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NHS SCOTLAND

The Health Promotion Contribution to Health Improvement

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Foreword

Following the Review of the Public Health Function and the Review of the Contribution of Nurses, Midwives and Health Visitors to Improving the Public's Health, the Public Health Institute of Scotland is delighted to present this report on the health promotion contribution to delivering health improvement in Scotland. The health promotion specialty comprises a diverse and motivated workforce, with a track record of working in partnership to tackle a wide range of influences on health. The particular niche and strengths of the specialty, and its place in the broader public health effort in Scotland, have not generally been well understood, however.

This report, which follows extensive consultation and discussion, seeks to address that gap. It makes several recommendations, the implementation of which would in our view contribute significantly to the achievement of the sorts of changes necessary if Scotland's health is to improve relative to our European counterparts.

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Executive summary

In May 2001, the Public Health Institute of Scotland (PHIS) was commissioned by the Implementation Group for the review of the public health function and the public health contribution of nursing, to make recommendations to maximise the contribution of health promotion to improving health in Scotland. This request was made in the context of the current emphasis being placed on the health improvement role of the unified NHS Boards, and the commitments of improving health and reducing health inequalities made in the Health Plan, *Our National Health* (Scottish Executive 2000). Within Scotland there is now a clear policy commitment to a broad model of health and its determinants, accompanied by a recognition that continuation of current approaches and levels of activity are unlikely to achieve the changes necessary to bring Scotland's health to a level equivalent to comparable countries.

Whilst both the review of the public health function and the review of the public health contribution of nursing made reference to the roles and importance of the health promotion workforce, neither paid close attention to the particular needs of that workforce nor made recommendations for its future development. This report is the culmination of a process of consultation involving health promotion specialists, health promotion managers, and stakeholders from across Scotland. During the first phase of consultation the current position and practice of health promotion were analysed and key factors external to this workforce identified. The full findings of this process were presented in a consultation document (Garman 2001) which sought views particularly on a draft set of recommendations for action. Included in that document and reflected in this one is a level of analysis undertaken by PHIS based on the information from the initial SWOT data.

This current final report has addressed comments received on the consultation document, particularly in relation to the recommendations. The revised recommendations form the basis of the action plan that can be found on pages 3 – 6. These actions seek to:

- achieve progress in further integrating the public health workforce within the NHS and with other organisations involved in health improvement, and
- recognise the need to strengthen the individual discipline of health promotion and to nurture the people who comprise its workforce.

Introduction

This report is the product of a process of consultation that took place over a number of months in 2001. The report was commissioned by the Public Health Function Implementation Group (PHFIG) that was set up by the Scottish Executive Health Department. PHFIG's main function was to implement changes following the review of the public health function (Scottish Executive 1999) and the review of the contribution of nursing to improving the public's health (Scottish Executive 2001). In considering the issues of implementation it was apparent that more detailed information was needed on the health promotion function. Whilst a body of evidence regarding the effectiveness of health promotion was already available, the current position of health promotion in Scotland was not. PHFIG decided that a SWOT analysis[1] should be undertaken and charged the Public Health Institute of Scotland (PHIS) with that task.

Consultation workshops were held with health promotion staff, managers and stakeholders throughout Scotland. These workshops involved participants in analysing the current position of health promotion in Scotland through the use of a SWOT analysis process. A synthesis of the outputs from these workshops was then tested further with health promotion managers and other stakeholders to ensure that the main messages were robust, relevant and valid. A report was then produced, which provided interpretation and analysis of the information captured as part of the SWOT analysis and made recommendations to maximise the contribution of health promotion to improving health in Scotland. Comments on this report were then gained through a further period of consultation. An action planning group (for membership see Appendix 1) was formed to consider these comments and to agree the recommendations and actions for this final report. This whole process has been conducted at a time when considerable emphasis is being placed on the health improvement role of the unified NHS Boards, and the commitments of improving health and reducing health inequalities have been made explicit in the Health Plan, *Our National Health* (Scottish Executive 2000). It is worthwhile to clarify the use of the term 'health improvement' in this document. We regard health improvement as an aim, the achievement of which includes the areas of work traditionally described as health promotion, public health and health care as well as a range of other processes. However the focus for our recommendations and actions is on the domains of health promotion and public health.

