about and the importance of their own health, if we are to engage in meaningful action that reduces demand on the health care system.

5. Deliverable 4: The Future State of Health Improvement

5.1 Introductory Comments

Deliverable 4 - 'The Future State' asked the Commission to provide commentary against a detailed list of technical specifications (listed in Appendix 2).

When first presented with this deliverable, the Commission considered the ask and advised the Public Health Reform programme board that we would present a modified specification. In essence, the Commission feels very able to propose functions of the Improving Health domain of Public Health Scotland and the context required around those functions in order for them to be successful. The Commission feels less able to comment in detail on details of structure and subsequent systems and skills, particularly while the overall requirements and needs of all the Commissions are still emergent.

This and subsequent sections therefore focus on functions and dependencies between functions. Our comments on structure and other specifications are very high level at this stage.

5.2 How will the proposed new Improving Health domain help achieve the vision of Public Health Reform?

Building on the ambition for health improvement developed by the Commission and referenced in Section 4.2, there are three aims or outcomes we are seeking to achieve:

- We all prioritise health as a human right
- We take a Health in All Policies approach
- We prioritise prevention and build community capacity

Leaving the question of structure and specific skill sets to one side, we offer a high-level summary of how the work of the Improving Health domain would look if organised around these three outcomes.

5.2.1 We all prioritise health as a human right

This means making the health and wellbeing of the population the highest priority when planning and developing policies and services. It is about sharing ownership and responsibility, across all public and social policy areas, to improve health and reduce the wider inequalities that underpin health inequalities. It is about raising the visibility of health and health inequalities and encouraging/stimulating public/political discourse, working more proactively through different channels, groups and agencies to bring health and inequalities to the top of the agenda.

The role of the Improving Health domain in this regard should include:

- Identify actions (both policy/ legislation and practice and national/local) that are most likely to be effective (including cost effective) in improving health and reducing health inequalities in a Scottish context.
- Design and deliver products and services, tailored to specific audiences, designed to raise the profile/priority of health and health inequalities and what can be done to improve them.
- Influence key stakeholders through coordinated and targeted engagement.
- Develop systems that challenge and hold stakeholders to account for population health outcomes

5.2.2 We take a Health in All national and local policies approach

This is about all public policy makers (national and local) considering the positive and negative health impacts of their policy. It is about explicitly and systematically considering the impact *on* health of all policies, not just those specifically *about* health. This is important, because it enables upstream action on the SEE determinants of health (housing, education, employment, social support, family income, communities and childhood experiences). It means that implementation can be coordinated across policy areas, and between national and local levels, to achieve the best outcomes for the population, particularly people with the highest needs. Taking this approach also means we can evaluate the impact of policies and services in order to continuously improve the evidence for our decisions.

The role of the Improving Health domain in this regard should include:

- Identify the policy areas that will have the greatest impact on the social, economic and environmental determinants of health.
- Provide public policy makers with the tools and support to systematically consider the positive and negative health impacts of their policy (including policy in housing, education, employment, social support, environment and so on)
- Identify actions (both policy/ legislation and practice and national/local) that are most likely to be effective (including cost effective) in improving health and reducing health inequalities in a Scottish context.
- Monitor and evaluate the impacts of policies and services in order to continuously improve the evidence for decisions.

- Engage with the individuals, groups and organisations responsible for these areas and build relationships.
- Support the implementation of relevant policy/practice by providing data and intelligence support, helping to design/redesign services, identifying and sharing good practice, and developing and disseminating relevant products and services.

5.2.3 We prioritise prevention and build community capacity

The Christie Commission[1] emphasised the extent to which public service delivery is absorbed with tackling the symptoms, as opposed to the causes, of inequality. Prevention can mean different things. In the context of the Improving Health domain of Public Health Scotland, we are proposing a focus on primary prevention – preventing people from getting ill and keeping them healthy and well for as long as possible. This will require a re-orientation of investment because currently there is more of a focus on the treatment of diseases. Reactive approaches are heavily resource intensive and represent a lost opportunity to have a more transformative impact.

