
PUBLIC HEALTH REVIEW: NHS BORDERS AND SCOTTISH BORDERS COUNCIL ENGAGEMENT PROCESS RESPONSE

Report by Joint Director of Public Health

Community Planning Joint Delivery Team

2 APRIL 2015

1 PURPOSE AND

- 1.1 **The aim of this paper is to appraise the Committee of the final response of NHS Borders and Scottish Borders Council to the National Review of Public Health in Scotland. The final draft response is in Appendix 1.**

2 RECOMMENDATIONS

- 2.1 **I recommend that the Committee approve the NHS Board and Scottish Borders Council Engagement Process Response to the national review of Public Health in Scotland.**

3 SUMMARY OF RESPONSE

- 3.1 The response highlights examples of partnership success in improving public health in the Borders including:
- Partnership work in the Community Planning Partnership, Alcohol and Drugs Partnership, also Community Safety Partnership.
 - An integrated health intelligence function across NHS Borders and Scottish Borders Council.
 - Established, effective Public Health programmes founded on health needs assessment:
 - Health Protection i.e. communicable disease control, environmental health,
 - Service improvement
 - Health Improvement e.g. Healthy Weight, Tobacco Strategy, Healthy Living Network
 - The recognition that having a joint DPH post in the Borders has greatly increased the visibility and penetration of Public Health issues into local authority and across the Community Planning Partnership. This post is able to link Public Health concerns across settings and departments and also act as broker for both knowledge and evidence and a support in developing practice.

- Local Public Health Specialists situated within and an integrated Public Health function to ensure that key public health services are aligned with the distinctive local Borders population needs and priorities.
- 3.2 However there may also be potential risks to the local public health function resulting from the Public Health Review. Some responses to the Review may highlight that there is some variation in resources, numbers, skill-mix, roles, services, policies amongst territorial boards. It could be suggested that diversity of local practice in meeting local public health needs can lead to differences in quality and standards of delivery and these views may lead to pressure to relocate public health resources to regional or national structures.
- 3.3 The attached Borders response highlights that even though Borders has a relatively small public health department compared to larger boards, resilience can be maintained and improved through greater vertical integration, e.g. networks between board Public Health Departments at regional or national level, and/or horizontally across Public Health domains (health improvement; health protection; service development; health intelligence) within the local Department as currently happens. The same applies to training, career development and succession planning, with horizontal integration being particularly important for training.
- 3.4 The attached Borders response also raises concerns that large scale organisational reform has the potential to break up the infrastructure of delivery and distract from the key aims of improving health and reducing inequalities. More centralised services may also jeopardise local connections with communities and other local services. Public Health works across the whole system so fragmentation of the specialist workforce, or fragmentation across different organisations could be very damaging to the ability of Public Health to deliver effectively.

4 BACKGROUND

- 4.1 A national ministerial review of Scottish Public Health was announced in November 2014 and an expert group established to report back to Scottish Government in 2015. The aim is to consider how to widen and deepen the influence of Public Health, both as a public service function and an important outcome in the specific context of tackling health and social inequalities and increasing healthy life expectancy in Scotland in a sustainable way. The review sits within the context of the Integration of Health and Social Care, the development of Community Planning and the Community Empowerment Bill and persistent, refractory health inequalities and recognises that responsibilities for addressing public health issues sit not only within the health sector but also in local and national government, the community and voluntary sector, and the private sector. The Review also recognises that the public health function, with its strong focus on prevention, equity and quality, is integral to health service values and aims in Scotland, and to public services reform.
- 4.2 It should also be noted that Public Health has been included within the 'Shaping of Future of Shared Services Programme (SSP)' for the Guiding Coalition. This Coalition comprises Board Chairs and Chief Executives and was established to consider the key strategic challenges facing health in Scotland. National Services Scotland staff are supporting the SSP and have stated that they will ensure that the work of Public Health Review Group

and the SSP is coherent, collaborative and completed to a jointly agreed timescale.

