**Scottish Directors of Public Health Position Statement**

**Locating and Specifying Public Health Services in Scotland**

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**1 Background**

At heart the business of any public health service is about being proactive in working with and for local people, communities and populations to meet their health and health care needs and reduce any inequalities in health that they experience. It recognises that central place that prevention should have in promoting and protecting the health of the population, and acknowledges the important of safe, effective care services when the health of individuals within the population has been affected

Scotland has recently been described as having one of the most stable, comprehensive, and effective Public Health functions in Europe.[[1]](#footnote-1) Yet it is something of a paradox that describing what *precisely* is encompassed by a Public Health Service, especially at sub-Scotland levels has proved to be more elusive.

When considering Public Health services, there are five characteristics that should be considered. These are:

1. Service “Outcomes” for Public Health;
2. Subsidiarity of service delivery;
3. Service competence;
4. Professional competence; and
5. Public Health governance.

Using these characteristics, the purpose of this position paper is to set out an approach by which the scope and outcomes of public health services in Scotland can be best described. It also explores the different structural “levels” (Scotland, regional, local and locality) at which different parts of the overall public health service can operate.

**2 Specifying Public Health Services**

**2.1 Service “Outcomes” for Public Health**

Public Health outcomes are commonly described in epidemiological indicators of population health status, yet these are poor indicators of the availability of public health services or the effectiveness and quality of service delivery. There are many reasons for this, but mainly they relate to the highly complex interactions between the varying determinants of health and the need to use indicators which act as proxies for the health – or more likely – illness consequences of such interactions.

Within clinical services, service quality and effectiveness “outcomes” are usually captured by considering the availability and effectiveness of a service against a set of agreed service standards. These have not been commonly used within the UK, but such sets of public health service standards do exist and have been piloted in Scotland.

At the national level in Scotland these have been effectively captured by a defined sub-set of the WHO (Europe) Ten Essential Public Health Operations.[[2]](#footnote-2) These describe the elements of service which are required to be available for the whole population.

At the differing sub-Scotland levels, Public Health service “outcomes” have been set out in the standards sets created by the US Centers for Disease Control (CDC) and administered by the Public Health Accreditation Board for the United States.

These standards have been piloted in Scotland (web link)) and shown to be effective in setting out a series of public health service outcomes, organised into domains of public health service activity.

Currently within Scotland, the “Core” domains for public health service which are delivered by each local Public Health Directorate are:

* conduct and disseminate assessments focused on population health status and public health issues facing the community;
* investigate and address health problems, communicable diseases, and environmental public health hazards to protect the community;
* develop public health policies and interventions; and
* advocate for, and promote strategies to improve equitable access to effective health care.

In addition, elements of all the following domains are being delivered in “badged” public health services, as well as more general public services in local government and via governmental agencies, at local, regional and national levels across Scotland:

* inform and educate about public health issues and functions;
* engage with the community to identify and address health problems;
* enforce public health laws;
* maintain a competent public health workforce;
* evaluate and continuously improve processes, programs, and interventions;
* contribute to and apply the evidence base of public health;
* maintain administrative and management capacity; and
* maintain capacity to engage the competent authority for population health.

Operational aspects of how these service standards are assessed as being met are considered further below.

**2.2 Subsidiarity of Service Delivery**

As implied in the last section, different parts of the public health service in Scotland are being delivered at different levels of the overall system.

1. services delivered within and for a “locality as defined in line with the principles of the Christie Commission”;
2. services delivered on an administrative health board (district) basis;
3. services delivered on a regional basis; and
4. nationally delivered services.

In public health terms, the basic premise is that services are delivered at the lowest level at which it is feasible to provide such a service safely and effectively. This is referred to as subsidiarity.

Of course not all services are delivered by the local or national Public Health Directorates or agencies. Many are delivered through formal or informal partnerships which bring together these services with local authority, national and local agencies, third, and, where appropriate, independent sector.

**2.3 Public Health Service Competence**

The concept of subsidiarity presumes that the public health service – however it is configured – is delivered in a manner that is safe and effective. This implies that the service is a competent one. That is to say the service is likely to provide the required level of availability and effective “outcomes” on an everyday basis.

