Title of consultation
Public Health Research – co-ordinating academic public health and achieving greater integration with the new public health body

Increasing the relevance, generation, use and impact of population health improvement research in Scotland - thoughts from Professor Laurence Moore, Director MRC/CSO Social and Public Health Sciences Unit, University of Glasgow (personal reflections)

Name of the consulting body
Public Health Reform, Scottish Government

Link to consultation
N/A

Why did the MRC/CSO Social and Public Health Sciences Unit contribute to this consultation?
Professor Marion Bain, Co-Director of the Executive Delivery Group for Public Health Reform invited Laurence Moore to submit a ‘think-piece’ on co-ordinating academic public health and achieving greater integration with the new public health body. This was one of a number of ‘think-pieces’ solicited by the Executive Delivery Group in the early stages of their work.

Our consultation response
A. Scope:
1. This ‘think piece’ focusses specifically on two of the recommendations included in the 2015 Review of Public Health in Scotland, reproduced in the box below:

   To build on these strengths, the following recommendations are made.
   148. **Action should be taken to achieve greater coordination of academic public health in Scotland**, building on successful models of collaboration in other fields, to develop a more strategic collaborative mechanism for public health research in support of the national strategy.

   149. **Priority should be placed on ensuring that public health policy and practice is more strongly underpinned by research and evidence – and that the research and intelligence functions in public health are focussed on being policy and practice-relevant.** This will require culture changes within policy, delivery and research organisations, as well as collaborative action to build the evidence base, incorporate a range of types of evidence, and to demonstrate the effectiveness and value for money of public health approaches.

2. Population health is substantially driven by the wider social and environmental determinants of health. Action to protect and improve population health requires a focus
on the distribution of health and its determinants and to focus on health inequality. Thus, in line with much of what is proposed in the Public Health Review Report, the scope of what is included in any consideration of ‘public health research’ and ‘academic public health’ must be broad, and include a wide variety of research, evidence and stakeholders from the full range of sectors, organisations and disciplines that can influence the improvement of population health and wellbeing.

3. Although it is most obvious in the case of health improvement, each of the three domains of public health are increasingly interdependent with factors outside the health service sector and thus a fit for purpose population health system cannot be designed principally around the traditional organisations and professions concerned with the delivery of the public health function. The corollary is that population health research and intelligence needs to broaden its horizons from the methods, disciplines and organisations traditionally engaged in public health research and, most notably, to increasingly focus on interdisciplinary applied population health improvement research.

4. The translation and use of evidence and data is crucial at local level, and much of the most promising innovation in practice also occurs at that scale. However, the co-ordination and integration of public health research needs principally to be considered at national and regional level and is the focus of this document. Notwithstanding this, access to, engagement with and the valuing of evidence, research and data by all members of the broader population health system is a critical element of any system that we should aspire to.

Assumptions

5. As highlighted in the report, the extent to which there is a co-ordinated integration of academic public health in national and regional public health policy development and practice is limited. There are multiple specific examples of projects which have benefitted from collaborative working between academic researchers and public health decision makers and professionals. These arise in a variety of ways and often depend on the existence of serendipitous relationships. There is a major risk that any individual project in the current system may fail to be taken forward optimally due to a lack of awareness of the availability of key skills, knowledge and resources that may be available in the system; awareness and connections are limited due to a lack of structure, process, time and incentives to facilitate greater interaction.

Examples of suboptimal practice (and waste) that arise from a poorly connected public health knowledge system:

Policy delayed or suboptimal due to lack of access to key evidence or theory in development process; research evidence peripheral to decision making.

New policy or innovation in practice not evaluated; ineffective interventions continue and future development are based on inertia and anecdote rather than evidence.

Academic research disengaged from evidence users’ needs. Development and delivery of more relevant research undermined by limits to what is possible within an academic environment (push towards small scale behavioural interventions); evidence base not matched to evidence users’ needs.
Decision makers have insufficient access, use and trust of formal sources of best knowledge that could help with decision making and an absence of social or professional networks to provide informal sources of relevant knowledge.

6. Of the three domains of public health practice, where this lack of integration is probably most evident in health improvement. In the two other domains, there appears (to my eye) to be greater interconnection, perhaps facilitated by the increased concentration of these domains (health protection and improving services (FPH)) in health service organisations and clinical professions. This impression may not be correct; I am sure that there are issues in these domains. For the rest of this paper, I will concentrate on health improvement, which is where I have the greatest knowledge; some of the points made and potential ways forward suggested, may also be relevant and appropriate across all three domains.

