Improving Services Commission: ensuring appropriate, effective & high quality health and social care services

Deliverable 5: Current and future state

Contents

1. Summary

The aims for Public Health Reform are to improve Scotland's poor health, reduce significant and persistent inequalities and address the unsustainable pressures on health and social care services. These aims came to explicitly underpin the principles for our Commission but in order to achieve them a major change is required in the way this domain is delivered in Scotland.

The main audience for the domain in the current state was service planners, mostly within NHS services. This meant that stakeholders outside of the NHS including from third sector organisations and local authorities were not familiar with the function but they were interested in its potential for influencing change in service provision.

Current leadership for the Health Care Public Health domain sits within a variety of its sub-functions spread throughout national and local NHS structures without a clear national locus. The broader context of Improving Services uses many different approaches, and leadership sits in a variety of organisations and structures across the public sector and third sector. Service improvement approaches do not always include an aim for population health gain and therefore public health might not always be involved in service improvement initiatives.

Stakeholder engagement suggested a need for a future state with strengthened overall national leadership and co-ordination of resource, and a proactive, consistent and distinctive offer to service planners within and outside of the NHS. A clearer articulation is needed of the added value of health care public health skills to Improving Services. Better collaboration across national agencies and across local structures could prevent confusion in national guidance for local practice and duplication of effort across Scotland. Stakeholders clearly valued analytical capability in public health to help ensure development and delivery of value-based services and more support was sought for evidence-based disinvestment and decommissioning alongside service investment and commissioning. The transformation potential of this function will lie in its shift towards a Scotland-wide cohesive approach to achieving population outcomes through service design.

The Commission Group reached consensus on a descriptor for the future state as 'Population Integrated Care' (PIC). The theoretical basis for PIC makes explicit a focus on population health gain in service design. It requires population needs assessment as a starting point and gathers and analyses a wide range of evidence on which to make robust decisions about investment and disinvestment of resource. Equity and sustainability underpin its ambitions. Integrated care planning is therefore considered within a population health strategy alongside the roles of determinants of health, people and communities.

The outcome for Population Integrated Care was agreed as being to 'Maximise benefits to the whole population from health and integrated care

services.' The principles underpinning the outcome agreed by the Group are commensurate with the value-based services approaches described in current Scottish Government policy and delivery plans, and with the ambitions of Public Health Reform for addressing population health gain and contributing to addressing health inequalities.

The future state for Population Integrated Care as a whole-Scotland function aims to provide capability, capacity, coordination and collaboration to deliver data and intelligence, stakeholder engagement, decision support and independent advice for the whole range of functions envisaged for an effective public health input to improving services from population. These can be summarised as including: Population needs assessment, service review and improvement, research and data analysis, prioritising, advising investment and disinvestment, monitoring and evaluation.

The group proposes a national function in Public Health Scotland that includes the components of leadership, development of new stakeholder relationships for PIC planning, network facilitation, collaborations and partnerships for wider service improvement and provision of and access to evidence sources.

A potential structure for a Population Integrated Unit within Public Health Scotland is proposed. At the time of writing the proposal has still to be worked up with existing teams and future PHS colleagues.

2. Introduction

The starting point for all of the Public Health Reform Commissions was to consider the ways in which public health could be transformed to hasten improvement in Scotland's poor health, reduction of significant and persistent inequalities and to address the unsustainable pressures on health and social care services. These ambitions came to explicitly underpin the principles for our proposed future state but in order to achieve them through the HCPH domain a major change is required in the way this domain is delivered in Scotland. The Group accepted the Commission Brief with just one adaptation, where we changed the term 'customers' to 'stakeholders' to strengthen the concept of collaboration in the function.

The first challenge for the Commission group was to define the overall improving services/healthcare public health function as there was no existing national locus or framework in place in Scotland. At the time of establishing the Commission Group the multidisciplinary workforce capacity and capability for healthcare public health and improving services lacked coordination and defied tidy description. The lack of national focus and visibility of the current function was clear from stakeholder discussions and the group struggled at first to articulate an aim or definition. Delivery of the current function was

explored within the group and further understanding sought through exploration of the wider stakeholder interfaces with HCPH. Proposals for the future state based on a widening of the current function were agreed at the Group's workshop on 11th December following completion of stakeholder engagement meetings. Current and future states as well as stakeholder requirements were developed through iterative discussions with stakeholders throughout the process. The workshop on 11th December included reaching consensus among participants on both the terminology and a descriptor for the proposed future function.

3. Describing the current state

The Health Services Committee of the Faculty of Public Health (FPH) defines Healthcare Public Health (HCPH) as one of the three domains for public health with the purpose of:

'maximising the population benefits of healthcare and reducing health inequalities while meeting the needs of individuals and groups, by prioritising available resources, by preventing diseases and by improving health-related outcomes through design, access, utilisation and evaluation of effective and efficient health and social care interventions, settings and pathways of care'[1]

The Public Health Reform Commissioning Briefing document set this domain within a broader aim of improving services and outlined the components of the FPH HCPH domain as a starting point for describing the current practice. The Commission Group worked through these components at an early workshop to explore the current function, gaps for the future function and the potential stakeholders. A survey by the group of specialists and practitioners working on HCPH identified examples of practice, mostly at Health Board or Integrated Joint Board levels (IJBs), with a smaller number of examples of national or sub-national projects. The questions and needs discussed with stakeholders were used iteratively in working up the descriptions and gaps towards a future state.

