NoSPHN CPD Event 26 May 2010

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A Community Planning Perspective

Introduction

Working in partnership is always challenging, and perhaps at a time like this it's more challenging than ever, for a variety of reasons I'll touch on, but at the same time, perhaps the need for good partnership working is more important than ever, and as always, with challenge comes opportunity.

I intend to briefly outline what community planning is (or at least, my understanding and experience of it), talk a little about SOAs, sketch out some of the key challenges I think are around at the moment, and suggest some things we need to think about to help address them. I think I have more questions than answers, but Pip assures me that's OK, and I think the parallel sessions will give us a great opportunity to explore the issues together and, hopefully, all come away a little bit more informed, and a big bit more enthusiastic about turning these challenges into exciting opportunities to really make a difference to the health and wellbeing of our population and communities.

Community Planning & SOAs

So, what is community planning? Well, there is legislation setting out the purpose of it and the duties of public bodies including the NHS, but in reality, it's simply about working in partnership with other agencies and

community and voluntary groups to address the needs and priorities of our population and communities.

I think sometimes we get a bit hung up on structures, and whilst for scrutiny, performance management and governance purposes these are important, and when you want something done its important to know where the power lies and understand the mechanisms & structures you need to work within to achieve it, a simple rule of thumb is that if you're working with partners and communities, in effect that's community planning in action.

Since the Holyrood/Local Authority Concordat came into effect in 2008, the development and delivery of Single Outcome Agreements have become the key mechanism for establishing priorities and plans for Community Planning Partnerships.

As with anything, the theory & practice are often different, and I think there's a fair bit to go till we can confidently say that the 'theory' of SOAs is delivering in practice for us, but I honestly believe (I have been called an eternal optimist) that SOAs offer a fantastic mechanism and framework for efficient and effective partnership working to improve health & wellbeing.

A Single Outcome Agreement is meant to set out the key local priorities for improving the lot of the local authority area population, within the framework of 15 national priorities. These 15 national priorities were agreed with surprisingly little difficulty, a very promising sign that there is significant consensus about the big issues affecting Scotland. The cynical amongst us would say that that was the easy part and I guess they are right, but let's keep positive, for now at any rate!

SOAs are supposed to be the very high level reflection of the local priority outcomes sought, and underneath each local outcome there may be a huge range of workplans, activities and the like. At the beginning there was a huge clamour of ‘it’s got to be in the SOA’, and a number of national interest groups undertook analyses of all 32 SOAs, counting how often their interest was reflected and castigating local partnerships when it wasn’t.

I think that whilst in some instances there was a legitimate case to be made, to a large degree it missed the point and purpose of what an SOA was and is meant to represent. That misunderstanding was reflected within local partnerships too sometimes. But just think about it, if all partnership activities and achievements were to be reflected in the SOA, each would be a vast document, using whole forests of trees and creating an enormous industry of plan writing! It certainly has created its own set of jargon, with ‘above and below the waterline’ and ‘golden thread’ being amongst them, and I’m sure you’ll each have your own favourites or pet hates, but actually these are quite important concepts, though I don’t have time to address them here.

Current Context

That was a very quick introduction to Community Planning and to SOAs and I now want to move on to outline what I think are some of the important dimensions of the current context in which we’re working before going on to touch on some of the challenges and opportunities I think they bring to Public Health and to Planners.

The aspects of the current landscape I want to mention today are the focus on outcomes, the financial climate, and the widening inequalities gap.

Outcomes

So, outcomes. It's been very interesting to be part of the struggle to think about outcomes as opposed to outputs and inputs, and sometimes a bit puzzling – how did we get to the point that we often can't articulate the outcomes we're seeking to achieve? I think there's a whole critique to be made there, but that's not for this presentation.