Frameworks

7. An important model or framework that underpins this paper is the Knowledge Exchange Cycle, represented in the diagram below. This cycle is key to driving improved performance throughout the system, including the research and academic sector, but most importantly in improving policy and practice. If there are barriers, for example disconnections or misunderstandings that interrupt the flow between each of the four key stages of the cycle, then there will be suboptimal performance, leading to the scenarios listed in paragraph 5. The concern is that practice and policy is disconnected from evidence generation and research. National and regional decision makers are distant from research commissioning and conduct; both in terms of policy and practice decision making and needs-related innovation. Researchers are driven by traditional disciplinary and academic incentives, processes and structures, where relevant, applied, translational research is challenging and unambitious.
8. **Knowledge into Action** is making some progress in improving Synthesis and Translation, but does not directly address the whole knowledge exchange cycle. A well-functioning health improvement system would support an uninterrupted and smooth knowledge exchange cycle, with collaboration and partnership between all key stakeholders working together through all 4 stages of the cycle. The involvement of other key stakeholders, notably the public, is also key to drive forward the research agenda and maximise engagement and understanding of public health policy and its importance.

9. A key stage that is not well served at the moment is evidence gaps / research questions. **Evaluability Assessment** is an important tool here. If decision makers worked jointly with researchers in conducting evaluability assessments around key areas of innovation and policy need, then this would be a key step in identifying where evidence is already strong; where further research is needed; or where new interventions or policies could proceed on an experimental or pilot basis.

10. **Transdisciplinary Science** approaches emphasize innovation in order to generate and translate scientific evidence that can be practically applied to address societal problems (Stokols et al., 2013). Such innovation requires sustained collaboration between multiple academic disciplines, practitioners, policy-makers and the public, whose diversity of knowledge, experience and perspectives maximise the potential for scientific and translational innovation and impact (Stokols et al., 2013). Transdisciplinary action research (TDAR) cycles are a process for cultivating and sustaining such collaborations in order to achieve shared goals by linking three types of collaboration: (1) TD scientific collaboration; (2) collaborations among researchers and community practitioners; (3) inter-sectoral partnerships for designing and implementing public policies (Stokols, 2006; Stokols et al., 2013).

Towards a solution

11. What is currently lacking is any organisational entity with the responsibility, authority, structure or processes to maximise communication and collaboration between key stakeholders and facilitate a smooth and holistic knowledge exchange cycle in health improvement or public health more widely. What might this look like?

12. It would need to have some capacity and not simply be a virtual set of processes and ambitions. It could be a **Network** provided there was a critical mass of staff capacity to maintain its profile and processes; more of a **Hub** with a physical and organisational base. A larger scale version would be for key affiliated organisations to fund or second staff to be placed (physically or virtually) with the hub, to maximise its external presence, the intensity of internal connectivity and the capacity and flexibility to be responsive to and deliver on new projects. This could be more of an **Institute** model.

13. A key consideration is the principal function. I think this would be to facilitate transdisciplinary collaborative teams working on projects at all stages of the knowledge exchange cycle. As the organisation matured, it may aim for these teams to work throughout all stages of the cycle, but in the short term it would be more feasible to view these as limited life task and finish groups.

14. From the academic perspective, I think it is important that the organisation is not based in any one University. This would be important in maximising engagement from all research organisations with the key function and processes of the organisation. Many of the projects promulgated by the organisation may be research or evaluation projects where the lead organisation may be a research organisation, and the project team ideally being...
both transdisciplinary and multi-institutional.

15. Similarly, it would need to be independent from Government. It could potentially be hosted by the new Scottish Public Health organisation, or be a separate entity.

16. There would need to be strong governance in which all key stakeholders had representation. The principal function of the organisation would be delivered by setting up transparent processes through which it would:
   a. consider whether or not to adopt requests from stakeholders to take on specific projects,
   b. identify organisations and individuals to be invited to join the project team
   c. identify resources available to the organisation to facilitate delivery of the project by the team.

17. The organisation would need to promote itself and have a significant presence, visible to key contacts throughout key partner organisations.

References

When was the response submitted?
18th February 2018

Find out more about our research in this area
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