This re-focus would give increased capacity for upstream interventions that meet support Scotland's Public Health Priorities. Communities will be a crucial partner working alongside mainstream providers.

The role of the Improving Health domain in this regard should include:

- Demonstrate through modelling, data and intelligence, the long term benefits (both financial and health) of a preventive approach.
- Provide leadership and influence the re-orientation of investment away from a focus on the treatment of disease and on failure demand.
- Help build services around people and communities and facilitate community-led approaches
- Give local communities the training, support and tools they require to co-design local solutions and demonstrate their impact
- Identify good practice and share this across Scotland

5.3 Functional Components Required for Improving Health Domain

The original Health Improvement thinkpiece, submitted to the Scottish Government Public Health Reform team in January 2018, included a description of all the key functions, tasks and knowledge required for a knowledge into action model of improving health (Appendix 1). Other thinkpieces and subsequent Commissions, while not discussed in detail here, are also relevant – for example, the Commission on Research and Innovation.

The Commission believes that the Framework in Appendix 1 continues to represent a comprehensive summary of the functions that Public Health Scotland needs to coordinate or provide at a national level in order for its purpose in improving Scotland's

[1] https://www.gov.scot/publications/commission-future-delivery-public-services/pages/8/

health to be fulfilled. However, the Commission's proposition is that not all of these functions need to or should be clustered in one domain of Public Health Scotland.

Drawing on Framework in Appendix 1, we suggest that there are **three direct functional components of an Improving Health domain (5.2.1)** and a number of related functional components that are best understood within a different domain or function.

Broadly speaking, our proposition is that the Improving Health domain operates at the 'Into Action' end of the Knowledge into Action model of public health. **We believe this implies that research, data and evidence analysis is supplied by the Underpinning Data and Intelligence Domain or related functions (5.2.2).** The interdependence between domains is critical, for example, to ensure that sufficient priority and resource is given to generating the most useful evidence in the most useful and timely way. It also implies a level of cross-over of staff between the domains, for example, when the 'Into Action' delivery of knowledge is best carried out by a person or persons who has been involved in the generation of that knowledge.

Secondly, our proposition is that health improvement services targeted directly at individuals or population groups are carried out within the **Improving Services** or **Protecting Health Domains (5.2.3)** of Public Health Scotland, not the Improving Health Domain.

Thirdly, our proposition requires a number of related functions. While not public health domains as such, we propose them as delivery functions in their own right:

Prioritising, Evaluation and Impact (5.2.4): This is described in Appendix 1 as 'a single clearing-house for prioritising and decision-making on what work is to be done.' We propose that this is core and central to all the domains of Public Health Scotland and drives the coordinated delivery of work to achieve the Public Health Priorities, by providing a mechanism that holds partners across the whole system to account for their actions to improve health and reduce health inequalities.

Communications, Marketing and Digital (5.2.5): These are key components of the design and delivery of many of the improving health messages and products that need to be produced.

Leadership and Capacity Building (5.2.6): To be further defined, but this function could take in leadership development to deliver health in all policies across the whole system, and could also support Public Health Scotland's own leadership and development culture, fostering an open and cross-organisational culture.

5.3.1 Direct Functional Components of an Improving Health Domain

Lead and support the delivery of actions to influence policy/practice at an international, national, regional and local level	Required to deliver this Function
Using the knowledge and evidence (from all sources) to develop relevant products and services, help design and deliver policy and legislation and support localities and communities co-produce local health improvement services that meet locally identified need. As part of this we must ensure we are well positioned to maximise reactive and proactive opportunities to influence-decision makers and policy-makers. • Understand the broad strategic context and be able to create and respond to opportunities to promote and position knowledge. • Appraise and advise on national and local strategy/policy/legislation • Develop and deliver products and services tailored to specific audiences • Influence and coordinate other organisations and agencies • Design and manage programmes with specific groups and communities • Influence or lead strategic planning • Build alliances and partnerships and collaborate to identify new solutions • Understand, work within and utilise political and democratic systems • Engage with communities and service providers to co-produce services that meet local need	Evidence on and knowledge of: • Housing • Education (lifelong learning) • Transport • Income & access to fair work • Environment, climate change and sustainability agendas • Planning & access to facilities e.g. quality open space • Licensing (e.g. food, alcohol, gambling) • The right to health • International health policy Skills in: • Knowledge management &translation • Policy • Influence • Leadership • Advocacy • Political acuity • Relationship building (local government, civil service, international partners)