Within Scotland there is now a clear policy commitment to a broad model of health and its determinants, accompanied by a recognition that continuation of current approaches and levels of activity are unlikely to achieve the changes necessary to bring Scotland's health to a level equivalent to comparable countries. This document draws together the ideas, energy and enthusiasm that exist to assist the health promotion workforce in contributing most effectively to the process of changing Scotland's record of poor health.

[1] A SWOT analysis is a detailed analysis of a subject's strengths and weaknesses and consideration of the opportunities and threats facing it in the external environment.

Recommendations and Actions

The recommendations and actions seek to:

- achieve progress in further integrating the public health workforce within the NHS and with other organisations involved in health improvement, and
- recognise the need to strengthen the individual discipline of health promotion and to nurture the people who comprise its workforce.

Some of the recommendations seek action by the health promotion community, to strengthen the discipline and further describe its competencies. Others set out actions that are sought from other parts of the system at local and national level, to enable the potential contribution of the health promotion discipline to be realised more effectively. The background and rationale for these recommendations is set out in the 'Issues for delivery' section of this report (pp 15-22).

RECOMMENDATION	BY WHOM	TIMESCALE
1. That a small working group (hereinafter called the Action Planning Group) is set up to progress the actions set out in this report, review progress and appraise the relevant management/ advisory structure of the new national health improvement organisation (previously HEBS and PHIS) of the results. **Action:** The Action Planning Group co-ordinates, reviews and reports on progress to the new national health improvement organisation	Action Planning Group	Report on progress by June 2003
2. That the Scottish Executive continues to clarify the locus and organisational responsibilities for providing national leadership for health improvement in Scotland. This includes the current work setting out the purpose and function of the new NHS Board for health improvement and the strengthening of the policy focus on health improvement through the creation of a Directorate within the Executive's structures. **Action:** The SEHD continues to strengthen national leadership for health improvement through establishing the new NHS Board for health improvement, clarifying its purpose and function, and developing a national health improvement action plan	Scottish Executive Health Department (SEHD)	Ongoing
3. That the unified NHS Boards and their Community Planning partners take ownership for actively progressing the health improvement agenda as set out in *Our National Health*, the Local Government Bill, the Performance Assessment Framework, and related guidance. This will be reported through the NHS accountability reviews and any other reporting mechanisms identified as part of the Community Planning process. **Action:** NHS Boards and partners prioritise the delivery of health improvement and develop as public health organisations	Unified NHS Boards and their Community Planning partners	Reporting through the accountability review processes

RECOMMENDATION	BY WHOM	TIMESCALE
4. That the unified NHS Boards focus on issues of NHS workforce planning for health improvement, connecting with national Human Resource strategies. In so doing, unified Boards should be clear about who locally comprises the wider public health workforce, their appropriate roles and the specific input of NHS health promotion specialists within that. Cognisance of the capacity of the wider public health workforce should be taken when unified Boards are developing Local Health Plans and Community Plans. **Action**: a) Local NHS systems consider local public health workforce planning to meet the requirements of Local Health Plans. This process should include collaboration with Community Planning partners to clarify respective roles and responsibilities b) Unified NHS Boards use local multi-disciplinary public health networks and multi-agency committees and forums to facilitate workforce integration	a) Unified NHS Boards b) Unified NHS Boards	Reporting through the accountability review processes
5. That employing organisations ensure that their health promotion staff are fully engaged in local and national mechanisms for delivering the health improvement agenda, and that they have the necessary skills to play their full and appropriate part. **Action:** a) Employing organisations identify, through a skills audit, the capacity and development needs of their health promotion staff to deliver the health promotion components of local and national health improvement agendas b) Employing organisations ensure that the identified health promotion skills and development needs are met through local mechanisms (e.g. organisational development plans and personal development plans) c) Employers ensure that induction and continuing education of staff at local levels build and maintain the agreed competencies (see recommendation 6)	a) NHS Boards, Trusts b) NHS Boards, Trusts c) NHS Boards, Primary Care Trusts (PCTs)/Local Health Care cooperatives (LHCCs)	October 2003 Reporting through the accountability review processes