In each part of Scotland, the way in which a competent service is delivered will vary. This is because of a range of factors associated with local resource availability, wider service capacity, and the critical mass of available professional staff. How the public health service will be organised is likely to take one of three basic forms:

1. services are competent within the resources available to a specific, specialist public health team/department;
2. services are competent within the resources available to a public health partnership, collaboration or coalition; and
3. services are competent within the resources available to a wider network of agencies and communities.

In all cases, it should be borne in mind that the levels at which such organisational arrangements function will vary too. In some parts of Scotland a public health service may be delivered for a locality by the specialist public health team, whilst in another area it is delivered through a partnership arrangement.

As a general rule of thumb, however, the more complex the public health service is, the greater the likelihood that it will be delivered in partnerships / collaborations and at regional or national levels, even where the expertise resides in an individual Board.

**2.4 Professional Competence:**

Professional competence relates to the formal staff competencies of the public health workforce. This is described in public health workforce terms as:

* specialists (e.g. DsPH, CPH, Nurse Consultants) – those with formal specialist public health competencies, both general & defined;
* practitioners (e.g Health Visitors, health protection nurses, EHOs) – those competent to undertake aspects of public health service delivery proactively, usually under some form of supervision; and
* the wider workforce (e.g. Health and social care professonals, local authority officers, Third Sector health workers) – those whose work make a contribution to public health outcomes in some way.

Whilst much of the discussion over that past decade in Scotland has focussed on the specialist workforce and on the specific competencies that may be needed by parts of the wider NHS workforce, attention is now being turned towards the competencies of the practitioner workforce and how it is accredited. Work in relation to the health protection workforce has led the way in this and recent pilots in more general accreditation of practitioners in health improvement have proved successful.

What is clear is that the competencies of the whole workforce need to be considered in the round, and not only for parts of the public health workforce.

**2.5 Public Health Governance**

Any public health service needs to be subject to effective governance. This will reflect:

* the governance of the structures in which public health services are managed and delivered;
* the governance of professional and supervised staff and the communities with which they work; and the
* governance of collaborative or distributed public health actions.

Ultimately such governance is there to ensure that the competent professional is working within a competent public health service and system that meets explicit standards of service delivery.

The form of any governance arrangement is usually mapped onto the arrangements of the statutory (or other) public body in which the public health service is delivered. However, in recent years, additional governance arrangements have been specified for public health partnerships or networks to provide necessary oversight for trans-organisational arrangements.

**3 Locating Public Health Services**

The present situation – in which public health services are located in both local administrative districts and national agencies – is only one potential model for locating public health.

Whilst the literature on models of public health services is relatively small, what does exist describes three other possible models. It is interesting to note that all of these have, to a greater or lesser degree, been used for locating specialist public health services in the UK over recent years; though, to date, none has shown itself to meet all the requirements of effective and efficient working

In the context of the current Scottish public sector landscape – apart from the status quo – the alternative models are described below. :

**3.1 A Localism “plus” model**

In this model specialist public health services are embedded into local arrangements which are arranged along Christie Committee principles. This presumes that public health is co-located with a range of possible local structures, depending on the local public sector arrangements. These will include local Integration Boards, where they serve a whole population. These may be coterminous with health board or local authority boundaries. This may also include, depending on wider public sector reform, integration of specialist public health services into single public body arrangements.

To ensure the critical mass necessary for safe service delivery, this would produce an increased requirement for regional and national collaborative mechanisms, whether partnerships or networks. These would seek to maximise limited local resources and make best use of highly specialist resources only available in one or two areas or at national level. One clear example of this is the work of the Dental Public Health networlk for South East Scotland. Another potential example for this model of public health service already exists in the work of the Scottish Health Impact and Inequalities Assessment Network (SHIIAN) which operates across Scotland under the overall auspice of the Scottish Public Health Network. Unlike the Dental Public Health Network, SHIIAN works as an advisory and supportive network, with no powers to take action and no requirement for local public health departments to commit to resources to SHIIAN or to action its recommendations. Providing mechanisms, by which SHIIAN could function such that it was empowered to act on behalf of the local public health department, working within the locally available resources and assets, would allow a more collaborative model to be implemented to improve overall effectiveness.