Identify effective/ ineffective practice and promote shared learning	Required to deliver this Function
We need to be able to quickly identify areas where things are/aren't having the impact desired and then act. Will require close cooperation between policy leads, localities/communities. • Develop criteria and processes to quickly identify effective/ ineffective policy and practice (linked to 2.6) • Design, deliver and support a range of products and services designed to share learning across the public health system • Lead and support the design/redesign of services/policies	Skills in: • Improvement methodology • Knowledge translation • Effective knowledge management system – national and local- access to stakeholders as well as public health system • Evaluation skills • Intelligence led planning/performance management

Identify and share ways for the health improvement system to continually improve	Required to deliver this Function
Health improvement needs to be at the forefront of ensuring public health systems/services are continually improving and must be able to adapt to changing circumstances and contexts. The function must be capable of being reactive and proactive. • Understand and keep up to date with emerging quality improvement literature • Develop and implement processes to embed that learning in the wider public health system	Skills in: • Taking a helicopter view – pulling out best practice and good examples. • Improvement methodology • Leadership

5.3.2 Data, Intelligence, Evidence, Research

Identify the causes of poor health and health inequalities	Required to deliver this Function
Understanding the causes of poor health and inequalities is a prerequisite to improving health. This will require close collaboration with academics and local communities who experience poor health and inequality, drawing on the experience of those groups and agencies already working in this sector. • Engage with communities and relevant organisations to capture lived experience • Access and appraise evidence and knowledge gained through systematic methods and through engagement with the wider research community, practitioners and service users • Critique published and unpublished research, synthesise the evidence and knowledge and draw appropriate conclusions • Design, conduct and commission research based on current best practice	Skills in: • Underpinning data & intelligence • Research commissioning • Evidence for action • Engagement with communities (part of Improving Health Domain) • etc

Measure, monitor and report population health and wellbeing and the causes of poor health and inequalities	Required to deliver this Function
Continually assess progress in the health of the population (and its drivers) at a local and national level across a range of groups, identifying current and future health improvement needs/priorities. • Engage with communities and relevant organisations to capture lived experience • Identify data needs and obtain, verify and organise that data and information • Interpret and present data and information	Skills in: • Underpinning data & intelligence • Research commissioning • Evidence for action • Engagement with communities (possibly part of Improving Health Domain) • Local data sets • etc

• Collate and analyse data to produce intelligence that informs decision making, planning, implementation, performance monitoring and evaluation • Build on the current success of the LST analyst capacity available to IJBs and primary care improvement • Ensure third sector organisations have access to the same high quality data.	

Identify actions (both policy/ legislation and practice and national/local) that are most likely to be effective (including cost effective) in improving health and reducing health inequalities in a Scottish context	**Required to deliver this Function**
Support action at national level (e.g. new policy/legislation) or at a local level (e.g. delivery of a new service/ redesign of an existing service). Must be collaborative, drawing a range of intelligence from published research, practitioner experience/wisdom and lived experience. Must be synthesised into easy to understand actions that are implementable in the context and build on the current community based activity through CPPs in particular. • Access and appraise evidence and knowledge gained through systematic methods and through engagement with the wider research community, practitioners and service users • Critique published and unpublished research, synthesise the evidence and knowledge and draw appropriate conclusions • Design and conduct public health research based on current best practice and involving practitioners and the public • Advise on actions that are most likely to be effective in a Scottish context • Identify gaps in the current evidence base that may be addressed through research • Work collaboratively across agencies and boundaries	Skills in: • Underpinning data & intelligence • Knowledge management • Research commissioning • Evidence for action • etc