RECOMMENDATION	BY WHOM	TIMESCALE
6. That Health Promotion Managers (HPMs), COSLA and HEBS describe the basic competencies of health promotion practitioners, thereby clarifying the particular set of health promotion skills and how these contribute to outputs in health improvement work. This should be part of a wider body of work to review and define public health competencies, and should link to UK-wide developments in workforce definition and planning. This work should acknowledge the current climate of an integrated, multi-disciplinary workforce, all aspects of which contribute to health improvement. In particular the outcome of such work may help place others' health promoting roles (including the public health practitioners in LHCCs, and the health improvement posts in local authorities) into context. Linkage should also be made, when competencies are agreed, with the public health education and training work being led by PHIS. The issue of accreditation should also be considered at that time.		
Action:		
a) Bring forward to the Action Planning Group a proposal from the Health Promotion Managers and HEBS as to how this work should be taken forward in Scotland	a) HPMs/HEBS	July 2002
b) Health Promotion Managers and HEBS produce a description of the minimum set of skills/competencies that should be present in NHS health promotion postholders	b) HPMs/HEBS	January 2003
c) Local authorities consider the competencies required for their health improvement posts taking into account the objectives that have been set for these posts	c) COSLA	To be decided
7. That Health Promotion Managers, working through local structures for professional development and with HEBS, remain focused on keeping the health promotion orientation alive through championing health promotion values, ongoing review and development of the practice and competencies of their staff, and active contribution to health improvement networks. In light of the current variations in health promotion practice and capacity, and the scale of the health improvement challenges facing us in Scotland, the health promotion workforce needs to sustain the quality and ongoing development of its professional practice.		
Action:		
a) Health Promotion Managers' Group considers how best to add to and communicate best practice in relation to the health promotion contribution to health improvement in Scotland	a) HPMs	March 2003
b) Health Promotion Managers ensure that staff personal development plans are linked to the competency framework when agreed	b) HPMs	March 2003

RECOMMENDATION	BY WHOM	TIMESCALE
8. That there is a clear national programme of work specifically focused on the use of evidence, access to evidence and ongoing research and evaluation of health improvement interventions. An ability to use and add to the health improvement evidence base should be a core competency of health promotion specialists. In addition, a strengthening of the national focus for developing and disseminating the evidence base and for supporting health improvement research is needed. **Action:** The new national health improvement organisation, together with other key stakeholders in Scotland, explores how best to strengthen national mechanisms for building the health improvement evidence base, and for using and sharing the existing evidence base more widely	National health improvement organisation	March 2003
9. That the new health improvement organisation is charged to carry out a future scenario-planning exercise (either as a complete one-off exercise or a series of projects) which looks at models of health improvement including those adopted in other countries, and builds on these to develop proposals suited to 21st century Scotland. **Action:** The national health improvement organisation takes a proposal to its new Board to meet this requirement	National health improvement organisation	January 2004

Background

Examination of the history of health promotion and public health provides key insights to the debate today. There is recognition that health promotion and public health have the same intrinsic goal of health improvement. It is acknowledged that public health, whilst being multi-disciplinary, has strong medical roots and a particular history of medical leadership. Health promotion too has a multi-disciplinary focus and has a different and more recent history. In the 1980s most health education departments within Health Boards were under the Director of Public Health (or at that time the Chief Administrative Medical Officer). Over that decade there was an expansion in the number of staff and in the confidence and roles of departments. The term health promotion reflected that practitioners were embracing a broader agenda, moving beyond and expanding on health education methodologies. With the increase in numbers, confidence and roles, a sense of professional identity grew stronger. Health promotion officers increasingly became known as health promotion specialists and attempts were made to “professionalise” health promotion.

The Touche Ross review of health education, which was commissioned during this period (SHHD 1989) noted the move towards health promotion and recommended that this development be supported, thus encompassing health education, prevention of ill-health and health protection under one approach. Later in the Shields Report (Scottish Office 1996) there was recognition that health promotion and education was an integral part of Health Boards’ work and that the function should be building links with local people, agencies and organisations, thereby gaining knowledge of local health problems.

During the 1990s and the period of the NHS internal market many in public health medicine embraced commissioning as the best way to influence health (through health services). While this was happening a large number in health promotion felt that they were left as the standard bearers for the broader view of health and some of the historical values of public health and health promotion (e.g. equity, empowerment, social justice etc).

