<u>Response from Scottish Directors of Public Health to Scottish Public Health Review</u>

12.03.15

1. How can public health in Scotland best contribute to the challenges discussed?

A national strategy for public health is necessary to engender a cohesive and coherent approach across Scotland.

Inequalities are the key challenge for Scotland, and the public health function should align with this prime focus in the interests of Scotland.

Although the Review focusses on the core/specialist workforce, the overall endeavour of public health is interdependent, with substantial investment in 3 tiers of people and teams: each tier has highly trained and motivated personnel within highly developed public health functions:

1. specialist/core workforce,
2. practitioner workforce,
3. wider workforce, including strategic and operational elements.

The steady increase in complexity and knowledge base of what works to tackle public health problems is engaging people from a steadily widening array of backgrounds. The new challenge of public health is to adapt to this reality and to value fully the contributions of all staff and teams. Contributions from the voluntary sector deserve particular attention, and closer integration with the academic community to harness its capacity for teaching, training, research and evaluation.

Specifically, what is your view and evidence of the Strengths, Weaknesses, Opportunities and Threats (SWOT) to the contribution of the public health function in improving Scotland's health and reducing inequalities?

STRENGTHS:

The key strength of public health in Scotland is its multidisciplinary, well-trained and quality assured specialist (and practitioner) workforce.

This workforce is highly adaptable, and has a commonality of skills and competencies across Boards working within local organisations to the national policy agenda, that gives it the capability to:

- provide direct and distributed Leadership to meet public health needs;
- work across organisational boundaries and within multiple organisational structures to achieve population health outcomes and reduce inequalities (including health inequalities);
- work within functional and task-oriented collaborative networks nationally, regionally and locally,
- understand the need for effective subsidiarity in determining appropriate levels for intervention and advocacy;

Additional strengths include:

- The relative stability of the public sector landscape in which the workforce operates. Structural reorganisation has the tendency to reduce short term efficiency and undermine long-term programmes of work. Ultimately, our strength lies in the effective relationships within the public health community, and within and between organisations across Scotland, that allow long term public health outcomes, often across generations, to be achieved.
- The influence of being part of a local organisation – experience tells us that working from outwith organisations is less helpful eg universities contribute to the academic evidence base but influence and implementation is stronger from working within and directly through the organisations that deliver and control resources.
- The DPH role as leader within local organisations, both the clinical professional leadership role of the workforce, and the more general leadership role of the wider public health function.
- 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.
- The population health perspective brought to inform policy, strategic needs assessment, prioritisation, service delivery and evaluation, including the advocacy role of public health at all levels – from national to local.
- Collective action and the potential for objective evidence based influence and the power of collective advocacy.
- Willingness and capacity to work across our specialisation through multi-disciplinary teams and across organisational boundaries to deliver the public health function.
- The integrity of specialist public health teams working within local organisations, recognising the appropriate contextual variability of size, shape etc in local NHS Boards.
- Flexibility – the ability to apply specialist public health knowledge and skills to the varied and diverse health and care Having a critical mass of the specialist workforce either at local Board level or through networking arrangements.
- Synergy between the different domains of public health.

WEAKNESSES:

- The lack of visibility of many public health activities, especially those with long term timescales to demonstrate effectiveness
- Lack of consistency in public health policy development and practice. There is variation in resources, numbers, skill-mix, roles, services, policies, on-call arrangements, input from academic departments and research units to territorial boards, and this may be a weakness in those areas where the variation is not an appropriate response to the local context. Diversity of local practice in meeting local public health needs can lead to differences in quality and standards of delivery, though may be the right thing to do to achieve change in local areas.

- In some Health Boards, there is limited capacity and resilience amongst the public health workforce. Recruitment and succession planning are being badly affected by this.
- Developing defined specialist accreditation and accreditation for public health practitioners (especially in health improvement areas) is lacking and out of step with the rest of the UK. This can lead to different standards of professional practice becoming normalised locally and- in the long run – undermine the professional development and career aspirations of public health practitioners and the wider workforce.
- There is variability in the use of and contribution to the evidence base on effective practice.
- Lack of a consistent coherent voice for public health in Scotland historically, limiting the potential impact of public health as advocate and driver of change.
- Unnecessary duplication of services – do we always need to do things 14 times? National, regional and local working is not always as well balanced as it may be, leading to unnecessary duplication of effort, especially at the local level when a “once for Scotland” approach may be more effective, or where opportunities for sharing may not be fully developed.

OPPORTUNITIES

- Making sure that the core skills set within public health is used to support evidence based policy.
- Public health standards already exist and have been adapted and piloted for use in Scotland. These may be helpful in clarifying the essential components of an effective public health system for delivering public health outcomes – how to make the most effective use of, and further enhance, the highly skilled and competent workforce already in place.
- Separating out structures FOR public health delivery, and structures OF public health – ensuring that we are positioned to work with whatever structures for public health delivery exist or develop in future– building on the strengths of working in and across the range of organisations who play a part in public health delivery.
- Our concern is to ensure we have the capacity to deliver the public health function whatever organisational reform / restructuring might happen in the public sector in Scotland.
- Importance of coherent national policy supporting public health aims, particularly on tackling inequalities.
- Review of resources to deliver public health functions – there are mixed views about whether a stocktake would be helpful.
- We have noted the shared services paper from NSS and how the review links to that, we have mixed views as to whether this represents opportunity or threat.