A major challenge for the Group was that there was no existing national locus or framework for delivery or governance for the HCPH function as a single domain equivalent to the other two domains of Health Improvement and Health Protection. The Group discovered at an early stage some differences in how the domain was experienced and described in Scotland. At the same time, specialists and practitioners in fields other than public health led and/or contributed to improving services in different ways, including some elements of HCPH, but were unlikely to use the FPH definition to describe their work.

[1] FPH Health Services Committee 2017. Healthcare Public Health definition (revised August 2017)

The Group survey found that the majority of specialist public health capability and capacity for HCPH is located within territorial NHS Board Public Health Directorates. Public health specialists and practitioners provide support and advice for healthcare decisions in Health and Social Care Partnerships, Health Boards, regional networks and national bodies at the discretion of their Director of Public Health (DPH). They often work on a variety of public health initiatives at the same time using the same skills and knowledge as they would for other domains. Consequently, they did not always describe themselves as 'HCPH' particularly in small Health Boards where they might be required to lead on work from more than one public health domain. At national level, there is a small cohort of public health specialists within the Information Services Division (ISD), NHS Health Scotland, and more recently, the National Services Division (NSD) with varying percentages of their time given to programmes or initiatives that might be described as HCPH. One estimate was that there could around there could be as little as 2.0 WTE specialist time attached specifically to HCPH work among 8-10 specialists located across Health Scotland and ISD. There is 1.0 WTE specialist recently seconded from ISD to National Planning in NSD and there are currently no specialist public health posts within Healthcare Improvement Scotland (HIS), although specialist public health input is often invited to HIS forums.

Additional capacity for national or regional HCPH projects comes from the Scottish Public Health Network (ScotPHN) which is hosted by NHS Health Scotland and reports to the Scottish Directors of Public Health (SDsPH). One of its roles is to coordinate requests for specialist public health support for HCPH developments at national and sub-national levels (for example when a number of Boards seek a solution to the same problem). Work on HCPH was estimated to constitute around 40% of ScotPHN's work programme. ScotPHN's role in this is co-ordination and the actual capacity for the work is drawn from local Boards, either to bring specific local expertise to a national request or to offer opportunities to specialists, practitioners or trainees for skills or interest development. The North of Scotland Public Health Network (NoSPHN) provides a similar coordination role for specialist public health support requests across the North of Scotland. The Public Health Service Improvement Interest Group (PHSIIG) is an informal special interest and peer support group for HCPH hosted by ScotPHN and offers an opportunity for members to share practice and keep up to date with new developments.

Each local authority and territorial NHS Board delivers geographically-aligned local information services and intelligence functions. In recent years that capacity has been increased through ISD's Local Intelligence Support Team (LIST), which delivers locally but is managed nationally. Stakeholders from IJBs universally welcomed the additional capacity received from LIST but there was a suggestion of variation in access to this service and to the level of analytical capability offered beyond information provision.

As discussed in the final D4: Stakeholder Engagement document, discussions with stakeholders helped Group members who were less familiar with the core public health functions to understand better the current state of HCPH. Three themes emerged as being particularly important for describing the current state and drawing out concerns or gaps for further discussion. These were

Leadership, Evidence and Service Improvement and key points are summarised below.

3.1 Leadership

The added value of including public health as a driver or contributor to service improvement is to ensure that services are based on evidence of population need, supported by specialist skills encompassing all aspects of population science and are part of a wider system approach for improving health and reducing health inequalities. As described above, leadership for local HCPH projects usually comes from local Health Boards in response to requests from local care systems. National leadership for HCPH tends to focus on discrete elements of HCPH. For example, ISD is responsible for data and intelligence, Health Scotland takes on planning for action on health inequalities through services, and ScotPHN leads co-ordination and supervision of some national or sub-national capacity for population needs assessments, evidence reviews or support for practice sharing networks. NSD have recently seconded in a full time public health consultant from ISD to increase capacity and capability for needs assessments, literature reviews, information and analytical support to inform national planning. Recommendations from early scoping of this role are included in discussion later in this document on Future State.

Much of the national work is established in response to requests as for local work. The ambition of those currently working in HCPH nationally and locally is to strengthen leadership and capacity in order to provide more systematic, proactive, evidence-based advocacy for improving services but the current state is not generally set up to do so. Leadership and governance for Improving services and HCPH are currently disjointed across the system with outcomes and parameters likely to be set for individual projects by the project commissioners. Stakeholder engagement suggested that the future state should have a strengthened overall national leadership and co-ordination of resource, and a proactive, consistent and distinctive offer to service planners.

Leadership: Summary of current state

- Accountability to Health Boards but majority of activity and influence in acute health services and IJBs
- Lack of national leadership, visibility and influence for the public health elements of the domain as a whole
- Inconsistent understanding among local services and national agencies of the value of a population needs based, whole system solution to improving services
- Experience and expertise applied mostly to NHS services
- Responsive to service improvement requests for population, whole system problem-solving, mostly at local level, but few opportunities for proactive influence
- Varied and inconsistent approaches to service improvement from local and national agencies.

3.2 Evidence Base

Public health brings experience of planning for whole systems which means the capability to draw on a wide range of research methodology and evidence sources to understand population need and effective service provision including from data and intelligence, evaluation, intervention development and evidence, service user experience and public involvement. There are potentially gaps in the evidence base for enabling an equitable right to health, equitable access to care for population groups with poorest health and services' roles in prevention. Stakeholder discussions suggested that better co-ordination is needed between organisations and structures developing and providing data, evidence and intelligence relevant to service improvement. This should focus on a Once for Scotland approach where possible, and ensure all types of evidence and expertise are accessible and relevant for maximising population benefits of services.