- 4.3 The Review Group asked key stakeholders, locally and nationally, to respond to a number of questions to help inform the considerations of the Group. The Joint Director of Public Health (DPH) took a lead in producing a corporate response to the engagement questions both for NHS Borders and Scottish Borders Council. This local engagement process was agreed by the Board and the Scottish Borders Council. A final draft response, pending approval by NHS Borders and Scottish Borders Council, was submitted by the deadline of 12 March 2015.
- 4.4 A number of national engagement events are due to be held during March and April to further discuss the responses received by the Review Group.

5 IMPLICATIONS

5.1 Financial

There are no costs attached to any of the recommendations contained in this report.

5.2 Risk and Mitigations

- (a) The review may result in changes in the delivery of the local public health function some of which may be helpful to improving health and tackling inequalities more effectively. Other changes may however have a detrimental impact on improving health and tackling inequalities unless these are carefully considered and delivered.

5.3 Equalities

- (a) At this stage no adverse equality implications anticipated in response to the recommendation contained in this report.

5.4 Acting Sustainably

There are no economic, social or environmental effects as a result of this report and its recommendations.

5.5 Carbon Management

No effects on carbon emissions are expected.

5.7 Changes to Scheme of Administration or Scheme of Delegation

There are no changes to be made to the Scheme of Administration or the Scheme of Delegation.

6 CONSULTATION

- 6.1 The Chief Financial Officer, the Monitoring Officer, the Chief Legal Officer, the Service Director Strategy and Policy, the Chief Officer Audit and Risk, the Chief Officer HR and the Clerk to the Council are being consulted and any comments received will be incorporated into the report.

Approved by

Name: Dr Eric Baijal

Signature

Title: Joint Director of Public Health

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Background Papers: Nil

Previous Minute Reference:

Note – You can get this document on tape, in Braille, large print and various computer formats by contacting the address below. Sheila Patterson can also give information on other language translations as well as providing additional copies.

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1. How can public health in Scotland best contribute to the challenges discussed? Specifically, what is your view and evidence of the Strengths, Weaknesses,

**NHS BORDERS
&
SCOTTISH BORDERS COUNCIL**

**Final Draft Response
to Public Health Review
Engagement Paper**

FINAL DRAFT

March 2015

Opportunities and Threats (SWOT) to the contribution of the public health function in improving Scotland's health and reducing inequalities?

We consider the current context of Public Health Practice to be:

- Community Planning – in the light of recent work by Audit Scotland
- Health and Social Care integration – because of its potential as a route to addressing inequalities
- The Community Empowerment Bill because of its potential as a significant and strong underpinning for co-production.

In terms of health and wellbeing, inequalities are the key challenge for Scotland, and the public health function should align with this prime focus in the national interest.

The discipline would benefit from national strategy which would enable clarity of the outcomes expected by key stakeholders, importantly the wider public as well as based on an informed position.

Our view of Strengths, Weaknesses, Opportunities and Threats to the contribution of the public health function in improving Scotland's health and reducing inequalities is as follows:

Strengths

National

Historical legacy of the Medical Officers of Health

Direct local leadership through Directors of Public Health

Strong National Public Health Policy

Supported by National Infrastructure

Robust infrastructure – collaborative work – ScotPHN umbrella and other networks (see p8)

Health Scotland – emerging strength in supporting tackling health inequalities

Catalyse change

Local

Versed in partnership working - examples of partnership success at local level include work in the Community Planning Partnership, Alcohol and Drugs Partnership, also Community Safety Partnership

Intelligence from information, including the application of health economics

In the Borders, an integrated function across two organisations

Established, effective Public Health programmes founded on health needs assessment –

- Health Protection ie communicable disease control, environmental health,
- Health service improvement and
- Health Improvement eg Healthy Weight, Tobacco Strategy, Healthy Living Network

Weakness

National

- Public health role of primary care contractors poorly defined and may make links between Integrated Health and Social Care Partnerships and primary care more difficult.
- Lack of strong Public Health leadership across Scottish Government directorates
- Lack of policy impact – long term outcomes

Local

- Small resource raising resilience issues.