What I have found hugely useful in helping people think about outcomes is logic modelling. I've now worked with a number of groups using this as a tool, and found it very useful to help people see the importance of thinking through what they want to achieve and how they might best get there. I know that logic modelling can be used for a wide variety of purposes and some of these will be explored in one of the parallel sessions, but what I've found it very useful for is to support the development of robust plans, evidence based where possible, and the related performance frameworks for these. Using a model like this to challenge thinking about what inputs might lead to what outputs and whether or not these are likely to contribute to the sought-for outcome, and how you'll measure this seems to help people who've previously struggled with these concepts. The fact that these models also deliver a performance framework has been very valuable.

One of the problems with the current state of play around SOAs is that the speed with which they've had to be developed has led to all sorts of inappropriate indicators to be used and logic modelling can help address this. But this has highlighted for me the huge gap we have in terms of

useful data and intelligence and in our evidence base, and I think there's an enormous, and enormously useful job for public health skills in leading and supporting the further development of these.

One of the traps I think we've fallen into is thinking that we need agency specific indicators at the high level, not helped by an Auditor General's report that said we needed to evidence specific agency contributions in partnership working. I think we can address this through robust logic modelling where we can measure agency contribution at the output or service delivery level and use more appropriate indicators of outcomes which may or may not be agency specific – after all, the idea is that we're dealing with the real 'knotty' problems of our society and the ultimate measures of change need to reflect this.

The question this work has also raised in my mind is about the balance between excellent and thorough, and good enough. Annie talked about the penalties of an approach that was too quick and dirty, but I wonder if the opposite is also a problem sometimes.

My own view that that a lot of what we have is not good enough, especially in terms of data collection and evidence, but I also wonder sometimes, especially in relation to processes and tools and models, if we don't put too much of our energy into developing our idea of the 'perfect', and in doing so, fail to make the difference that we could at this point in time, whilst continuing to search for that illusive ideal tool or process of course. I'm not suggesting we should restrict ourselves to good enough but just that we avoid missing opportunities whilst taking too academic an approach. In the absence of robust evidence we sometimes have to make a leap of faith and I've found logic modelling a helpful tool to strike that balance and reach a consensus.

The risk we run is that we use inappropriate indicators and therefore set targets that create perverse incentives, and I think there's a big role for public health in helping us strike the right balance at any one point in time, whilst continuing to work on refining and improving the tools, data and evidence base that will make for better planning and better outcomes.

Financial climate

The second element I want to consider is the current financial climate. If we thought partnership working was difficult in times of relative plenty, we ain't seen nothing yet I suspect!

I think we need health economics now more than ever, and I guess the question of quick and dirty versus ideal applies here too. Are we skilled and experienced in using the concepts and tools to apply to the partnership issues we face? What about the robust economic arguments for working upstream and avoiding longer term costs – perhaps there's an opportunity here as we are starting to realise how long and deep this climate of financial restraint will be.

We need to be making the arguments about the potential cost to health and to health services of some of the savings decisions our partners are considering, and similarly we need to be thinking about the impact our plans might have on the services delivered by partners. Do we know the pressing issues for our partners well enough to know what trade-offs we could offer? That's one benefit of the SOA – it gives us an opportunity to look across all our plans and perhaps identify these trade offs. 'Don't cut home care as it'll impact on admissions and on waiting times and delayed discharge and we'll do more of this, or we won't do something we might otherwise do', for example.

We've not quite had the Glasgow experience of an implosion in partnership working, though some might feel we've had our close shaves, but are we doing enough to avoid that as a possibility?

The voluntary sector are rightly hugely worried about what the economic climate will mean for them – do we know enough about what they deliver, what it costs and what benefits it brings, and how that understanding might be applied to decisions about where we invest, and in what? Can we support things like developing social enterprise more than we do? Would this be a worthwhile avenue to explore further?

Can we articulate these issues to the public? Can we involve them in our work on this – do we use community groups as well as we could in terms of the huge intelligence they can add to our work on impacts or do we sometimes rush too quickly to dismiss their fears and their criticisms of us?