Working within such a model has the clear benefit of working through local organisations to deliver public health services and achieving public health outcomes. It allows the whole public health workforce to be more engaged with delivery, whether for whole service programmes (e.g. specialist health promotion or health protection) or in relation to specific public health contributions within wider services (e.g. reducing Healthcare Acquired Infection, or developing local community amenities as vehicles for health improvement). Such local arrangements also provide support for the development of public health delivery through mainstream services, ensuring the contributions from the wider workforce are effective in meeting identified health needs in a sustainable manner. It allows for improved co-production with health and social care service providers and local communities in the “cycle” of public health that starts with assessing need, identifying local assets to support and influence change in organisations and enable community participation, getting local ownership of opportunities and possible developments, facilitating service redesign or introducing new services to meet the needs, and the supporting service evaluation and quality assurance.

At the same time, whilst the model promotes an approach to “Horizontal integration”, it can also limit the extent to which access to expertise is available unless there are strong, appropriately resourced national collaborative mechanisms.

**3.2 A Regional model**

This model allows for situations in which the current regional public sector arrangements remain the same, are enhanced or new ones are created into which specialist public health services are embedded or aligned. Public Health service models already exist which illustrate differing regional approaches. For example, the relationship between the North of Scotland Regional Planning Group and the North of Scotland Public Health Network show how such an arrangement can work, without there having been the need for structural change. In other possible scenarios, however, were there to besome form of regional NHS restructing or the establishment of more regional governmental agencies it is arguable that this would be an impetus for changes in Public Health alignments.

In such a model, there is the potential for local teams to come together where there is a shared agenda to support, strengthen and learn from each other and where services are not viable except at regional level. However, delivering public health services in this model would require the type of national up-reach collaboration noted above and provide local support and PH leadership to the local bodies and communities across the region and at the local level. For this model to function most effectively, there would be an urgent need to develop the local workforce, strengthening the Public Health Practitioner roles and energizing the wider workforce to deliver public health outcomes on the ground.

It is difficult to assess the major benefits and limitations of working within such a model. In many regards, the key challenges facing the current, Health Board based model of public health service delivery are likely to apply, with the added complication of maintaining additional partnership and network working vertically across local, regional and national levels, and .horizontally within levels. Whilst cross-organisational working and inter-agency relationships can strengthen delivery, there is a strong sense that organisational structures can also get in the way. Co-location within any organisation structure does have the tendency to create allegiances and expectations.

**3.3 A National model**

In this model all specialist public health services are moved into a single, national agency with subsidiarity as its principle for regional and local working, such as already exists in Wales and Northern Ireland. Embedding more regional and local teams could be possible, depending on circumstance and the type of PH issue being addressed.. The exact configuration of services, and the role of the national model in such configurations, would need to be subject to a national and local stakeholder agreement, but such approaches do exist and do deliver effective services.

Within Scotland, it would be possible to suggest that such a role definition would follow the domains of public health practice to which the Essential Public Health Operations relate (see Box One).

**Box One: Preliminary Role Definition for a Scottish National Public Health Agency**

The role of a national agency in regard to health protection services would be to:

* work with the Health Protection Oversight Group and the new Health Protection Network to establish the standards for Scottish Health Protection services and to ensure the highest possible standards of advice and support to the NHS, local authorities, Scottish Government;
* review the configuration of local health protection services to ensure they can deliver reductions in infectious disease and environmental harm including the configuration of local health protection teams;
* lead the field epidemiology service in Scotland, to strengthen the epidemiological science underpinning local responses to infectious disease and environmental hazard outbreaks and incidents;
* work with Public Health England and the other devolved administrations to develop the professional and scientific base for health protection services to ensure the population is protected from current and future threat; and
* lead the nationwide elements of the Health Protection services including national leadership of the immunisation programmes.

The role of a national agency would in regard to health improvement be to:

* develop and monitor the implementation of a public health strategy and outcome framework for Scotland;
* review the configuration of local Health Improvement teams to ensure that they have the capacity, competencies and opportunities to develop local public health initiatives to support Scottish public health strategy;
* ensure that Health Boards, Health and Social Care Partnerships, local authorities and local partnerships have access to the highest possible standards of advice and support to support their public health responsibilities; and
* work with Public Health England and the other devolved administrations to develop the professional and scientific base for health improvement initiatives to improve the health of the people of Scotland.

The role of a national agency in regard to health service improvement would be to:

* review the configuration of public health support to Regional Planning Groups, Boards, Health and Social Care Partnerships, local authorities and other local partnership;
* ensure that they have access to the highest possible standards of advice and support to support their service planning roles and responsibilities; and
* work with Public Health England and the other devolved administrations to develop the professional and scientific base for service improvement initiatives.