Identify gaps in understanding and commission relevant research	Required to deliver this Function
This requires both quantitative and qualitative methods using a range of different study designs and needs close collaboration with research and academia. • Identify evidence and knowledge gaps that could be addressed through relevant research • Design, conduct, commission and manage public health research based on current best practice	Skills in: • Knowledge management • Research commissioning • Evidence for action • etc

5.3.3 Improving Services and Protecting Health Domains

Prevention, health improvement and reduction of inequalities are valid and key aspects of the health and social care partnership (H&SCP) landscape but how this is currently interpreted and plays out in H&SCPs is different from the upstream work that we propose for the Improving Health domain. In H&SCPs the current focus has been much more of service provision and mitigation role where prevention, in practical terms, means keeping people out of hospital and self-managing conditions etc. Work to directly support services such as reducing isolation, improving mental health, fuel poverty and benefits realisation could sit in the Improving Services domain. Services aimed at harm reduction or protection from harm could also conceivably sit in the Protecting Health domain.

Whilst understanding that these are also 'health improvement' responsibilities, albeit downstream, it is therefore suggested that national leadership and support of these functions should come domains other than Improving Health, recognising of course that in local areas, particularly remote and rural areas, an equivalent 'separation' in workforce resource may neither be practical nor desirable.

The list below is not exhaustive, but includes examples of services currently provided by NHS Health Scotland which it is proposed sit better in the Improving Services domain than the Improving Health Domain at a national level

	Notes
Support to improve equity of NHS services	
Smoking cessation coordination/strategy	
Elearning in support of health behaviour change	
NHS Leadership support/HPHS	
Healthy Working Lives Programme (including Adviceline)	Aware of separate review of these services. If this review not complete and implemented by 1 December 2019, Improving Services seems a more optimal location of this service than Improving Health.
Awards schemes (Healthy Working Lives, Healthy Living etc)	Again, there is a separate review of the value and benefits of awards schemes and their future. Again, Improving Services seems a more optimal location.

5.3.4 Core Prioritising, Evaluation and Impact

Public Health Scotland needs to have the authority and mechanisms to support partners across the whole system to hold each other to account for the effective implementation of policy that works to tackle the determinants of health and the disinvestment from what does not work. It requires a function that keeps the whole organisation and the whole system focused on its mission and focused on the Public Health Priorities. We propose a central unit of some sort which, through evaluation and impact, maintains a focus on how policies and systems in Scotland are working at national and local level and how decisions are impacting on health gain. The 'unit' would connect closely with the Innovation Cycle proposed by Brendan Faulds and it would be closely linked to the organisation's governance structures. 'Membership' of the 'team' should extend beyond the organisational boundaries of Public Health Scotland, as a very direct way of bringing in whole system knowledge and accountability.

Monitor and evaluate actions to measure impact, recommend change in direction and prioritise actions	**Required to deliver this function**
• A single clearing-house for prioritising and decision-making on what work is to be done. • Identify a mechanism/criteria for assessing and prioritising work • Apply this to inform annual business planning and ad hoc requests that come in mid-year • Align and deploy resources (staff and money) towards clear strategic goals and objectives • Effectively decommission/delay existing work deemed to be low priority	Skills in: • Relationship Management • Performance Management • Innovation • Improvement • Strategy • Evaluation • Health economics • Strategic Planning • Stakeholder Engagement • Leadership

5.3.5 Marketing, Digital and Communications

Digital engagement, connection, delivery of information to a very wide group of different stakeholders, interaction with the public in new ways – as well as ongoing focused effective public affairs and policy work – will all be key to the delivery of the Improving Health Domain and more broadly across Public Health Scotland.

