A consultation on the new national Public Health Body

'Public Health Scotland'

Introduction

The Glasgow Centre for Population Health (GCPH, 'the Centre') was established in 2004 in response to growing concern about health and inequalities in Glasgow and the West of Scotland, in the context of Scotland's overall poor health record. As is the case for the current reform process, part of the rationale for the establishment of the Centre was that the scale and complexity of the challenge required new ways of thinking and working, centrally informed by research and evidence, and premised on new partnerships with (national and local) government, third and private sector, local Universities and local communities. The GCPH generates insights and evidence, supports new approaches, and informs and influences action to improve health and tackle inequality. Working with a wide range of partners, we conduct research of direct relevance to policy and practice; facilitate and stimulate the exchange of ideas, fresh thinking and debate; and support processes of development and change.

The GCPH is a partnership between NHS Greater Glasgow and Clyde, Glasgow City Council and the University of Glasgow, funded by Scottish Government. These partner organisations are formally engaged in establishing and supporting the Centre's strategy, priorities and work programmes through its Management Board and Executive Management Team. Membership of the Board is drawn from all of the Centre's core partners, and from the Glasgow Health and Social Care Partnership. In addition to this formal partnership and governance structure, as already noted, we work collaboratively with a wide range of stakeholders and partners from a range of organisations, sectors and communities. To a significant degree, the GCPH is a highly successful model of the shared governance and whole system working that underpin the proposals for Public Health Scotland. Members of the GCPH team work across the spheres of policy, service delivery, research and community life to develop and support the application of evidence-informed approaches to improving health and reducing inequalities. In addition to contributing to a wide range of forums and developments, the Centre has been co-opted as a member of Glasgow's Community Planning Partnership, has worked with the University of Glasgow to establish a social research hub in the East End of Glasgow, and has been instrumental in

securing an ambitious shared agenda for public health in the city, led jointly by the City Council and the NHS.

A separate paper on learning from the GCPH which has direct relevance to the process of public health reform in Scotland has been submitted to the reform team. Further information about the Centre is available at https://www.gcph.co.uk/

Question1: Do you have any general comments on the overview of the new arrangements for public health?

We welcome the proposed design principles for Public Health Scotland (PHS) and the proposed high level responsibilities for the new body. We support the inclusion of the responsibility to offer independent expert advice. Such independence will require careful management and protection given the proposed organisational and governance model. We also recommend the inclusion of a further principle, relating to environmental sustainability. PHS should be a leader in demonstrating environmentally sustainable ways of working and in advocating for sustainable practice more broadly. This is a core part of its responsibility for the health of Scotland's population.

More generally, there are four key features of the proposed arrangements that we feel require further emphasis and working-through in the operating model: the relationship between the national body and all of the public health work that is progressed at different sub-national levels; the role of Public Health Scotland in the international arena including in relation to global influences on Scotland's health; ensuring that research and evidence are at the heart of the culture and operations of Public Health Scotland; and the focus on reducing inequalities in health within Scotland (which requires sustained and proactive attention to social and economic determinants of health, the targeting of resources to where they are needed most, and the tailoring of approaches to different communities and groups). These points are developed in response to later questions in this consultation.

Question 2: (a) What are your views on the general governance and accountability arrangements? (b) How can the vision for shared leadership and accountability between national and local government best be realised?

The proposed governance and accountability arrangements fit well with the organisational responsibilities and the aims of the reform process. As noted above and in paragraph 8 Chapter 2 of the consultation document, there will be a tension between the provision of *independent* advice and the proposed accountability mechanisms. An approach will need to be agreed and formalised in a Memorandum of Understanding (or similar), to ensure that PHS can perform the desired role of 'trusted and impartial champion'.

Shared leadership and accountability between national and local government will be realised partly through the structures and processes that are put in place, and partly through the behaviours and cultures established in the new body. The reform process to date has been exemplary in demonstrating this shared leadership in practice, and embedding it within all of the activities that have taken place.

Question 3: (a) What are your views on the arrangements for local strategic planning and delivery of services for the public's health? (b) How can Public Health Scotland supplement or enhance these arrangements?

We believe that there should be flexibility in the nature of the local arrangements, reflecting levels of need, local circumstances and population characteristics. There should be no expectation that they will look identical in all parts of Scotland.