The role of a national agency in regard to health intelligence would be to:

* maintain and develop the Scottish health data systems and the statistical/analytical capacity for public health surveillance;
* ensure that all Scottish agencies have access to the highest possible quality of statistical and health data, and the advice and support to fulfil their respective roles and responsibilities; and
* work with the UK Statistical Authority, Public Health England and the other devolved administrations to develop the professional and scientific base for health intelligence.

The major benefit of a national arrangement would be to formalise delivering things “once for Scotland” and reducing unnecessary duplication of effort across the whole system, whilst remaining sensitive to the diverse strengths and needs of our varied Scottish communities. This would include areas such as the development of effective public health policy, delivering public health services that meet agreed, national service standards, developing and maintaining professional competence across the whole workforce and being able to evidence the use of scarce resources across the system, without prejudicing the capacity of the public health system to meet the needs of the total population it services across the whole of Scotland; not just the needs of those in selectively targeted areas.

**3.4 Function not form**

The outlines of the alternative models show that an effective public health service can be delivered irrespective of the structures into which it is embedded. The characteristics for public health services described in the first part of this paper provide more than a set of descriptions, they provide a basis for a comprehensive mechanism by which the service can be understood and governed in a safe and effective manner.

In many respects, whatever form the structure **of** public health service take – there are a number of “givens” about the delivery system:

* we must consider public health services as a population level and whole system function, so any changes in one part of the system requires that its impact across the whole system is understood by the NHS; Local authorities/locality bodies; and the population and its communities of geography and interest;
* delivery of public health operations is more effective when these are integrated
* subsidiarity as a means of public health delivery is a given, whatever change is proposed needs to recognise it is in operation already;
* in delivering public health outcomes, there needs to be a realistic shift in resource to reducing health inequalities and prevention / early intervention; and
* the focus on social and economic determinants of health is necessary for population health, rather than “icing on the cake”. Public Health investment is a requirement for a healthy economy, but it is not a “quick fix”; benefts are seen on a generational basis and not on short-term outcomes.

There are also some structural issues which need to be addressed to make the structures ***for*** public health become more efficient:

* public health policy is clearly moving in the right strategic direction, but this can be easily “dwarfed” by ‘realities of service delivery in differing organisations, especially when they are subject to competing “must do” priorities;
* expectation in what can be delivered in terms of health improvement / health inequality reduction must be set in the context of the actual priority afforded to prevention services; making it a priority that commands the necessary resources for effective delivery will only happen when collaborating organisations become obliged to rebalance the financial split between prevention and remediation services. Take, for example, the step change in delivery of smoking cessation and alcohol brief interventions when dedicated resource was released by Government is clear and;
* partnership working is harder to achieve and sustain than meeting organisational / structural obligations: this allows distraction to the work, often towards organisational reform rather than service delivery.

**4 Conclusion**

In this position paper we have explored both the possible locations of public health services and the characteristics by which they can be configured and subject to governance to promote a safe and effective system.

To make any part of the whole system work for public health outcomes, we consider that the specialist public health system does need to be supported to deliver its services through:

1. working within structures that create an “authorising environment” for public health service delivery;
2. a legislation framework, with clear duties and powers, including the independent “voice “ of the Director of Public Health to advocate for population health;
3. collaborative and networked mechanisms that are enabling for effective public health delivery;
4. robust governance and risk management arrangements that are consistent across Scotland;
5. protecting the existing flexibility / fluidity that public health needs to go where the need is and respond to it (e.g in delivering “surge capacity”);
6. recognising that public health challenges are dynamic, that the “role definition” of what constitutes a public health need will change with the changing external environments.

Finally, we feel that sustaining such changes in Public Health services will need Scottish and local political support underpinned by supporting policy, the evidence, viible champions, an agreed implementation plan, suitable engagement, evaluation of the changes, recognition of the need for evolution in services after the change, and appropriate levels of funding.

1. Foldspang, A. & Otok, R. (2014). Scotland’s Public Health System and Public Health Education and Training: Preliminary report from ASPHER’s ShapePH Programme. Brussels, ASPHER. [↑](#footnote-ref-1)
2. WHO (Europe).The 10 Essential Public health Operations. (Available at: <http://www.euro.who.int/en/health-topics/Health-systems/public-health-services/policy/the-10-essential-public-health-operations> last accessed 5/5/2015.) [↑](#footnote-ref-2)