Evidence base: summary of current state

- Training and experience for HCPH provides skills for developing and drawing together evidence from a wide range of sources for making recommendations, including:
    - Quantitative data and analyses of population needs, risk factors, disease prevalence and trends
    - Intervention evidence
    - Situation analysis
    - Patient/service user experience and values
    - Service evaluation
    - Economic evaluation
    - Audit
    - Clinical effectiveness
    - Cost effectiveness
    - Service improvement processes sometimes rely only on data without accessing wider evidence analyses
    - Opportunities to develop proactive analyses, for example on unequal service access, are often limited by set questions for a commission or timescales
    - Value based health care aspects
- Much of the evidence is provided by or through national public sector bodies, currently Scottish Government, PHI, Health Scotland, HIS, Improvement Service
- ScotPHN co-ordinate some Once for Scotland or sub-national needs assessments, with capacity coming mostly from locally based public health staff
- Data and intelligence underpins population needs assessment and access is good and provision is strong
- There is potentially confusion in the system about the difference between the provision of data or information and its advocacy, and the provision of intelligence where data is analysed and interpreted for a given situation. Further, a wide range of population sciences such as illustrated in the list of evidence sources above is central to

development of recommendations for prioritising investment in integrated care
- There are likely to be duplications and gaps in the system, and the current capacity for providing and analysing evidence might be better optimised with better co-ordination

3.3 Service Improvement

There are many approaches to improving services and these are reflected in the variety of sectors and organisations at national, sub-national and local levels involved in service design and improvement. The opportunities for Public health staff to be directly involved in decision making for service improvement are variable across Scotland and across services. Service improvement decision makers might not always be aware of, or have access to public health input. Public health roles in service improvement include drawing together evidence from a wide range of sources, setting up collaborations to interpret the evidence for a specific service and population context and agreeing recommendations for prioritisation and service design. There was a need expressed for more system support for disinvestment where evidence is clear. Stakeholders suggested that the articulation of the added value of public health skills to service improvement is needed, and that better collaboration, particularly across national agencies would perhaps prevent duplication and confusion in national guidance for local practice.

Service improvement: summary of current state

- HCPH specialists often work to help problem-solve a service issue or investigate new need at the request of clinicians or service planners
- Examples of good practice where public health has led or contributed to service improvement is evident, demonstrating strong relationships and collaborations with service planners and providers, good access to data, intelligence and a wide range of research evidence, producing innovative recommendations and influencing change
- Focus is mostly on Board-level or IJB services
- Practice is shared between HCPH specialists through the informal network PHSIIG
- Some HCPH specialists work exclusively with NHS services, others work across PH domains
- There are many disciplines and sectors involved in service improvement and mapping of national resources and leadership for improving services could potentially reduce duplication and confusion.

In the process of describing the current state, a number of concerns and issues arose from the Group and from stakeholders. The first challenge for the group was to clarify the description and aims of the function.

4. Reaching consensus on terminology

The group continued to work over a number of meetings to reach consensus on a descriptor for the future state. The starting point was the Faculty of Public Health (FPH) definition for the Health Care Public Health (HCPH) domain described above. While the HCPH components listed in the Commission Briefing document provided a very helpful starting point for the group to explore the current state and gaps for the future state, the terminology linked to HCPH was the basis for a great deal of discussion and debate. With no existing national framework in place, stakeholder perspectives were crucial in shaping the descriptor and we took an iterative approach to its development. The group first came to a general consensus on principles and aims that would be most likely to take us towards transformation of services and we worked to build a potential framework that could be implemented consistently in practice. These developments together led to consensus on the outcome and descriptor. The context and considerations for the descriptor are outlined below.

At the final workshop, the group agreed to propose a title for the improving services/Health Care Public Health function as:

Population Integrated Care

The theoretical background for the term is outlined below.

4.1 Context

Population Integrated Care (PIC) brings together two concepts described in different papers by Public Health England and the King's Fund: population healthcare and integrated care. Population healthcare focuses on populations defined by a common condition and therefore takes healthcare beyond hospital services[2]. Integrated care can describe integration of services within the NHS and it can describe care that involves NHS, local authorities and the third sector working together to meet the needs of their local population. The King's Fund proposes that the most ambitious forms of integrated care aim to improve population health by tackling the causes of illness and the wider determinants of health (Figure 1 below).[3] They also argue that integrated care should be considered within a population health strategy alongside the roles of determinants of health, people and communities. This broader approach describes an explicit aim of equitable care for the whole population. It aligns to the Scottish Government's 2016 Health and Social Care Delivery Plan triple

[2] Gray M. Population healthcare: a new clinical responsibility. Journal of the Royal Society of Medicine, vol. 109, 12: pp. 437-438. , First Published December 6, 2016.