Since the Scottish Parliament and the Labour administration have emphasised a broad understanding of health and health improvement, health has become a much more dominant part of the agenda for unified NHS Boards (and previously for Health Boards) and local authorities. As such, health promotion specialists find themselves in a situation where causes that they have championed consistently over time, are being taken up by political and organisational leaders. This often does not acknowledge the role played by health promotion departments in ensuring that at least some work on the broader determinants of health has developed during a time when the national policy emphasis was on lifestyles. The Health Promotion Managers’ Group (2001) documents the change in policy emphasis towards improving the public’s health and tackling health inequalities. They cite *Towards a Healthier Scotland* (Scottish Office 1999) and social inclusion policies as evidence for this shift in perspective.

The health promotion movement arose as a development of health education and reflected intellectual and ideological debates of the 1980s. Various attempts have been made to define health promotion and none has satisfied all those with an interest in the field. However it may be useful to suspend debate and to work with the Ottawa Charter (WHO et al 1986) definition of health promotion as “the process of enabling people to increase control over, and to improve, their health”. This definition suggests that effective health promotion leads both to changes in the determinants of health and to the health of populations. Using a socio-

ecological or holistic model of health assists the health improvement endeavour. This is accomplished through a wide and eclectic approach to the understanding of how health is created and the need to be informed by a wide variety of disciplines in the way that health improvement is achieved.

The current position of health promotion in Scotland reflects this historical, policy and definitional context. The position of those working in health promotion is often seen to be an uneasy one, and health promotion staff have (through this consultation, and elsewhere) expressed a range of needs as summarised in Table 1 below. These expressed needs can be contrasted with a statement, provided by PHIS, on the more desirable state of affairs for maximising health improvement in Scotland in the future (Table 2).

Discussion on how to move from the position in Table 1 to Table 2 is contained in the next section.

Table 1: Expressed Needs	Table 2: Desired Position
• Recognition of the historic and current contribution that health promotion specialists make to health improvement.	• An end to debates over models of health because we now have a policy context where there is a full commitment to a broad (socio-ecological) understanding of health and its determinants.
• A clearer definition of roles and responsibilities.	• An integrated and flexible workforce where each plays his or her part in confronting those aspects of the determinants of health that they are most skilled or able to address.
• A more satisfactory career structure.	• A meaningful career structure for all who contribute to the core functions of health improvement (including health promotion specialists) to ensure that Scotland attracts high quality staff and individuals have satisfying careers.
• An opportunity to contribute to leadership of health improvement from a distinctly health promotion base.	• Continuing flexibility so that the workforce can quickly adopt new approaches and tasks as required.
• Greater influence within NHSScotland and its partner agencies to bring the health improvement agenda to fruition.	• An absolute commitment over the next few years to delivering a step change in Scotland's health, leading to action on the ground to change the determinants of health.

Issues for delivery

1 Strategic Focus

1.1 As already mentioned, this report is preceded by the review of the public health function and the review of the contribution of nursing to the public's health. Whilst both reviews make mention of health promotion, greater analysis of the discipline's current position was required to ensure identification of all the issues over the total workforce with a locus in the health improvement agenda.

1.2 **We recommend** that a small working group is set up to progress the actions set out in this report, review progress and appraise the relevant management/advisory structure of the new national health improvement organisation of the results.

1.3 The original SWOT analysis identified that further cohesion around the national/strategic health improvement agenda was necessary. A concerted national effort is required to address the major national health improvement priorities (including the health targets in *Towards a Healthier Scotland* (Scottish Office 1999)). The lack of clarity over how leadership and delivery should be exercised has subsequently been addressed, at least in part, through the proposed joining together of HEBS and PHIS into a new health improvement organisation. This will help to provide clarity in relation to some of the concerns expressed among health promotion specialists, who saw HEBS' work as a definite strength and the emergence of PHIS as an opportunity, but felt that the place of health promotion was potentially threatened by current developments. It will also be necessary for this new organisation to work in conjunction with other national organisations that have a locus in health improvement.

1.4 It will be encumbent on this new health improvement organisation to ensure a clear relationship and connections between its work and that of the health improvement efforts at a local level. The extent to which national policy and strategy reflect local experiences and, conversely, national initiatives are supported locally, could also be significantly improved. There is an overwhelming feeling of a huge amount of activity but a lack of local-national cohesion. There was also a call for stronger national leadership.