Experience has shown the GCPH model to be an effective means of ensuring evidence-informed and locally-embedded agenda-setting and planning for improved population health. There is an invaluable role for a relatively local collaborative space and strong partnership relationships, enabling iterative dialogue that focusses on 'common good goals', shaping implementation and ensuring that research is close to the 'action'. We advocate not only acknowledgement and value of the GCPH model but also replication of it elsewhere in Scotland.

We are concerned that the establishment of a large new national body will result in the diminution of local expertise and resources to influence change on the ground. Arguably, the reform process should lead to a smaller national core to support an enhanced local, community-based public health system.

Question 4: What are your views on the role Public Health Scotland could have to better support communities to participate in decisions that affect their health and wellbeing?

We strongly support the aspiration that *'Public Health Scotland will aim to increase community participation in decisions that impact on community health and wellbeing, as well as supporting communities to develop innovative solutions to significant challenges.'*

As a central body, PHS could usefully work with the Scottish Community Development Centre and others with the specialist expertise to develop community development leadership, support and resources (financial and other) which could be made available to local organisations and communities to boost local work. Further development of existing place-based approaches, such as the Place Standard and application of the Place Principle, to ensure that local physical, social and economic environments are health-enhancing would be another important role.

Referral systems should be set up to ensure that any requests made to PHS by local communities are signposted to local contacts. As far as possible we suggest that PHS should seek to partner and support organisations that are already working in communities. Ideally, PHS staff would be allocated to specific areas so that relationships can be built over time. This would increase accountability and allow long-term relationships to develop.

Emerging information from the implementation of the Community Empowerment Act to date and the GCPH work to engage communities has highlighted the need to build capability and capacity in communities, and particularly in deprived or vulnerable communities, so that they are able to engage. This requires developing relationships of trust, as well as putting in place adequate resources. Without investment in building local capacity and

capability in local communities, there is a risk that the communities which are best resourced (and often most affluent) will be more able to take advantage of the opportunities that the CEA offers.

Although there is a range of research/evaluations underway to understand how the Community Empowerment Act is being implemented, PHS should have a key role in coordinating, overseeing, synthesising and drawing learning from these about the impact on health and inequalities of different aspects of the Act.

Question 5: (a) Do you agree that Public Health Scotland should become a community planning partner under Part 2 of the Community Empowerment (Scotland) Act 2015? (b) Do you agree that Public Health Scotland should become a public service authority under Part 3 of the Community Empowerment (Scotland) Act 2015, who can receive participation requests from community participation bodies? (c) Do you have any further comments?

Our experience, and that of our partners, is that national organisations without a direct local connection and locus find it difficult to contribute as effectively to Community Planning as do organisations with a local presence and responsibilities. Our view in Glasgow is that Community Planning membership from the local NHS Board, HSCP and GCPH provides a strong and locally-informed public health input to community planning. PHS could provide support and expertise, and will itself benefit from an awareness of the local community planning discussions and issues, but we are not clear about the value of its direct membership as a named community planning partner. Our preferred model would be of an agreed mandate/statement of relationship between the CPP, local public health teams, and PHS – with the public health representation on the Partnership being provided locally not nationally.

We support PHS becoming a public service authority, while noting that this is but one route to enhance community participation.

Question 6: (a) What are your views on the information governance arrangements? (b) How might the data and intelligence function be strengthened?

The section on 'information governance' (paragraphs of 70-72 of Chapter 3) sets out some high-level aims and principles, rather than proposing specific arrangements to which we can respond. That said, given that ISD Scotland, Health Protection Scotland and NHS Health Scotland (as well as NHS Scotland as a whole) will have extant information governance policies, protocols, guidelines and regulations, a sensible approach to developing a new set of arrangements for the new organisation would be to review those existing policies (and, possibly, those of other relevant external organisations) and develop a new proposal based on existing 'best practice'. In doing so, it should be emphasised that while data confidentiality is obviously extremely important, at the same time health related data collected or held by the new organisation need to be accessible (i.e. without excessive hindrance) to researchers and, ultimately, policy-makers in order that it may be used to monitor and improve population health. Historically this has not always been the case

within relevant parts of the NHS in Scotland.