[3] Kings Fund 2018. Making sense of Integrated Care Systems. Integrated care partnerships and accountable care organisations in the NHS in England: https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems#comments-top

aim of Better Care, Better Health and Better Value[4], and to Realistic Medicine's value-based approaches for equitable, safe, high quality and patient-centred services.[5]

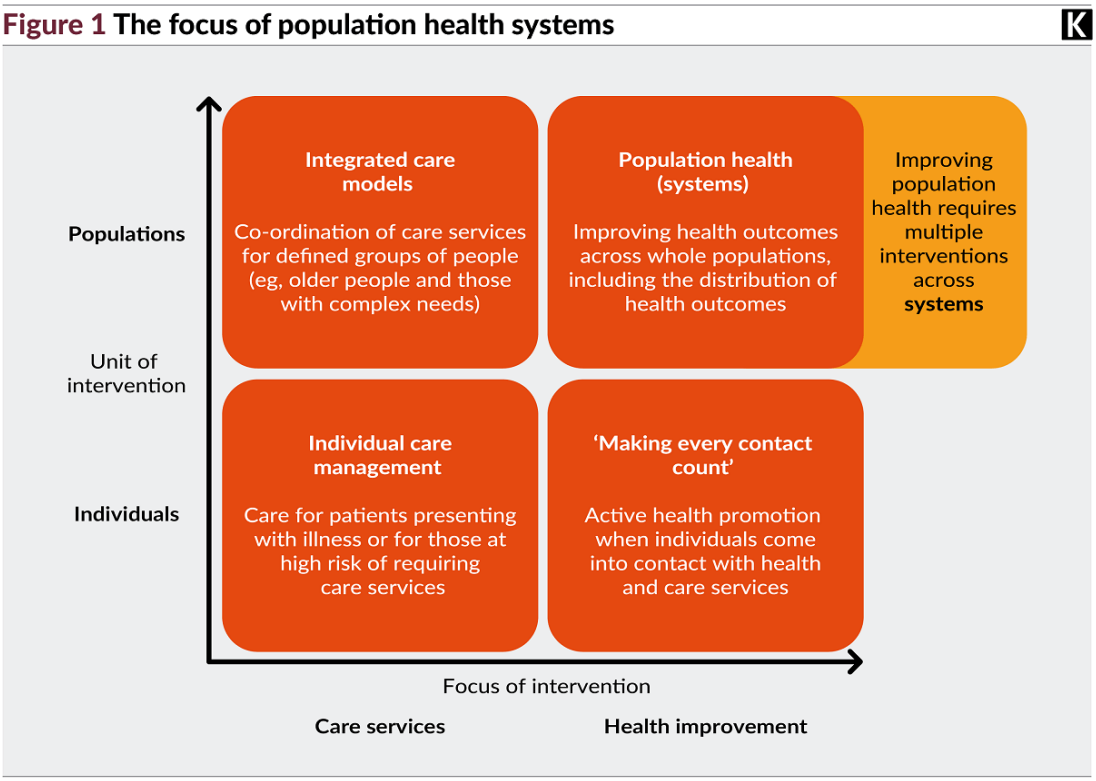


Figure 1. The Focus of Population Health Systems. King's Fund 2018[6]

4.2 Development of the descriptor

The group began by exploring the three terms that were used in the paperwork for the Commission: Health Care Public Health (HCPH), Health and Social Care Public Health (HSCPH) and Improving Services (IS). Stakeholder discussions tended to focus on the principles and tasks associated with the role of public health in service improvement rather than the terminology but there were high levels of discomfort within the group with all three terms. The main objections to each can be summarised as follows:

HCPH: this is the name given to the domain by the FPH which describes a set of specific standards and competences for education, practice and specialist regulation and registration. While the FPH includes social care in the detail of

[4] https://www.gov.scot/publications/health-social-care-delivery-plan/pages/2/
[5] https://www.gov.scot/publications/practising-realistic-medicine/pages/7/
[6] Kings Fund 2018. Making sense of Integrated Care Systems. Integrated care partnerships and accountable care organisations in the NHS in England: https://www.kingsfund.org.uk/publications/making-sense-integrated-care-systems#comments-top

its definition of HCPH, the omission of social care in the title created an expectation that the function was to be focused only on the NHS. The group believed that we should reflect a more inclusive approach to integrated services.

HSCPH: while this term broadens the function beyond healthcare there were concerns expressed that this might also suggest a single service approach, that is, within the NHS and within social care rather than being clear about an assumption of integration between and beyond the two structures. There was also concern about a potential interpretation where all public health functions could be misinterpreted to come within health and social care. HSCPH, in common with HCPH, required a long explanation to demonstrate and explain the population science approach taken by public health for the purpose of achieving equitable service provision.

Improving Services: while service improvement is one aim of the function, actions to improve services do not always include an aim to improve population health. Stakeholder discussions demonstrated that there are a wide range of disciplines and organisations involved in and leading service improvement. A variety of approaches are available to service planners, which might or might not include population needs analysis drawn from evidence from across the spectrum of population sciences.

None of these terms sat comfortably with group members' ambitions for the function or with stakeholder requirements and they stimulated a great deal of debate throughout the process.

5. Articulating the outcome for Population Integrated Care

The group believed that the descriptor and outcome should reflect public health's unique population focus in care provision, our commitment to patient values and to equity, and that integration and insight into social determinants of health should be recognisable. The descriptor should be clearly stated without long explanations and should avoid technical terms.

Population Integrated Care (PIC) as suggested by the theories outlined above met at least some of these criteria and was the tightest phrase we could find that had potential for establishing clarity in its further discussion. The **outcome** for PIC is to:

***Maximise the benefits to the whole population from integrated health and care services*.**

The **principles** underpinning the outcome agreed by the group are in essence those articulated by Scottish Government health policy and summarised in the **'value-based services'** approaches in the Scottish Government delivery plans referred to above. The population health gain ambition described by the

group put further emphasis on **equity** and the additional ambition of achieving **sustainability** (in all its interpretations).