Digital, Marketing and Communications activity associated with policy and practice influence	**Required to deliver this function**
This function would contribute to Public Health Scotland's aims through development and delivery of strategic marketing and communications plans that would establish Public Health Scotland as Scotland's national public health agency. It would employ digital first principles, base activity on insight and evidence about what works, measure impact and effectiveness and ensure a strong customer focus. • Promote knowledge and the use of data and intelligence as the basis of future public health policy and action • Help deliver health protection programmes, developing multi-channel content to support informed consent alongside professional support and public information campaigns • Support local health and social care, by implementing Once for Scotland campaigns and materials that target inequalities • Inform and motivate the public – work with the wider health and social care sector plus voluntary and Commercial organisations to deliver integrated campaigns that ensure citizens understand what Action they can take to live longer healthier lives • Develop innovative tools and tactics to support positive individual behaviour change or to help professionals deliver their public health role • Promote PHS's remit and establish a strong brand identity.	• Social media • Digital communications and marketing • Publishing • Digital content design and delivery • Digital systems development • Campaign planning and management • Social marketing • Creative development • Identity/brand development and management • Insight gathering • User testing • Evaluation • Direct marketing • Internal communications and inequalities-sensitive engagement • Stakeholder engagement • Public affairs • Media relations and media handling • Crisis communications • Event management

5.3.6 Leadership and Capacity Building

Public Health Scotland needs to have the authority and mechanisms to support partners across the whole system to hold each other to account for the effective implementation of policy that works to tackle the determinants of health and the disinvestment from what does not work. It must be also able to galvanise strong, collective and ambitious leadership at all levels and all sectors. Recognising that the Leadership in Public Health Workforce and Specialist Workforce Commissions are likely to lead in the development of such a function, inclusion here is to indicate that this is an important dependency for the Improving Health domain. Skills in collaborative leadership, influence and whole system mapping and engagement are some of the skills that are likely to need to be stepped up in order to build capacity for a health in all policies approach across the whole system. The obligations and aspirations on CPPs and H&SCPs to engage with communities and build on their capacity to participate are likely to be important levers in this regard, as are the National Standards for community engagement.

Leadership and Influence to build competence and capacity for a health in all policies approach	**Required to deliver this function**
A capacity building and leadership function that is relevant to the whole system: • Shared leadership • Public health competencies • Collaboration • Policy Influence • etc	Skills and Knowledge: Leadership at local as well as national level to enable effective use of the operational capacity

6. Structural Options for the Improving Health domain

6.1 Introductory Comments

The Commission has given brief consideration to six structural options for the Improving Health domain. It should be noted that when we use the word 'domain', we are not intending to imply that we have a particular structure in mind. We are very aware that any recommendations on structure have implications for the whole of Public Health Scotland. Rather than make a specific recommendation, we have therefore set out some very high level pros and cons for various structural options that we are aware of at this stage. We would be happy to engage further in discussions on this and in particular to elaborate on the assumptions made here.

6.2 Structural Options

6.2.1 Option 1: Status Quo

To assume that the current structure of NHS Health Scotland (as Scotland's current national agency for health improvement and as the agency fulfilling most of the functions set out in the Thinkpiece) offers the right basic framework.

Pros	***Cons***
None identified	Experience from NHS Health Scotland and locally suggests that this structure creates some barriers to delivery

6.2.2 Option 2: Improving Health (Structure based on Public Health Domains)

To create a functional Health Improvement structure within Public Health Scotland that has a sub set of the functions set out in Appendix 1, with the remaining functions described in Appendix 1 being 'dispersed' to other domains.

Pros	***Cons***
The domains are clear. Gives equal credence to all the domains. Strong external focus to improving health and its external partners. An outcomes based approach is possible in this model e.g. this domain would focus on outcomes relating to education, housing and so on.	This is similar to the current status quo. Will it lead to the improvements that PHS seeks to make?

6.2.3 Option 3: Influencing Health

To create a functional Health Improvement structure within Public Health Scotland, but named differently. This is working on the premise that the overarching and collective purpose of PHS is to improve health, but that the focus of this domain is on influencing policy and practice in the underlying social, economic and environmental determinants in health.