1.5 **We recommend** therefore that the Scottish Executive takes action to clarify the locus and organisational responsibilities for providing national leadership for health improvement in Scotland. This includes the current work setting out the purpose and function of the new NHS Board for health improvement, establishing the Health Improvement Directorate within the Executive's structures, and developing a national health improvement action plan.

1.6 Action at a strategic level has already been demonstrated through the Healthy Scotland Convention 2001, which focused on what might be needed to secure a step-change in Scotland's health. The potential value of a more focused Scotland-wide emphasis on particular issues was one of the messages that was communicated at that Convention. Another strong theme was the need for us collectively now to focus on delivery: to put our efforts into 'doing' and 'how to'. Since the Convention, a clear framework for a national health improvement strategy is emerging, details of which will be finalised over

the next 6 - 12 months. This should help to respond to the concern expressed by some in the consultation that things would be better if there was a clearer national view on priorities, linked to a national health improvement strategy.

1.7 Simultaneous action throughout and within NHS Board areas on major priorities should provide an impetus for health gain. A key message from the consultation was recognition of the need for effective partnership working. This is also reflected in *Our National Health* (Scottish Executive 2000), that directs NHS Boards and local authorities to work together. Action on this front will help us move towards the core aims of building a national effort to improve health and reduce inequalities in health. Such advances in the delivery of health improvement will also be identified in the progress charted through the Performance Assessment Framework and in particular the Health Improvement Performance Assessment. Community Planning, identified as a significant opportunity, provides us with a vehicle to co-ordinate the efforts across all the partner agencies thus addressing social exclusion and supporting the overall social justice agenda. This current report makes no recommendations about organisational structures to achieve this, nor does it seek to set a new strategic or policy agenda. However, it does indicate that the emphasis now needs to be clearly placed on delivery of programmes which secure better health, and in particular the need for effective partnerships. Given that we have in recent years been through a phase of debate and extensive policy development, the focus for the next five years needs to move to delivery of programmes which are effective in securing health improvement.

1.8 As a result **we recommend** that the unified Boards and their Community Planning partners actively progress the health improvement agenda as set out in *Our National Health* (Scottish Executive 2000), the Local Government Bill, the Performance Assessment Framework, and related guidance. It is important to underline the need for local health improvement systems to take ownership of and remain accountable for this agenda. The policy context provides all the appropriate drivers for NHSScotland to concentrate on delivery of health improvement with its partners.

2 Unified NHS Boards: Delivering Health Improvement

2.1 This report is being produced at a time of change and opportunity. The creation of the unified NHS Boards has brought together, into a single structure, many of the decision-makers responsible for improving the health of their local population. Whilst each of the Board members will bring a particular perspective and carry their own responsibilities, health improvement is the responsibility which requires the concerted focus and active contribution of all members of the unified Boards. In so doing, all the members help develop and sustain the Board as a public health organisation.

2.2 As well as this important change to the health system, we currently have a national policy context which seeks to emphasise the need to promote good health in Scotland. This policy context recognises that health is created and destroyed by a complex interaction of determinants of health that operate at many levels. *Towards a Healthier Scotland* (Scottish Office 1999) summarised this in terms of the ‘three-level’ approach (involving life circumstances, lifestyles and health issues) and set targets to be met by 2010; *Our National Health* (Scottish Executive 2000) reinforced this approach with the additional emphasis on reorienting the NHS to become a National Health Service, rather than a National Sickness Service; and the Scottish Executive is putting considerable effort into ensuring that health is a cross-cutting issue for all Departments and policies. As discussed above, the Healthy Scotland Convention 2001 initiated a process moving towards a more integrated framework for national health improvement initiatives which reflects this commitment to a broad view of health.

2.3 In rising to the challenges of improving health in their areas, NHS Boards are being asked to develop as public health organisations. Scottish Executive Guidance has been produced (January 2002) to highlight the issues likely to be confronted by the unified NHS Boards in taking forward their health improvement responsibilities and propose how they should seek to develop their efforts to improve health. Additionally, the Scottish Directors of Public Health and PHIS have together published a paper *Delivering Better Health: NHS Boards as Public Health Organisations* (Scottish Directors of Public Health Group and PHIS April 2002), setting out the challenges that need to be grasped in this regard.