The **approach** to achieving the outcome could be described as embedding evidence into action for population health gain through care services. This requires multi-disciplinary working with the process encompassing all elements of population science including population needs assessment, prioritising on the basis of equitable population health gain and ultimately implementing innovation and change. An area where many stakeholders suggested that public health could make a particularly strong contribution to service planning was in the 'data-to-decision journey' (as described by PHE[7]) where population data and intelligence is analysed within a specific context to produce an independent set of recommendations for service or system change. Population integrated care would provide independent evidence for decision-makers to ensure population health gain from integrated services and would also lead or contribute to developing the strategy for action.

Knowledge sources for population integrated care to achieve system and service change include data and intelligence (including evidence from research), service user experiences and preferences, expert opinion and theory-based approaches. The application of population science to improving services is described in health and social care delivery plan as population-based planning, and in Realistic Medicine as a value-based population healthcare approach. Important to many of the stakeholders was to establish clarity, and to access capacity and capability for the data-to-decisions analyses required for robust decision making on value based, efficient and effective services. For the group members, proactive opportunities to contribute evidence-based, independent recommendations to service planning was uppermost.

Stakeholders and the group shared ambitions for the future for better, integrated care provision contributing to population health gain. A theme was emerging for proactive, multi-disciplinary knowledge into action processes to be embedded in service improvement at national, regional and local levels. The next stage was to consider the actions and structures that the group and wider stakeholders wanted to see within the future Population Integrated Care function.

6. Future state

As described above the commission group propose that Public health Scotland will support a national Population Integrated Care (PIC) function in becoming a respected, independent source of expert guidance and interpretation of evidence. The aim will be to ensure quality and value in improving population health gain through services, and will guide both investment and disinvestment decisions. Population Integrated Care as a

[7] https://publichealthmatters.blog.gov.uk/2018/12/05/from-data-to-decisions-building-blocks-for-population-health-intelligence-systems/

whole-Scotland function aims to provide capability, capacity, coordination and collaboration to deliver data and intelligence, stakeholder engagement, decision support and independent advice in collaboration with partners for all elements of service improvement:

- Population needs assessment
- Research and data analysis
- Pathway design, review, improvement and development
- Prioritisation, commissioning and decommissioning
- Monitoring and evaluation.

The PIC function in Public Health Scotland should address stakeholder requirements and gaps identified by the Commission as summarised below:

Vision and leadership

- Clarity of the Population Integrated Care (PIC) vision, principles, function, roles and application across sectors in Scotland
- Articulation of the added value of PIC as a driver or contributor to improving services
- Consistency of 'offer' for service planners.

Capacity and skills

- Increasing capacity and capability for population health knowledge and skills through better support for and use of existing staff across Scotland
- Flexibility of staff to enable skills development and deployment across structures, domains and career pathways
- Capacity created for PIC to map sources of evidence relevant to population health gain through integrated care planning, and address duplications of provision and gaps in the evidence base
- More capacity for Once for Scotland population needs assessments and equity assessments
- Support for skills development where gaps are identified, including research and data analysis, economic analysis, innovation, user-led service design and partnership development
- Greater focus on capacity and capability for translating knowledge into recommendations for action.

Working Differently

- Horizon scanning function for proactive prioritisation and planning of PIC work programmes across Scotland
- Clearer relationships across national organisations for integrated care planning and service improvement, ie between Public Health Scotland and other national agencies such as NSS, HIS, Improvement Service, COSLA in order to identify priorities and maximise impact of expertise and resources

- Assumption of a cohesive approach to service planning across Scotland with cross sectoral working and integrated approaches nationally, regionally and locally
- Processes established for routine public and patient involvement in research and decision-making on service design
- Connections made explicit between PIC priorities and public health priorities.

Making difficult decisions

- Moving away from business planning for data services driven by individual customer priorities to strategic collaborations for population health gain
- Strengthened collaboration between national and local PIC functions for joint action and strategic change in decision-making on investment and disinvestment priorities
- More opportunity nationally, regionally and locally to influence proactive proposals and decisions for service priorities, resource allocation and delivery.

The group proposes a national PIC function in Public Health Scotland that is set up to support and enhance the function across Scotland. It assumes that most of the specialists and practitioners working on PIC continue to be based in local areas but work to the nationally agreed aim of improving population health gain through integrated care planning. The main audience for the PIC unit will be local and national planning structures with support offered to them through supporting and enhancing (where needed) existing public health staff resource in local and national NHS Boards. The Unit should include the following components:

- **Leadership** to further define the function in collaboration with stakeholder groups and to support prioritisation of national, regional and local PIC projects
- Further **development of stakeholder relationships**, for example, partnerships for change with primary and acute care, IJBs, local authorities, third sector organisations and service user groups and for advocacy with policy makers and politicians to support potentially difficult decisions
- **Network facilitation** and development for prioritising PIC initiatives and practice sharing
- **Development of national partnerships and collaborations** to map opportunities and gaps and reduce duplications within the broader arena of service improvement across national and local levels
- **Direct access to evidence sources** including data and intelligence, analytical support and service user experience to provide Once for Scotland support where possible to the networked function across Scotland
- **Capacity and capability** development where required.

Five options for establishing and configuring resource in Public Health Scotland to deliver the above components were drawn up for consideration by the Group at the December workshop. In order to consider these within the context of future Public Health Scotland structures two illustrative structures were offered for consideration of the potential PIC substructures. These structures and the process are described below.