THREATS

- The potential of organisational reform to break up the infrastructure of delivery, and distract from the key aims of improving health and reducing inequalities, whilst recognising the need for change to adapt to the changing public sector context post-Christie. May also act as disincentive to attract staff to Scotland.
- The risks of a fixation on seeking to find the “perfect” organisational structure of public health. Rather, we are interested in a consideration of the structures which are “fit-for-purpose” in delivering public health outcomes across all three domains of practice: health protection; health improvement and inequality reduction; and care quality and efficiency supported by high quality public health intelligence.
- That reform to improve on some areas of weakness will result in unforeseen impacts for instance the balance of reducing variability with maintaining local responsiveness and appropriate flexibilities.
- The threat of fragmentation – 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. There needs to be 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.
- The threat of unrealistic and particularly short term expectations of the pace 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.

We would commend the work done recently by the Committee of the Faculty of Public Health in Scotland which has described the variety of challenges facing public health in Scotland across the three domains.

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

Public health leadership needs to be exercised at national, regional and local level. Currently the most visible leadership is that of the DsPH at territorial NHS Board level. Previous (some but not all) Chief Medical Officers at the Scottish Government have had public health backgrounds which has provided strong national leadership from a central point. The Scottish Directors of Public Health have a robust network with a unified national voice on specific issues; this role could be strengthened and developed into national leadership with accountability and authority to deliver the national aspects of a newly developed Scottish public health strategy.

There needs to be a positive step change in expectations and delivery of public health leadership. Leadership should be more inclusive, influential, consistent within a clear framework, organized to cover domains and roles, nationally and locally, connected much more effectively internally and externally, and accountable. Aligning leadership within an agreed national strategy would offer opportunities for much greater

effectiveness. It must respect the contribution of all contributors. It must adapt to changing circumstances.

Leadership needs to be understood as existing at several levels and for differing purposes. So there is a need to maintain and enhance the public health leadership that is provided within specific Public Health roles or functions. Of these the clearest examples are the territorial leadership provided by the Director of Public Health and the leadership provided by the public health specialist workforce who lead public health actions across the wider workforce and with communities on a day to day basis.

Public health leadership also needs to be understood in the context of the wider shared responsibility for leadership in the public sector. Leadership should span agency boundaries and professional disciplines. For leaders with specialist public health roles, the key task is to shape and influence others effectively on issues that span many sectors – the role of a public health leader is to understand the issue and its context, promote other people's understanding, to influence change by influencing decision makers and influencing practice and advocating for those whose voices are less likely to be heard.

For public health leaders in public, private and independent sector organisations across Scotland, the challenge is to understand the potential for public health benefit that lies within their organisations, and to ensure that such outcomes directly within their control remain within their core delivery of service, whilst collaborating in those areas where their contribution is required to improve the public's health.

There must be a development of the contribution and visibility of leadership at a national level for DsPH collectively, to include a stronger professional voice for public health through lobbying, briefing, collating evidence, marshalling national resources such as ScotPHN.

There are specific opportunities for the development of leadership for the public health function:

- through Post Graduate public health training and CPD to make it more systematic and incorporate succession planning;
- building on public health leadership in specific areas such as health protection, health improvement and reducing health inequalities and programmes such as screening for effective delivery both locally and nationally.

One option to strengthen national influence and leadership would be to constitute the national DsPH group to have formal accountability reporting to SG to comment on public health policy across SG and raise issues of public health relevance. We would welcome further discussion with the Review Group on how the DsPH group could exercise stronger national leadership.

3. How do we strengthen and support partnerships to tackle the challenges and add greater value?

Public health is a collaborative endeavour and building and maintaining partnerships to achieve outcomes of benefit to the public's health is part of the core set of public health competencies, whether for the public health professional or the public health

system. This is linked to our understanding that the way in which achieving enduring public health outcomes requires “whole system” responses, rather than being the responsibility of a single agency or professional activity.

It might be helpful to understand both those partnerships and collaborations which are developed informally to meet a specific public health need and those which are formally established. Informal partnerships exist to further a public health objective; formal organisational partnerships ***may*** further a public health objective through that partnership, if it is agreed as part of the local or national arrangements.

There is a wide research literature on the composition and effectiveness of partnerships. It may be helpful to distill and translate this into guidance on creating and sustaining partnerships that have a focus on the delivery of public health objectives. Irrespective of the final configurations of the public health workforce or the organisations in which it sits, such partnerships also require a single, shared vision of what is to be achieved. The creation of a Scottish Public Health Strategy, setting out the high level outcomes required and recognizing the need for local and regional collaborations and partnerships, may be helpful in creating such a vision.