2.4 In order to deliver their Local Health Plans and Community Plans, and to operate well as public health organisations, unified Boards need to turn their minds to issues of public health workforce planning. Therefore, **we recommend** that Boards, working with their community planning partners, develop clarity about who locally comprises the wider public health workforce, the appropriate roles of different components of this workforce and the specific input of health promotion specialists within that. We further recommend that local multi-disciplinary public health networks and multi-agency committees/forums are used to facilitate the integration of different parts of this workforce.

2.5 What, then, is the particular contribution – or set of contributions – that the health promotion workforce can make to this agenda? The consultation process has helped to define the unique contribution of health promotion. Although the sizes and structures of departments vary greatly throughout Scotland, the characteristics described in Table 3 should be found within the health promotion workforce in all Board areas.

2.6 The consultation exercise elicited a wide range of views about the strengths and weaknesses of health promotion – demonstrating a lack of consensus on many issues and a diversity of experiences across Scotland. That said, it is our view that the set of characteristics in Table 3 summarises the main distinct features of what a health promotion department at its best brings to the health improvement responsibilities of NHS Boards. In concordance with the continuous improvement agenda that is a feature of clinical or health governance in NHSScotland, consistent and improving quality requires to be delivered in all health promotion departments.

2.7 **We recommend** that employing organisations focus on ensuring that the health promotion workforce is fully integrated into local and national mechanisms for delivering the health improvement agenda and that it has the necessary capacity and skills to play its full and appropriate part. Thereby, two parallel issues will be addressed. First, unified Boards will need to actively consider all the skills that they can use in meeting the agenda set before them and secondly, the health promotion workforce will need to continue to develop and operate within a multi-disciplinary context. At the same time there is a requirement for the health promotion workforce to acknowledge the commitment of the Scottish Executive and NHSScotland to a broad view of health and its determinants, and to have confidence in the current policy context's reflection of that commitment.

2.8 As well as ensuring that the necessary skills are in place, there has to be agreement on workplans. A guiding principle should be that 'if we're going to make a difference, we have to make a difference'. In other words, the focus of effort and the dose and duration of intervention need to be high enough to yield health benefit. A strong feeling emerged through our consultation process that the health promotion workforce gets pulled in too many directions. In particular the difficulty in bringing together the community priorities with the nationally driven agenda needs to be recognised. A greater degree of focus is likely to enhance job satisfaction as well as the effectiveness of interventions.

Table 3: Characteristics of the Health Promotion Workforce

- Health promotion staff come from a range of professional and intellectual backgrounds. This can yield useful insights into how health is created, and enables a Board's approach to health improvement to be informed by a wide variety of disciplines.

- Linked to this, health promotion staff are at ease with a broad view of health which encompasses a wide range of determinants, and which recognises different dimensions (physical, mental and social) of health.

- Working with this broad view of health, the health promotion emphasis is mostly on population- or community-level interventions to promote good health and prevent disease, illness and injury.

- Unusually within the NHS, health promotion departments have a particularly good understanding of non-NHS structures and how they work. They will often be well networked across public, private, voluntary and community-sector organisations within the Board's area; and experienced in partnership working across structures, and between organisations and communities.

- Working at their best, and provided with the necessary support and resources, health promotion departments are good at operationalising strategy in a way that is true to a broad model of health and how it is created. Similarly, they can provide invaluable insights from communities and partner organisations to strengthen strategy development and ensure it reflects a broad spectrum of operational realities.

- There are a number of distinct features of how health promotion staff go about their work. Many are extremely innovative and creative – and thrive on finding new approaches to address long-standing challenges. Others are particularly skilled as 'change agents', and at helping people in different roles and organisations see what they can do to improve health. Others work very strongly on a community development model, supporting local people in identifying and addressing issues of particular importance to themselves and their communities (which may or may not be issues of priority to the Board). Perhaps common to the many ways of working in health promotion is an emphasis on challenging a traditional, NHS-owned, approach to addressing health issues.

- In doing this, health promotion staff should remain true to the guiding principles of health promotion, as set out in the WHO strategy for Health for All (WHO 1981), which remain as relevant today as they did when they were originally stated 20 years ago. There are also strong theoretical and evidence bases for much health promotion activity (including methodologies for behaviour change, peer education, social marketing, partnership working), and specific interventions (like smoking cessation, exercise referral, and breastfeeding support). Health promotion staff should be well versed in these.