Pros	***Cons***
The domains are clear – but confusion is avoided where some perceive 'health improvement' either as health behaviour change or as the overarching focus of the whole organisation. Gives equal credence to all the domains. Strong external focus to improving health and its external partners. An outcomes based approach is possible in this model e.g. this domain would focus on outcomes relating to education, housing and so on.	Similar risks to above, although the name change useful in itself in heralding change. Name change may be open to interpretation as to what this function is about

6.2.4 Option 4: Knowledge into Action

An alternative to the public health domain approach is an organisational structure based on the Knowledge into Action domains of Knowledge Generation, Knowledge Management and Knowledge Implementation. In this case, all of the improving health functions described here would most likely sit in the Knowledge Implementation area, supported by Knowledge Generation and Knowledge Management functions.

Pros	***Cons***
Knowledge into action model. Very clear into-action focus for the Improving Health domain Highly dependent on effective horizontal working with other parts of PHS (a pro if we can get this right, a con if ways of working cannot adapt to meet this challenge)	Where would 'Expert knowledge' sit and how would it be drawn in. It is hard to envisage how an outcomes planning model would sit across this. It is less clear how the other public health domains would be arranged in this structure.

6.2.5 Option 5: Public Health Outcomes

An ‘overt’ outcomes model is under consideration by at least some of the other Commissions.

Pros	***Cons***
Reporting against outcomes/public health priorities ‘made easy’ Multi-professional teams	It does not directly address, and could exacerbate, one of the fundamental principles of the IH Future State proposals, which is that there is an operational separation between upstream and downstream activity.in PHS How are skills and knowledge specific to the stakeholders identified with IHC focused? Does this work equally well for all of the public health domains?

6.2.6 Option 6: Stakeholder

Another alternative is a Stakeholder approach. From an Improving Health domain perspective there are some attractions. Given that effective whole system working is the aim of the Improving Health domain, this could allow very targeted and focused skill and relationship development in the key areas.

Pros	***Cons***
Specialist knowledge and skills on relationship building with particular stakeholder groups allows long term relationships and strategies.	A clumsy and awkward division of knowledge areas that cut across stakeholder groups.

7. Transition Requirements

We are aware that the Public Health Reform have also requested detail on the transition arrangements to achieve this Future State, including those listed below. While work has begun to look at this, we suggest that feedback on this Proposal from the Programme Board, staff within both organisations, other Commissions and some key stakeholders of this Commission on this Future States should be sought before coming to conclusions on these questions. This is particularly because there are a number of structural options which are very dependent on decisions beyond the scope of this Commission.

- Staffing models and levels
- Additional skills and training requirements
- The areas staff will be transferred from
- Additional IT and information systems needed for the transition from the current organisation to the new
- Infrastructure and processes needed
- Organisation and Leadership
- Locations/ Geography
- Information systems
- Suppliers
- Management systems
- Finance, revenue and funding

8. Appendix 1: Framework for Health Improvement

Main functions, tasks, skills and knowledge required for health improvement (drawing from the Public Health Skills and Knowledge Framework)

Function	Rationale and main tasks	Skills and knowledge required
2.1 Identify the causes of poor health and health inequalities	Understanding the causes of poor health and inequalities is a prerequisite to improving health. This will require close collaboration with academics and local communities who experience poor health and inequality, drawing on the experience of those groups and agencies already working in this sector.	• Engage with communities and relevant organisations to capture lived experience • Access and appraise evidence and knowledge gained through systematic methods and through engagement with the wider research community, practitioners and service users • Critique published and unpublished research, synthesise the evidence and knowledge and draw appropriate conclusions • Design, conduct and commission research based on current best practice
2.2 Measure, monitor and report population health and wellbeing and the causes of poor health and inequalities	To assess if we are making progress we have to continually monitor the health of the population (and its drivers) at a local and national level across a range of groups, identifying current and future health improvement needs/priorities.	• Engage with communities and relevant organisations to capture lived experience • Identify data needs and obtain, verify and organise that data and information • Interpret and present data and information • Collate and analyse data to produce intelligence that informs decision making, planning, implementation, performance monitoring and evaluation
2.3 Identify actions (both policy/ legislation and practice and national/local) that are most likely to be effective (including cost effective) in improving health and reducing health inequalities in a Scottish context.	We need to know what is most likely to be effective in a Scottish context. This will include action at national level (e.g. new policy/legislation) or at a local level (e.g. delivery of a new service/ redesign of an existing service). Must be collaborative, drawing a range of intelligence from published research, practitioner experience/wisdom and lived experience. Must be synthesised into easy to understand actions that are implementable in the context.	• Access and appraise evidence and knowledge gained through systematic methods and through engagement with the wider research community, practitioners and service users • Critique published and unpublished research, synthesise the evidence and knowledge and draw appropriate conclusions • Design and conduct public health research based on current best practice and involving practitioners and the public • Advise on actions that are most likely to be effective in a Scottish context • Identify gaps in the current evidence base that may be addressed through research • Work collaboratively across agencies and boundaries
2.4 Prioritise these actions.	Having identified effective actions we need to prioritise these (for both the	• Identify a mechanism/criteria for assessing and prioritising work