7. Structure options appraisal

Two scenarios were offered for potential Public Health Scotland structures as the wider Public Health Scotland context is likely to impact on delivery of the future PIC function. The two scenarios were first, an outcomes led structure model and, second, a skills led model (Appendix 1). The latter is similar to the current arrangements with different domains and skills sets sitting in different organisational structures. There was limited knowledge within the Group of the current arrangements in the national organisations. However the Group were generally agreed that a different arrangement is needed to achieve the leadership, capacity building and cohesion sought by the Commission. The two options in Appendix 1 were briefly discussed in the group for the purposes of considering potential impact on the PIC functions but the detail was not fully worked through. Therefore they are given here only as illustrations of the context for the Group's final proposal.

Five options for PIC structures were offered for consideration for a SWOT analysis. The five options were drawn up from the conclusions on the principles and components for the PIC function outlined above and presented to the group for discussion. The Group had limited time for the SWOT analysis but nonetheless concluded within the workshop timeframe. There was opportunity for further email discussion but the Group's conclusion remained. The five options are given in Appendix 2.

The conclusion of the group was that a slightly amended version of a model based on Option 4 plus Option 2 would be most likely to meet stakeholder requirements. A summary of the SWOT options appraisal is given in Appendix 3. An outline for the proposed structure for PIC is given below.

8. Proposed model for a Population Integrated Care function in Public Health Scotland

The preferred option for Population Integrated Care in Public Health Scotland is as a standalone, outcomes-based unit (outlined in red in Structure 1, Appendix 1). The PIC unit aims to provide strategy development and population health leadership; data, evidence, analyses and advocacy; and network leadership and facilitation. The main audience for the unit will be locally based integrated care planners across Scotland, and national and

regional integrated care planning structures. Most of the work of the unit will be in supporting and delivering data and evidence analyses on a ‘Once for Scotland’ basis, or in collaboration with local public health teams in order to prevent duplications and make best use of specialised resource across the system. Collaboration across Scotland-wide local delivery and between national, regional and local structures will be enhanced through a formal network led by the PIC unit. Better use of specialised resource should enable more opportunity than currently exists for new research and proactive proposals for effective and efficient integrated care planning.

The PIC unit would provide capacity and capability to support the national, regional and local public health contribution to PIC planning. It would provide the functions that can be delivered on a Once for Scotland basis and enhance in situ capacity for specialist skills where required. The main functions would include:

- Leading population health outcomes planning and prioritisation for the unit and in partnership with the formal network for the wider PIC function
- Delivering data and evidence analysis for national, regional and local population integrated health and social care initiatives
- Leading and co-ordinating a PIC network in order to establish a Scottish PIC function across national, regional and local levels, including for prioritisation and planning of collective resource
- Providing research and knowledge services for support and co-ordination of access to a wide range of evidence sources
- Providing capacity for stakeholder engagement and network development and facilitation
- Supporting local specialists and practitioners to lead and deliver local integrated care planning projects and to collaborate on regional and national projects when required
- Establishing partnerships and collaborations with other national bodies to collaborate on service improvement including HIS, NSS, Improvement Service, COSLA, NHS 24, NES and others.

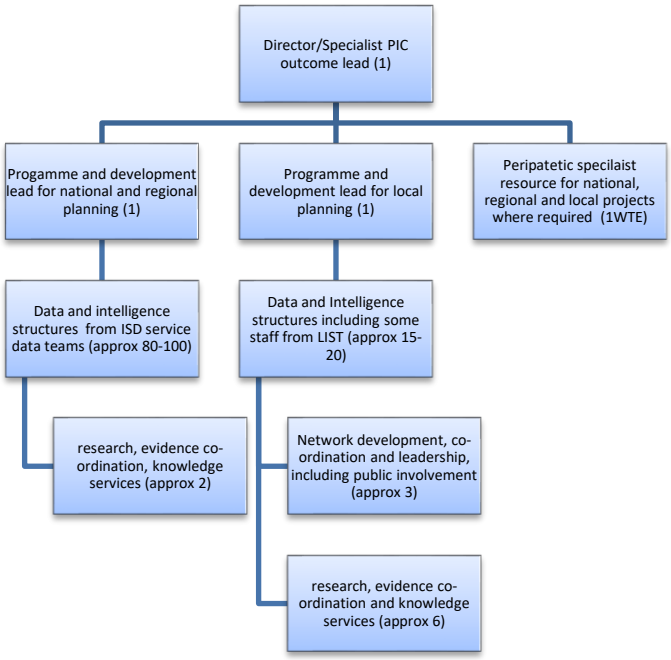
The proposed model has still to be worked through with stakeholders and the Group are aware that other discussions are ongoing to explore the best model for connecting national, regional and local elements of all the public health functions. For example, regional hubs are being explored for the LIST team and new models such as these should be considered for the PIC unit in its further development.

We propose at this stage that the PIC unit would comprise multi-disciplinary teams that include skill sets in data, research, analysis, innovation, strategy, knowledge brokerage (for influencing action), network facilitation and practice development. It would have specialist leadership for meeting population health outcomes and assumes some additional elements of matrix management and professional leadership for specialist functions across PHS. The model also assumes underpinning resource shared across PHS for data management, information governance, skills and knowledge development, IT

and other cross organisational functions (illustrated in Structure 1 in Appendix 1).