3 Developing the Health Promotion Workforce

3.1 The consultation has highlighted a striking lack of agreed core competencies or standards for health promotion in Scotland. Whilst the diversity of skills and perspectives brought by health promotion staff is recognised as a strength, the variations in what staff can and do offer is certainly problematic. Health promotion staff are often not sure what is expected of them and partners are not sure what they can expect to receive from health promotion. There is variation both within and across departments. There is also a lack of an agreed career structure and often little opportunity for progression.

3.2 Health promotion specialists in our consultation placed considerable emphasis on their strategic roles and contributions – emphasising these over their more operational delivery roles. Reasons for this include that strategic jobs are more senior and better reimbursed, and that if working in a small department there is not enough person power to do a lot of programme delivery.

3.3 Furthermore, the relationship between health promotion and other NHS functions is not clear. Particular issues arise in relation to the role of the new LHCC-based public health practitioners, the public health role of nurses more generally (particularly health visitors and school nurses), and relationships with departments of public health in NHS Boards. To some extent these issues reflect historical relationships and difficulties, but perhaps more significantly they reflect the conflicting ideologies and power bases at play within the NHS family.

3.4 The variations mentioned above, combined with the need to have a clear fit with other health promoting roles, leads to a requirement for the basic health promotion competencies to be further described. **We recommend** that health promotion managers and HEBS draw upon existing UK standards to describe the basic competencies that are needed to practice in health promotion and which clarify the specialist health promotion role. This work needs to be carried out in the context of UK developments in this area. It should acknowledge the current climate of an integrated, multi-disciplinary workforce, all aspects of which contribute to health improvement. In particular the outcome of such work would place others' health promoting roles (including the public health practitioners in LHCCs) into context. To ensure a fit with other public health workforce developments in the health improvement community, focus should also be directed to the health improvement posts in local authorities.

3.5 Given the scale of the health improvement challenges and the variations in existing health promotion practice it is important to recognise the need for active professional development within local health promotion departments. **We recommend** that health promotion managers, working through local structures for professional development and with HEBS, remain focused on keeping the health promotion orientation alive through championing health promotion values, ongoing review and development of the practice and competencies of their staff, and active contribution to health promotion networks.

3.6 The lack of clarity about the health promotion role, and the absence of any minimum standards, should be addressed and we have recommended (see 3.4) that this takes place. There is a tension here, though, between those who are looking for a professional development model for health promotion and those who are looking for an integrative model.

3.7 The professional development model would lead to the establishment of the health promotion workforce as a distinct entity, defined in terms of a discrete body of knowledge and skills, with associated qualifications and standards specific to health promotion. Work has been progressed in the past by the Care Sector Consortium (1997) to develop and establish occupational standards for health promotion. Indeed these have been piloted in Scotland, and several departments use some version of standards/competencies as a basis for staff development. However, there has been no common acceptance of a particular set of standards.

3.8 An integrative model, on the other hand, would locate the health promotion effort within the context of a broader effort to improve health – with the associated definition of theory, skills, knowledge, standards and so on, being related to that broader effort. The Healthwork UK (now Skills for Health) initiative to develop occupational standards for specialist practice in public health has produced a common definition of the key functions involved in public health (see Appendix 2). Within Scotland, this work is embedded within the drive to involve, and where appropriate integrate, a range of agencies and disciplines in the public health effort. The aim is to create a flexible public health workforce, in which movement between posts and levels is facilitated and new types of posts can be introduced. It is intended that the Healthwork UK occupational standards will provide a template for relating posts and ensuring that specialist staff, no matter what their professional background, have accreditation and revalidation standards. That said, the issues of equity between medical and non-medical staff (and of power, status and career opportunity) remain a fundamental problem, which will not be resolved simply through the introduction of common standards.

3.9 We seem to be faced with a choice, therefore, between investing effort in developing standards for the health promotion workforce or investing in the development of a multi-disciplinary public health workforce involving different disciplines but all working to common standards. The consultation process yielded no clear consensus on which of these routes would be preferable.

3.10 It is our strong view, however, that the resolution lies with integration (i.e. the creation of a truly multi-disciplinary public health workforce) whilst at the same time investing in the development of the wide range of public health values and perspectives. The tangible representation of this would be the operation of well-integrated multi-disciplinary public health workforces[2] (both locally and nationally), in which the different disciplines are strong and their perspectives distinct and equally valued.