How do we support the wider public health workforce within those partnerships to continue to develop and sustain their public health roles?

One essential component is to be clear – on a national basis – about what constitutes the core public health workforce across the three tiers of specialist, practitioner, and wider workforce.

The public health roles and responsibilities of those within the practitioner and wider workforce need to be supported by effective training, regulation and quality assurance to ensure their professional contribution is of consistent quality and valued by their employers.

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

To not fundamentally change the organisational base for the specialist public health workforce to minimize disruption to service i.e. less organisational change, more focus on delivery. Or to be clear about what we are seeking to achieve and then focus organisational change to best deliver on that.

To be effective, well co-ordinated and resilient, we should be prepared to consider structural and organisational change where that may achieve better national and local identity, quality and sustainability, ensuring a critical mass for essential public health operations nationally and locally where appropriate. This may be achieved under shared services programme or network arrangements. In the realm of health inequalities, most determinants and partnerships range well outside of the health sector, and the resource should be orientated to best effect to reflect this reality.

Judgements of effectiveness are often based not on an external benchmark (even when they exist), but on subjective assessments of what was felt to be wanted or wanting at a given point in time. The lack of visibility of public health mentioned above can also make assessments and perceptions of effectiveness difficult. Often the test is when, at any given time, something may happen – pandemic H1N1 disease most recently – which requires the short- term reorientation of the resource to deal with the immediate, acute action, rather than longer term sustainable programmes. This is linked to the concept of "critical mass", and the notion of an effective public health resource on a day-to-day basis that delivers the function on a proactive, planned basis, with surge capacity arrangements to deal with unforeseen or 'rare event' pressures.

It is helpful to answer the question also at different levels of population health: "local" territories for effective public health delivery across all three domains to differing public service agencies, "regionally" to support defined NHS (or larger population) planning and co-ordination functions, and "nationally" in a mix of highly specialised support services for the local public service agencies. At each level there is a need for strategic, tactical and operational resource.

Ultimately, the specialist public health resource can – and will – work more effectively with greater clarity on public health objectives, on effective partnerships to achieve these, and on the necessary resources available.

The question also seems to carry a sub-text which focuses on organisation of public health teams and services: geographical versus functional; local versus national; inter-domain public health versus intra-domain public health structures.

It is our view that there is no one, clear organisational structure of public health which is better or worse than any other. All structures can be made to work; indeed it is one of the competencies of specialist public health practice to be able to work within and across different organisations, structures and sectors.

What is needed in Scotland now is the recognition that the structures in which public health works are both a means of supporting certain types of action, whilst also limiting it in other ways. For example, embedding specialist public health resources within Community Planning Partnerships (CPPs) will help deliver local public health objects and improve alignment with many of the levers for reducing the social and economic inequalities that lead to health inequalities. Yet such an approach will require highly effective co-ordination of such actions across 32 CPPs to ensure national outcomes are achieved, that meeting local needs does not create geographical inequalities in access to public health services, are not wasteful of resources by creating 32 approaches which may have been best served by a single, national approach to be developed and then locally implemented, and do not result in fragmentation of the specialist workforce. This should not be seen necessarily as an appeal for a single national public health system.

What is needed is a public health system that provides, at a national level, the type of strategic coherence of public health activities, support for action and consistency of professional practice that can support meeting local needs through the delivery of local (or regional) actions that have the potential to achieve agreed public health outcomes in an effective manner.

The determination of what should operate at which level – nationally, regionally, and locally – has more to do with understanding how best to achieve subsidiarity in public health activity and the organisational geography of the agencies that form public health's key partnerships.

We see the key to resilience as being a workforce confident in its skill base and its evidence base, with strong leadership to maintain delivery through a changing environmental context (whether that be the environment of public sector reform, or the underlying changing demographic and political environment).

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

This would be supported by more active specialist workforce planning including succession planning, and the potential for the contribution of NES in the development of multi-disciplinary public health. It should include the needs of people already in core / specialist roles who need continuing support to take on and adapt to changing roles.

We would add our support to the outputs of the Workforce Development Group, and see key priorities in:

- Confirming Scottish support for UK Faculty of Public Health and People in Public Health work on, and refreshment of, core competencies, at different levels;
- Aligning Scotland with the rest of the UK on supporting the regulation of generalist and defined specialists in public health and developing the accreditation and quality assurance of public health practitioners, along with integrated professional development;
- Promoting the recognition of, and respect for, the wider workforce and its contributions to public health;
- Developing wider approaches to public health leadership across disciplines, including opportunities for leadership development and training;
- Allowing greater flexibility amongst the public health workforce for part-time working, joint appointments out with the NHS or the public sector; movement in and out of academic posts;
- Ensuring the continued development of academic centres linking across all health boards and public health teams, to fulfil their role in developing the public health workforce, in education, training and research.