The term 'whole system' is used more than once but requires clarification. Equally, it would be useful to be clearer about who will need access to data and intelligence – who will use the data. Who can access data may well differ from who uses the health intelligence generated via those data, and this will also influence the level of access/use that is required.

Given the current level of detail in the consultation document it is difficult to comment on how the function might be strengthened. However, we would emphasise the importance of due attention to the balance between confidentiality on the one hand and researcher access on the other. In addition, in the era of 'Big Data', it is important that the new organisation facilitates linkage of its various important data sets (e.g. in relation health service use) to external information relevant to health, and also works closely both with other data providers and others (e.g. academics) working within the data linkage field. Given the importance of getting good data and translating this into useable intelligence for research, policy and practice, it may be valuable to assess the key strengths and weaknesses of how these processes are managed currently within the existing bodies that will form PHS.

Question 7: (a) What suggestions do you have in relation to performance monitoring of the new model for public health in Scotland? (b) What additional outcomes and performance indicators might be needed?

We welcome the proposal to use the National Performance Framework (NPF) as the starting point for monitoring. The recent (June 2019) Scottish Leaders Forum highlighted the need to move from multiple local, sectoral, and organisational performance indicators to a system whereby organisations are accountable for their contribution to the national outcomes and purpose set out in the NPF, including accountability for reducing inequalities between population sub-groups and geographies. The establishment of PHS at this point in time provides an opportunity to be an exemplar in this regard and to apply this performance monitoring approach from the outset, building on the developing articulation of the ways in which PHS will contribute to the national outcomes and purpose. Indicators of organisational efficiency will still be required but should be seen as the means to effective performance not an end in themselves.

Question 8: What are your views on the functions to be delivered by Public Health Scotland?

We are broadly supportive of the key functions proposed for Public Health Scotland. However, as noted in response to Q1, we believe that the organisation's role in relation to international/UK public health and the global/UK influences on Scotland's health should be included. We also recommend that the organisation's responsibilities with regard to taking action on environmental sustainability, and for advocating for sustainable practices more broadly, should also be made explicit.

The organisation's responsibilities for evidence-generation and application are under-stated. PHS should have a key role in supporting/coordinating the evaluation of policies and practice, ensuring that policy and practice is informed by the best evidence from diverse

disciplines, and that innovations are also evaluated in terms of their impact on population health.

It will be essential that the functions are delivered in an integrated way, with attention to the relationships between them. The twin focus of supporting a shift to prevention and of acting to reduce health inequalities should be the golden threads than run through all of the functions.

We have a specific concern about the third section of Paragraph 4 in Chapter 5, in relation to its focus simply on alignment of resources. We believe that there is a need for PHS also to apply public health evidence and intelligence to advocate for the funding of services (within and beyond the NHS) in a way that enables effective prevention and population health improvement. How services are funded, how funding is allocated and how long it is allocated for are factors central to improving outcomes and responding to local needs.

There are some details of the functions proposed in Paragraph 4 that we would question (for example, PHS should not in our view seek to be the voice and champion for public health services); and we are surprised to see (in the second last dot point) the proposal that PHS should 'Identify elements of the public health system that may be better undertaken at a national level, such as coordination and employment of public health specialists', given that such decisions would appropriately be made in a much more inclusive way. However, we recognise that the principles mentioned earlier will, in their application, ensure a greater degree of stakeholder involvement than is implied here.

Question 9: (a) What are your views on the health protection functions to be delivered by Public Health Scotland? (b) What more could be done to strengthen the health protection functions?

(No response.)

Question 10: (a) Would new senior executive leadership roles be appropriate for the structure of Public Health Scotland and, (b) If so, what should they be?

We believe that this should be a decision for the incoming Chief Executive and Board.

Question 11: What other suggestions do you have for the organisational structure for Public Health Scotland to allow it to fulfil its functions as noted in chapter 5?

We believe that organisational structure should be a decision for the incoming Chief Executive and Board.

Question 12: What are your views on the proposed location for the staff and for the headquarters of Public Health Scotland?

We believe that the organisation should have a presence in different parts of Scotland, and should operate as much as possible as a location neutral organisation.

Question 13: Are the professional areas noted in the list above appropriate to allow the Board of Public Health Scotland to fulfil its functions?