Opportunities

National

- Strategic alignment of the specialist resource across Scotland
- Registration, accreditation - under active development for non-medical specialists and practitioners
- New CMO
- Integrate public health more firmly into Scottish GP contract to ensure effective partnership working with Integrated Health and Social Care Partnerships.
- Policy implementation
- Advantages of National Public Health Services for some topic areas
- Standardised quality of practice
- Improve resilience
- Workforce planning, development, career progression, succession planning
- Joint posts and teams between local authority and NHS
- Recognition of Public Health initiatives with local authorities and other partners
- Health Protection - the profile of Health Protection has increased significantly in recent years with issues such as immunisation, food borne infections, pandemic flu, ebola, healthcare associated infection and communicable diseases regularly being in the public eye. Health Protection services can have a major impact on health inequalities e.g. universal immunisation; promotion of healthy environments; targeting of specific vulnerable groups e.g. persons who inject drugs and other forms of substance misuse; controlling TB amongst new entrants. As a result a Health Protection services in Scotland have recently been reviewed by a Stocktake Working Group established by the Scottish Government in 2010 and a National Planning Forum (NPF) subgroup in late 2012. The recommendations from these reviews are currently being implemented by Scottish Government, the new health protection governance group (Health Protection Oversight Group), Health Protection Scotland, the Health Protection Network (made of new and existing topic or functional groups) and Board Health Protection Teams.

Local

- Better connectedness between specialists, practitioners and other professions who would not normally think of public health as being a core part of their role.
- Wider partnership working including Health and Social Care Integration Partnerships, Community Planning Partnership, Third Sector
- A focus on partnership and flexibilities in use of resources and working across organisational boundaries and with whole system programmes, but

preserving the strengths of a coherent public health function in local specialist teams working across the public health domains.

- Public Health can bridge the gap between services and population health

Threats

National

- Policy may negatively impact on health and wellbeing eg benefit reform
- Global interests e.g. trade and financial agreements, may overwhelm local Public Health action
- More centralised service might jeopardise local connections with communities and other local services.
- Fragmentation – Public Health works across the whole system so fragmentation of the specialist workforce, or across different organisations likely to impact negatively Unrealistic, short term expectations of change for some public health outcomes – particularly those that will need change over a life cycle or generations, recognising that short-term actions are often helpfully used as the basis for measuring effectiveness, and public health tools such as logic modelling help show the links from shorter term goals, actions and impacts to longer term outcomes.
- Complexity of influences that promote or damage health means it is hard to attribute causation.
- Many Public Health activities are not recognised as such.

Local

- Risk that national structural reform necessary to deliver appropriate transformation negatively impacts locally on areas of Public Health Practice that are currently successful

2. How can public health leadership in Scotland be developed to deliver maximum impact?

In responding to this question we need to consider the nature of the leadership and the impact desired at different population levels. Those levels are variously defined – national, regional, local, locality, community and so on. An intersectoral collaboration needs to involve specialist professionals at local and national level including academics. Leaders must be visible at both Scottish Government and local levels. Leadership needs to be able to give direction. To give that direction, impact or desired outcomes need to be co-produced by public health specialists and key stakeholders including the public. Different stakeholders have different expectations. These need to be prioritised. There has not been sufficient clarification of this. There needs to be more effective collaborative leadership. This depends on greater cohesion and collaboration. It should not be dissipated across a wide range of individuals but embodied particularly in specialist professional leaders such as the Directors of Public Health (DsPH) who have a unique combination of a wide range of competencies. This helps equip them for the DPH role as leader within local organisations. They provide the independent and objective voice of public health, specifically of the DPH and the tools available to them such as the Public Health Annual Report. Such leadership could channel more energy into advocacy exploiting social media far more. Different forms of media have different users or readers with particular political demographics which might well be sympathetic or unsympathetic to particular public health issues and

so need to be targeted appropriately. A prerequisite for such leadership is consistent training across Scotland.

Public Health leadership nationally has benefited from a strong focus from Scottish Government and CMO. Locally, having a joint DPH post in the Borders has greatly increased the visibility and penetration of Public Health issues into local authority and across the Community Planning Partnership. It has also is of added value in contributing to national debates. This post is able to link Public Health concerns across settings and departments and also act as broker for both knowledge and evidence and a support in developing practice. We would recommend a similar model be adopted elsewhere. These issues are developed in more detail below (response to Q3).