	organisation and the wider system). This should be managed through a central clearing-house.	• Apply this to inform annual business planning and ad hoc requests that come in mid-year • Align and deploy resources (staff and money) towards clear strategic goals and objectives • Effectively decommission/delay existing work deemed to be low priority
2.5 Lead and support the delivery of these policy/practice actions at both a national, regional and local level	Prioritised actions then need to be delivered. Using the knowledge and evidence (from all sources) to develop relevant products and services, help design and deliver policy and legislation and support localities and communities co-produce local health improvement services that meet locally identified need. As part of this we must ensure we are well positioned to maximise reactive and proactive opportunities to influence-decision makers and policy-makers.	• Understand the broad strategic context and be able to create and respond to opportunities to promote and position our knowledge. • Appraise and advise on national and local strategy/policy/legislation • Develop and deliver products and services tailored to specific audiences • Influence and coordinate other organisations and agencies • Design and manage programmes with specific groups and communities • Influence or lead strategic planning • Build alliances and partnerships and collaborate to identify new solutions • Understand, work within and utilise political and democratic systems • Engage with communities and service providers to co-produce services that meet local need
2.6 Monitor and evaluate these actions	We need to assess if the actions are being delivered in the right way, why they are working or not and are having the desired impact. This links closely to 2.2 and needs to take account of local variation.	In addition to the functions identified in 2.2: • Conduct impact, process and economic analysis of actions and services • Evaluate complex systems • Where relevant develop and/or implement standards, protocols and procedures
2.7 Identify effective/ ineffective practice and promote shared learning	We need to be able to quickly identify areas where things are/aren't having the impact desired and then act. Will require close cooperation between policy leads, localities/communities. Links closely to 2.5 and 2.6.	• Develop criteria and processes to quickly identify effective/ ineffective policy and practice (linked to 2.6) • Design, deliver and support a range of products and services designed to share learning across the public health system • Lead and support the design/redesign of services/policies (linked to 2.5)
2.8 Identify gaps in understanding and commission relevant research	This requires both quantitative and qualitative methods using a range of different study designs and needs close collaboration with research and academia.	• Identify evidence and knowledge gaps that could be addressed through relevant research • Design, conduct, commission and manage public health research based on current best practice

2.9 Identify and share ways for the health improvement system to continually improve	Health improvement needs to be at the forefront of ensuring public health systems/services are continually improving and must be able to adapt to changing circumstances and contexts. The function must be capable of being reactive and proactive.	• Understand and keep up to date with emerging quality improvement literature • Develop and implement processes to embed that learning in the wider public health system

9. Appendix 2: Specifications requested under Deliverable 4, Future State

List of Deliverable 4 Specifications

- proposed benefits and benchmarks,
- related proposed organisational structure diagrams,
- any required changes to senior management roles and responsibilities,
- proposed staffing models,
- any additional skills and training requirements needed,
- any additional IT systems needed,
- any infrastructure and processes needed,
- any additional physical equipment and building that may be needed,
- any additional business processes, support processes or service management functions that may be needed,
- related financial costings as appropriate for any additions to the current arrangements.