The unit would draw in a proportion of ISD staff currently working on service related projects, including a proportion of the LIST team, and potentially a proportion of current ScotPHN resource (or similar skills from other parts of the merging organisations) would be brought into the PIC function. The model would also draw in some of Health Scotland's current research, knowledge services, practice development and networking functions.

An outline structure chart might be constructed as follows:



The staff numbers are estimated in advance of full discussion with the current structures and teams implicated. Estimations for illustration of a potential structure are as follows:

- Total of approximately 100-120 staff, split between local and national/regional projects
- Multidisciplinary team led by a generalist specialist in population health
- Two programme leads for national and regional stakeholder development, project leadership, network leadership and team management
- One peripatetic specialist to enhance resource for external projects
- Approximately100-120 data and intelligence staff (including existing management arrangements), currently employed by ISD and working on NHS and integrated care national, regional and local data and intelligence projects
- Approximately six researchers and two knowledge management specialists
- A team of three for network development and facilitation.

PIC would require the current business model of customer led planning and funding for data and intelligence activity to shift over time to a strategic, collaborative, multi-sector approach to population integrated care planning. The model assumes a re-configuration of existing staff from ISD and Health Scotland teams with the requisite skills and expertise for meeting the new PIC outcome. It also assumes a need for development work to establish new areas of practice as well as to serve the current needs of the system, for example, for supporting regional planning, primary care and the development of new partnerships and collaborations with other national teams or organisations.

Programme and development leadership would be based on a Knowledge into Action (KIA) approach and involve all relevant partners in planning and delivery across the KIA cycle. The model assumes willingness, or development work, for those currently involved in HCPH delivery in local Boards to work collaboratively with colleagues from other geographical areas and with the proposed national unit. The proposed structure could be adapted to a model of national employment with local deployment if the wider PHS organisation adopts that model, or if the collaborative nature of the PIC function is not achieved through the network model proposed.

In the event of PHS adopting a skills-based structure (Structure 2, Appendix 1) the proposed PIC functions could potentially be delivered on the basis of explicit collaboration across skills-based teams. However, Group members agreed that there is likely to be strength and cohesion in having a multi-disciplinary team working together towards the same outcome, principles and delivery assumptions.

As the staffing of the proposed PIC unit would be drawn from existing teams in ISD and Health Scotland, line management arrangements would largely mirror existing contract arrangements. IT and infrastructure needs and staff transfer arrangements should be taken into account within arrangements for whole organisational transfers. Final numbers of staff could be confirmed following further exploration of the model with stakeholders and existing staff structures.

9. Next steps

The Commission Brief requests details of transition requirements but further discussion is necessary. First, further engagement with stakeholders on the proposed outcome, theory base and ambitions for Population Integrated Care is needed to confirm acceptability across the system. Second, discussion is needed of the proposed model and structure with the Public Health Reform team and Programme Board, other Commission groups and with existing teams in ISD and Health Scotland in order to further develop and test out the proposed model.

APPENDIX 1

Two potential approaches for PHS structures: examples provided for context for the population integrated care function

Structure 1: outcomes based structure

Public health leadership for outcomes within all groupings. All high level outcome teams are multi-disciplinary and include data, research, analysis, innovation, strategy, knowledge brokerage (KIA) and practice development. Matrix management and data and research supervision and leadership might sometimes be provided across more than one division if economies of scale require. Cross boundary working ensured by outcomes planning system.					
Health in All Policies	**Population health and prevention**	**Health Improvement strategy implementation (could be incorporated to Pop health)**	**Population integrated Care**	**Health Protection (cross over with other functions but largely sitting as a function)**	**Comms, publishing etc**
Outcome: improved population health	**Outcome:** improved health for targeted topics or groups	**Outcome:** reduction in health risk behaviours	**Outcome:** Maximise population benefits of integrated health and care services		
Should include: economic (income and wealth), right to health, power, place-based policies, community planning, physical	Should include: Population trends, Burden of disease Early years – children, young people and families Mental health	Should include: Alcohol, tobacco, food and drugs. Legislation, regulation, community based support, community	PH contribution: application of public health principles and population sciences for population-based planning and value-based population		

activity, travel and transport, housing, environment, climate change, etc Audience: Planning and data support for local partnerships (eg place standard, Triple I tool) and national policy and strategy	Gender related action Age related action Inclusion health Equality legislation (would a screening unit fit here??) Focus on evidence based public health priorities identified by SG and by PHS. Identifying risk, early intervention and prevention. Audience: Planning and data support for local partnerships and national strategy	led action, health promoting service provision HS work on smoking cessation, ABIs etc would be included in here. Link with place based planning	healthcare approach with central emphasis on equity and sustainability (would a screening unit fit here??) Audience: national and local NHS and integrated service decision makers and designers		
Underpinning all: Data management, information governance, establish a Scottish PH workforce fit for purpose, skills and knowledge development, HR, IT etc					

Structure 2: Skills base structure

Matrix management for delivering each set of skills against outcomes, each outcome led by a team head/consultant/specialist with skills-focused management and leadership. Cross boundary prioritisation of outcomes and collaboration ensured by planning system (similar to current state within separate organisational systems across HS and NSS)					
Data management	**Analytics (300 staff)**	**Skills group 3 (e.g. epidemiologists, evaluators, health economists, evidence experts)**	**Skills group 4 (e.g. publishing, comms, knowledge brokers)**	**Strategy team: eg incl workforce development**	**HR, IT etc**
Data systems, information governance etc	Includes LIST and other teams working locally, regionally and nationally	Internal collaborations or commissions through organisational planning to access expertise as required	Would include facilitation and comms expertise for service user and service provider engagement	Expertise and consistency for public health skills and knowledge development, stakeholder engagement, PHS organisational strategy	Internal focus and/or shared services
Note for population integrated care: Would need a Hub of some sort to coalesce resource from across PHS and ensure access to expertise and evidence resources as required. Similar to current structures with Hub idea similar to HS strategic priority planning.					