We recognise the need for leadership actions across all four functions of Public Health, including health improvement. There is considerable added value from the integrating of Health Improvement within the rest of the specialist Public Health function. It maintains the profile of this important area of work in local planning and service development.

Locally, the joint DPH and Public Health team have ensured that the cross cutting nature of Public Health is understood and responded to. Improving population health requires the active engagement of partners across sectors nationally as well as locally and there is need to reinforce Public Health leadership in influencing and supporting this. Strong and focused leadership is needed to build the active engagement and commitment to make an impact on the wider determinants of health. It is encouraging that the crosscutting relevance of Public Health is increasingly clearly articulated in other policy areas both in the NHS (for example, Patient Safety, Healthcare Improvement) and more widely (for example in Education). However, this needs to be translated more consistently into implementation on the ground and supported to maintain momentum.

Public Health leadership is not role specific and needs to be adopted across various levels and areas, for example through Children's Services, Community Planning Partnerships and Health and Social Care Partnerships. Public Health must be able to influence planning in these areas.

It may be possible also to develop the visibility of the Faculty of Public Health in Scotland.

Use of the different roles of the DPH or equivalent post

The different roles of the Director of Public Health have been adumbrated as:

- The expert
- The critical friend
- The adviser
- The provider
- The catalyst

The focus of this model is maximising the benefits of partnership working. The DPH will use this role to develop trust and a shared understanding across two very different organisational cultures. Technical expertise is still required about the balance of time will be weighted towards networking activities. The models are not

mutually exclusive but one might be more appropriately dominant in particular joint appointment.

Collaborative leadership for health – the role of the Joint DPH

Tackling health inequalities is not the preserve of anyone organisation acting in isolation. Therefore collaborative leadership is essential. The wider public health workforce within partnerships requires strategic leadership for health to continue to develop and sustain their public health roles. This needs to be in place and understood by all. There is a danger in thinking that the appointment of a professional lead in the form of the DPH removes the need for other strategic leaders to give health their attention. Quite the reverse is true. Joint DPH posts are one way of collaborating and these are discussed in more detail below.

Joint Director of Public Health Posts

*Added value:*¹

Check and Counterbalance

A joint DPH post between the local authority and NHS is a check and counterbalance against short-termism and prioritisation of acute services compromising the longer term agenda of health improvement and protection of health and prevention ill health, viewing the latter as an option rather than a duty. In fact it is a legal obligation for both local authority and NHS.

Mechanism for collaborative leadership

Joint posts are a practical mechanism to contribute to collaborative leadership, and while they will add value they are not necessarily appropriate for every area. It has been argued that joint appointments form merely a step towards eventual merger as an endpoint.

Joint Directors and teams between NHS and local authority are important in strengthen and supporting partnerships to tackle the challenges and add greater value. Local government has a long history of involvement in the public health agenda. The Annual Reports of the Medical Officers of Health are amongst the evidence of the success of this work, including improvements in sanitation, occupational health and infant and maternal health. The added value of having a joint DPH post as opposed to one within the NHS is that local authorities have a greater influence over the key determinants of health. Local authorities provide services that obviously link to taking forward the public health agenda include social welfare, housing, regulatory services including environmental health, planning and economic development.²

Arguably, the local authority has many more opportunities to influence decisions and improve health in view of its powers and responsibilities to create conditions and opportunities that support health and wellbeing in these arenas, giving a *greater scope for professional practice*. It might be argued that local government is the natural leader for public health

More effective professional practice

¹ <http://www.adph.org.uk/wp-content/uploads/2013/08/Perspectives.pdf>

² http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/improving-the-publics-health-kingsfund-dec13.pdf

Local authorities have a much broader concept of health, orientated to promoting well-being. A greater closeness to elected members makes it quicker and easier to inform and appraise them - so providing the basis for informed decision-making.

A jointly employed DPH has the opportunity to be a credible commentator and advocate on a wider range of social issues, all of which have a huge public health dimension. In many of the most disadvantaged areas, addressing social and economic regeneration are important elements of addressing health and reducing health inequalities. On the other hand NHS posts continue to have a clear responsibility to tackle aspects of inequalities. A joint post enables a more comprehensive overview of the health and well-being of the population that is the responsibility of the director as often evidenced by comprehensive strategic assessment which would be much more limited if done by professional placement in the NHS.