What impact will the Patient's Rights Bill and the potential for elections to NHS Boards mean for Community Planning? Very interesting questions – these are future developments that we could perhaps use to support better population health but how do we prepare for this?

What can we contribute to promoting the notion of the best use of the public pound as opposed to the best use of the NHS pound, or the council pound or whatever?

Can we find ways to influence the private sector operating in our local areas?

It does highlight the truth about the importance of building relationships I think –if we don't have the trust of partners and stakeholders that we've built and nurtured over the good years, can we do so in the bad? We

certainly have to try or we've no chance of mitigating the worst impact of the current economic climate.

It also raises questions for me about the extent to which we've built the capacity of our partners and the public to think in a public health way.

From a very practical perspective, Public Health can't be involved in every Community Planning Group, or even in all of them we think most important. The particular skills of health intelligence, assessing evidence and health economics are rare and in much demand. I think we need to consider how we work this. Do you want to be commissioned to do specific pieces of work? How can we plan for this? How do partners know what skills are on offer, and as someone said earlier, how do we help them recognise they'd benefit from these skills in the first place? If we put these skills on offer and are taken up on that, can we deliver? How do you decide what's most important when it doesn't come in a neat way at the beginning of the year and you can plan for it? How do you decide between urgent health service redesign work and longer term partnership work with less clear outcomes that are almost certainly further down the line?

Do you restrict yourselves to the areas of work where the skills that really only reside in public health are done by public health? Do the rest of us have more generic skills that can be used when the really specialist skills are not needed? Can you help skill us up? Which items in Sarah's toolkit can be found elsewhere in our agency and in our partnerships and how can we work together to utilise these?

Inequalities

But to move on quickly – for me, all of these questions about working within the current economic climate are about preventing even further inequalities and, as far as we able, about reducing them.

The 15 national outcomes include one specifically about reducing the significant inequalities in society. That's great but we also need to consider where and how we can build in an equalities/inequalities perspective throughout all the others. So when aiming for the reducing carbon emissions outcome, or the developing a competitive economy one for example, can we equalities-proof our approach to these?

Even within our work specifically geared to achieving the reducing inequalities outcome, I think we need to be more sophisticated in our thinking about how we tackle this. In NHSH we're in the midst of preparing our next gender equality scheme at present and working towards our first Single Equality Scheme. I think we have a huge amount to do in the NHS to think in a more integrated way about socio-economic and other inequalities. For example there's a lot of evidence about the differential impacts on men and women of health and other services that I think we sometimes forget about, or fail to address properly when designing services or developing health improvement initiatives. I've been struck by the number of times I've heard that we don't need to think about the equalities agenda or equalities risks in a particular initiative because it's designed to target deprived communities or individuals. What about the health gradient within these communities and what we know of the different issues facing BME groups or disabled people within these populations for example? The requirement now to identify equalities risks to achieving our HEAT targets gives us a big push towards this. Indeed we've had a message from Scottish Government that we should be reflecting an equalities/inequalities

perspective in addressing all of our HEAT targets – I don't think they've been particularly explicit about this in the past so I'm personally very pleased to be given this message, even though it will make some of these targets even more challenging for us.

The new Equalities legislation, if enacted in full by the new Westminster Government, will bring a duty to consider socio-economic circumstances when developing strategies and setting priorities. This is a huge opportunity. In NHS Highland we already consider this in our EQIAs and we have, fairly crudely but usefully, integrated health impact assessment with equality impact assessment. Our partners in the public sector have a legal duty to do EQIAs – what can we do to help them integrate thinking about health impact in these? We need to undertake equality impact assessment of proposed savings, as do our partners – are we taking full advantage of this to support consideration of the health impact of savings?

Finish

This has been a very quick look at some of the challenges and opportunities I think are around in partnership working in the current climate and I look forward to hearing ideas throughout the rest of today on how we can work together to address them for the benefits of our communities.

Thank you