PC 10/12/18: for workshop option appraisal purposes only

APPENDIX 2

Structure options for Population Integrated Care

Option 1

Either outcomes- or skills-based structure: ***the status quo***

- Current national work supporting HCPH through ScotPHN, LIST and ISD continues to respond to requests and collaborate where required
- Mix of specialist and business management leadership
- Local HCPH specialists respond to IJB and sub-national requests as capacity allows
- PHSIIG continues as an informal practice-sharing network for locally based specialists.

Option 2

Either outcomes- or skills-based structure: ***MCN proposal from shared service review***

- PHS establishes and runs a Managed Clinical Network for Population Integrated Care
- Specialist led
- Coordinating role for all disciplines and organisations involved in Population Integrated Care, including university departments, third sector and service user groups

Option 3

Outcomes Structure 1

- PHS 'Division' for Population Integrated Care would include all PHS staff involved in delivery, coordination and collaboration for data and intelligence, stakeholder engagement, decision support and independent advice
- Specialist led
- PHS provides capacity and capability for all functions to national and regional planning, other sub-national planning and local partnerships when capacity and prioritisation requires or on request including Once for Scotland projects where possible
- PHS develops relationships with other national bodies to collaborate on all other aspects of service improvement and service delivery eg HIS, NSS, NHS 24, NES, Third Sector etc

Option 4

Outcomes Structure 2

- Division for Population Integrated Care would include all PHS staff involved in coordination and collaboration for leading and delivering data and intelligence, stakeholder engagement, knowledge services decision support and independent advice
- Specialist led
- PHS provides capacity and capability to national and regional planning, other sub-national planning as capacity or agreed prioritisation allows including Once for Scotland projects where possible
- Local specialists lead local and sometimes regional planning projects, taking a local co-ordination role within areas
- PHS provides national capacity to support local projects with data, intelligence, evidence, facilitation decision support and practice sharing
- PHS develops relationships with other national bodies to collaborate on all other aspects of service improvement, guidance and advice and service delivery eg HIS, NSS, NHS 24, NES etc

Option 5

Skills based structure

- National, regional and local planning structures access PHS data and intelligence and population science evidence or support as required
- PHS develops a Hub to co-ordinate internal resource for Population Integrated Care, formal and/or informal network facilitation and Once for Scotland projects where possible
- PHS Hub develops relationships with other national bodies to collaborate on other aspects of service improvement, guidance and advice and service delivery eg HIS, NSS, NHS 24, NES etc

For all options

Consider long term future functions 5-10 years hence, and the structures that would support development towards these from day 1 of PHS. In addition, consider stakeholder requirements, including accessibility of the function to stakeholders, and the values and criteria from the group and the Public Health Reform Programme in accompanying functions and criteria paper.

APPENDIX 3

SWOT Analysis for future Population Integrated Care Function within Public Health Scotland

	Option 1 **The status quo** Generally reactive, multiple players - ScotPHN, LIST, ISD, PHSIIG, local HCPH specialists	**Option 2** **MCN proposal from shared service review** Specialist-led MCN, co-ordinating role across sectors including academic and third sector	**Option 3** **Outcomes based model 1** PHS specialist led 'Division' to include all functions required for PIC. PHS employs and devolves all PIC resource where required throughout the system	**Option 4** **Outcomes based model 2** As Option 3 but PHS employs staff to support local PIC work (Once for Scotland basis), but not deliver it, plus staff to support and carry out national and sub-national initiatives. Local partnerships and Boards employ staff for local PIC delivery (supported by PHS). capacity except for Once for Scotland	**Option 5** **Skills based PHS structure** PHS employs staff to deliver population science, networking, practice development functions etc. Hub formed in PHS to draw PIC resource together nationally and locally.
Strengths	• National locus for population science expertise	• Pragmatic - quick and simple to establish • Some improvement on the status quo	• Critical mass of a body of people doing the work • Profile • Leadership • Prioritisation across Scotland • Accountability • Advocacy	• Local credibility • Critical mass of a body of people doing the work • Flexibility of moving national resource around to where its needed • Profile • Leadership • Prioritisation across Scotland	• National locus for population science expertise

				• Legitimacy nationally and locally • Accountability • Advocacy	
Weaknesses	• Disjointed leadership and prioritisation of tasks • reliant on informal relationships • limited opportunity for Once for Scotland planning • competitive rather than collaborative environment	• Doesn't bring the whole workforce together – clinical model and language will not sit well with most • Very dependent upon who the clinical lead • Dependent on time given on top of 'day job' • No governance accountability	• Centralised (not local) • Will take a long time to set up and deliver • Difficult to achieve local credibility	• Dependent upon the Josephine's of this world (ie open to different levels of prioritisation locally) • Current models haven't got us to where we want to go • Current tensions continue • Potential duplication of effort	
Opportunities		• Networking	Link the national, regional and local public health workforces	• Build relationships – channel resources more effectively • Build on some current work but opportunities to strengthen	
Threats			• Being in a corporate structure you lose advocacy		
What it needs to make it 'Norway plus'		Authority, dedicated time			