Experience locally and in England³ has shown that joint posts and joint function with local government strengthens and supports partnerships. However this makes for a huge job in terms of scope with the accompanying expectations of delivery.

An effective joint DPH working in the right local environment can add value and help health through faster and more effectively than would otherwise be the case. It helps speed information flow between organisations to help interpret one to the other. It is easier to align objectives, targets measures, timetables and managerial process. A joint appointment permits faster and deeper collaboration. While this may happen without a joint appointment they happen more effectively and efficiently with one. Experience locally indicates that a joint appointment facilitates effective deployment of public health expertise within both the NHS and the local authority. For example under a joint director, the Health Improvement function is able to have greater reach and engagement with core local authority services than would otherwise be the case. The joint director is able to facilitate access to and foster working relationships with other departments towards agreed outcomes.

A DPH has expertise in harnessing, handling and communicating health information. Combining this with the considerable capacity and capability of local authorities to describe the local area and produce evidence-based strategies and action plans (for public, professionals and politicians) with similar resources within the NHS adds enormous value.

A jointly appointed DPH has the opportunity to influence national policy through the local government route as well as the NHS route which should contribute to more informed policy-making and therefore strategic approach.

So a joint DPH appointment gives more effective efficient process as well as improved outcomes

Development of the Public Health Role of Local Authorities.

Development of public health role of local authority - use of DPH Annual Report as a corporate performance management tool. There is added value – closer collaboration, better understanding of different cultures and approaches in

³ Redgrave P (2007) in *New Perspectives in Public Health* Oxford: Radcliffe Publishing

relationships one organisation providing the resources that others do not e.g. health intelligence commissioning locality engagements and connection.

Local Evidence of Success

Locally, the post of Joint DPH managing a Joint Health Improvement Team with other specialist areas within public health in both the NHS and the local authority effectively works as a joint directorate. This has provided collaborative leadership to transform information into intelligence, identifying public health priorities and gaining resource commitment to these. This necessitated oversight and governance of local public health action. The post has been a, if not the, key enabler of significant impact.

For a joint director of public health to function effectively they require to be supported by resource for basic epidemiology, needs assessment and commissioning. Such a post can add value by bring together resources in both organisations, maximising their capacity and competence.

Local successes

include

Political mandate – for an inequalities strategy

Endorsement by Full Council of national government's plan for alcohol minimum pricing.

Support for local bye-laws on drinking in public places

Elected members modelling healthy behaviours

Joint Health Protection Plan

Joint Tobacco control plan – work in progress including smoking prevention and cessation

Suicide Prevention Work

Healthy Weight Programmes through schools and sports and leisure trust.

Healthy Living Network to improve health and well-being in disadvantaged communities – close collaboration with range of local authority community services, the third sector and other local community groups

Development of “Resilient Communities” through the Council's Emergency Planning Function

Close involvement with community enterprise companies.

Range of innovative health improvement workstreams in early years across services and sectors, including nutrition and breast feeding, , income maximisation.

3. How do we strengthen and support partnerships to tackle the challenges and add greater value. How do we support the wider public health workforce within those partnerships to continue to develop and sustain their public health roles?

Public health is collaborative so partnership working must be one of the core competencies of both professionals and organisations involved. In this context and that of positive local experience, we recommend adoption of an integrated model of the local Public Health function across NHS and local authority.

There is an ignorance and lack of recognition of the significant role local authority colleagues have in addressing the Public Health agenda. These include staff in intelligence and policy, those working to address the need so children and young people such as those in education, culture, leisure and sport, those involved in economic regeneration, whole town planning as well as the more commonly recognised partners such as those in Environmental Health. Locally, Scottish Borders Council has a history of a culture attune to promoting health and well-

being.⁴ This is agenda which has been advocated by the Directors of Social Work and Education.⁵

There is a real challenge around engaging clinical colleagues in particular. NHS colleagues are under-represented in multi-agency training and development. National perspectives on implementing the HPHS CEL reflect our local experience. DPHs have a key role – supported by NHS Chief Executives – in providing this in-house and wider influence within clinical leadership.