We believe that knowledge/experience of specific sectors is less important in Board members than their generic skills and abilities. We strongly support diversity within the Board and the establishment of a shared vision and core values to underpin its work. We would advise against seeking to locate all aspirations for participation, advice and diversity within the Board, recognising that the organisation will be in a position to establish a range of approaches to fulfil its ambitions and needs in these regards. The core function of the Board is a governance one, and its membership should ensure that that is exemplary.

Question 14: (a) What are your views on the size and make-up of the Board? (b) How should this reflect the commitment to shared leadership and accountability to Scottish Ministers and COSLA?

(No response)

Question 15: What are your views on the arrangements for data science and innovation?

The report of the Commission on Leadership for Public Health Research, Innovation and Applied Evidence made detailed proposals concerning the ways in which PHS should support research and innovation, including the establishment of a Scottish 'hub of engagement' linked to other such hubs around the UK. This would help to establish a strategic partnership between PHS and its academic partners, and we would like to see such arrangements progressed early in the body's activities.

More generally, we are concerned by the individual, behavioural approach and tone of this section of the document. This is particularly the case with paragraph 1 of Chapter 9, which, despite one mention of structural determinants of population health, sets the tone for the rest of the section with references to (for example) individual decision-making being achieved by data that are 'personalised to [individuals'] lifestyles'. This is concerning for two, related, reasons: first, the clear evidence that such individual decision-making is influenced considerably by the wider social and economic context in which people live; second, that there is little or no evidence that the type of 'digital applications' to which the section later refers (e.g. 'smart and wearable devices' – paragraph 2) have any meaningful impact in terms of improving health and narrowing health inequalities. On the contrary, the evidence shows clearly that regulation**,** legislation, price, and other structural improvements (e.g. to the physical environment) are the interventions which are effective in this sense.

Related to the above, the section alludes to the adoption of a 'precision' public health approach. However, this has been criticised by epidemiologists recently as being the 'Emperor's new clothes' (Taylor-Robinson & Kee 2018[1]). At the very least, this is a highly debated, and debatable, topic, and it therefore seems an unhelpful approach for a new, national, public health organisation to take, at least until a consistent, and compelling, evidence base has been developed which supports its application.

[1] Taylor-Robinson D., Kee F. Precision public health—the Emperor's new clothes. International Journal of Epidemiology 2019; 48(1):1-6.

The section also refers to the need to 'identify the social, economic, environmental and behavioural determinants of health and well-being' as core to its data science innovation programme. However, these determinants are already well established and understood. We support the general ambition to make the most of Scotland's strengths in data science and innovation for the benefit of population health, but the approach presented in the document is ambiguous and terms such as 'innovation' and 'whole system' appear frequently, but without clear meaning. It will be important to develop a clear understanding of what innovation means in the context of public health, where the foundation is about the organised efforts of society not personalised medicine and the scope for innovation sits at least as strongly in arenas such as wellbeing economies, social enterprise, community leadership and environmentally sustainable practices as it does in data science. Linking innovation to data science is limiting.

Question 16: What are your views on the arrangements in support of the transition process?

We welcome the clarity provided about proposed timescales and support these.

Question 17: (a) What impact on equalities do you think the proposals outlined in this paper may have on different sectors of the population and the staff of Public Health Scotland? (b) If applicable, what mitigating action should be taken?

EQIAs should be carried out as a separate process (not as part of this consultation) and should be supported and promoted as a key tool for analysing the impact on equality groups and in developing mitigating actions. A focus on tackling inequalities in health for equality groups should be at the heart of the new public health system, and the data collected and used to formulate policy and programmes should represent the experience of equality groups. In this regard, qualitative and experiential data as well as quantitative data will be essential.

It will be important for PHS and the process of reform more generally to address the concentration of BAME in the West of Scotland, and also to apply Fairer Scotland assessments to its strategies and policies to ensure that its impact on reducing socio-economic inequalities is maximised. Once the organisation has completed its transition arrangements, and enters standard recruitment procedures, its recruitment strategy should reflect a strong commitment to representing Scotland's diversity at all levels of the organisation.

Question 18: What are your views regarding the impact that the proposals in this paper may have on the important contribution to be made by businesses and the third sector?

(No response.)