Public Health can learn from third sector partners who have long experience of engagement with 'targeted' group, for example CHEX and VHS and it would be important to encourage more cross sectoral dialogue within the extended Public Health community. Public Health Protection Services also work closely with third sector partners who have long experience of engagement with 'at risk' groups, for example in needles exchange or sexual health services. It is important to encourage more cross sectoral dialogue within the health protection community particularly around pathways of care and joint training initiatives.

It is not clear to us that the Public Health visions of the 'wider public health workforce' is one that necessarily resonates with that workforce itself. We recognise the work done at a strategic level to make those connections e.g. via Health Scotland and COSLA have done work such as the inequalities brief for non-exec NHS directors. However, we feel there is a need to further develop this consciousness at strategic levels nationally and locally. For example, there may be potential to improve links between the ADsPH and colleagues in Education at national level, police, local authorities and COSLA.

4. What would help to maintain a core/specialist public health resource that works effectively is well co-ordinated and resilient?

Public Health requires specialist knowledge and skills, which are constantly changing. A good quality public health service demands a 'fit for purpose' workforce educated and trained to the highest standards. These standards are informed at UK and European levels and public health workforce developments in Scotland must take cognisance of these frameworks. The UK Public Health Skills and Career Framework will be useful to support people into the specialty from the wider workforce. It will give a clear indication of the unique complement of knowledge, experience and skills required to be developed. The Faculty of Public Health also has an important role in setting health protection training standards and competence frameworks.

The national support for developing health intelligence and evidence from a range of sources such as SCOTPHN and Health Scotland supports local action: it allows us to demonstrate need, make an evidence based case for intervention and develop work to implement programmes locally. This support function is highly regarded and of vital importance to our work.

⁴http://www.scotborders.gov.uk/info/695/council_information_performance_and_statistics/1013/research_information_and_statistics/4

⁵ http://www.scotborders.gov.uk/downloads/download/103/ageing_well_handbook
Scottish Borders Council, 2 April 2015

The form of Public Health varies across areas and therefore there are sometime opportunities missed, e.g. linking with colleagues on specific topics/approaches may be 'silo'ed into a particular arena.

National specialist networks are important. However experience of providing Public Health functions within a local area reinforces the continuing need for a level of specialist knowledge and experience within the local service system that can support delivery of key public health services aligned with the distinctive local population needs and priorities.

To get ownership from clinicians and managers to recommendations and to implementation local context, perspectives and views must be incorporated during the work. Greater contact with colleagues working in service improvement in other areas would be beneficial – for support, challenge, CPD and to avoid re-inventing wheels (maximise efficiency). It is also important to facilitate access to a wider skills base to support work, such as health economists, information analysts and statisticians etc. More highly specialised areas could be addressed across a wider area, e.g. tertiary centre service issues across south-east Scotland. Resilience can be maintained and improved through greater vertical integration, e.g. between current board Public Health Departments, and/or horizontally across Public Health domains as currently happens. The same applies to training, career development and succession planning, with horizontal integration being particularly important for training.

There is a need for specialist teams are sufficiently large to provide resilience not only in terms of general lists but also sub specialists, for example in Health Protection. Such resilience and also coordination can be delivered by managed networks such as ScotPHN and the networks that sit under its umbrella eg SIAN, SMASH, HENS

5. How can we provide opportunities for professional development and workforce succession planning for the core public health workforce?

Public Health involves a community of diverse organisations and individuals, each providing particular services. The workforce comprises specialists (professionals including consultants and nurses working full time in public health); practitioners (professionals including non-specialist nurses and epidemiologists, and environmental health officers in local authorities) and the wider workforce (a much larger group of staff including those who spend only a part of their time on public health work). Career development for non medical public health professionals has in the past usually been opportunistic rather than as a result of workforce planning and more thought needs to be given to the development of careers for non medical professionals. The developing work relating to non medical registration of public health protection practitioners is very important but needs to gain more prominence and support as at times it feels as though it is an add on and the work is done on top of people's 'day jobs'.

12 March 2015