3.11 Issues about the quality, usefulness and usage of the evidence base for health promotion also arose as an ongoing theme of the consultation process. Health promotion specialists felt they had strengths in being reflective practitioners, being at ease with qualitative and quantitative data, and in valuing monitoring and evaluation processes. That said, there are unresolved debates about 'what counts as evidence?' and indeed fundamental differences of opinion as to whether there is a strong applied evidence base for health promotion or whether this is actually fairly weak.

3.12 It was not the purpose of the consultation process to review the evidence for health promotion, or to make an assessment of its quality. However, in the context of our aim to maximise the health promotion contribution to health improvement in Scotland, we

[2] The issue was raised as to why the health promotion workforce should ally itself to NHS-based integration along the Healthwork UK model, given that health promotion stands significantly for partnership, tackling the broader determinants of health and community development. It is our view that the development of inclusion of health promotion as an integral part of a broad public health workforce is an important tactical move, which reflects the current direction of travel of NHSScotland and recognises the supporting policy context.

were certainly concerned with issues about the use of evidence, access to evidence and ongoing research and evaluation of health promotion practice. An ability to use and add to the health promotion evidence base should certainly be a core competency of health promotion specialists. In addition, a strengthening of the national focus for developing and disseminating the evidence base and for supporting health promotion research is needed. **We recommend** that the new health improvement organisation, together with other key stakeholders in Scotland, should explore the strengthening of national mechanisms for building the health improvement evidence base, and for using and sharing the existing evidence base more widely.

4 National and Local Health Improvement Efforts

4.1 Another powerful theme that emerged from the consultation process concerned the relationship between work at the national level and more local working and the need to strengthen their combined effectiveness. Government policy currently places great weight on the importance of locating the health improvement effort within local communities. Specific examples include the public health role given to LHCCs; the establishment of Healthy Living Centres; the investment made in, and importance placed on, Social Inclusion Partnerships; and the establishment of Community Planning as the key process for securing co-ordinated improvements to the quality of life of local communities. Funding processes similarly emphasise the importance of finding local approaches to address health improvement challenges (for example through the Health Improvement Fund). The community development approaches that are integral to local health promotion efforts, together with the networks and partnerships that involve community representation, are fundamental to the effective delivery of these initiatives. Health promotion staff, therefore, usually play a key role in developing proposals, securing funding and ensuring delivery.

4.2 However, in terms of improving Scotland's poor health, this set of approaches is, of itself, inadequate. There are several reasons for this, but three seem particularly pertinent in relation to our considerations of health promotion.

- First, the identification of priorities on a very local basis – and particularly if led by communities – does not yield an adequately comprehensive and coherent health improvement strategy. In particular, major public health issues which are not 'visible' in communities (for example immunisation and sexually transmitted infections) and, contrastingly, those which are embedded within the culture of the community (for example cigarette smoking and men's health issues) are rarely addressed through community-led approaches.
- Second, community development without associated processes of organisational development is set to be ineffective. Organisations need to be clear about what their community development processes are seeking to contribute as part of an overall health improvement strategy. They then need to be willing to delegate power and responsibility for the achievement of this contribution to the communities and those working with them. These processes of role clarification and delegation of power and responsibility need to happen consciously and systematically within organisations and be supported by changes in staff behaviour.
- Third, as already discussed in Section 1.3, where a concerted national effort is required to address major national health improvement priorities there is a lack of clarity over how leadership and delivery is exercised. While consultees expressed the need for a greater understanding of the roles of HEBS and PHIS in particular, there is also a similar need for clarity and understanding of the roles of COSLA, ISD (Information and Statistics Division) and SCIEH (Scottish Centre for Infection and Environmental Health)

in order to maximise the scope for health improvement at a national level. Such organisations also have the requirement for local-national cohesion.

4.3 We would reiterate then that there is real need for greater national-local cohesion. This would be demonstrated through clarity of roles in national organisations and through clear, transparent processes for setting priorities at local and national levels.

5 Looking to the Future

5.1 A major component of the consultation process involved consideration of the issues external to health promotion which are likely to influence health promotion practice in the future. In doing this, the complexity and changing nature of the structures, environment and challenges for health improvement in Scotland became apparent. In considering these issues, we wanted to make sure that our recommendations would not only reflect the experiences of the 1990s, but would deliver an effective health promotion contribution for the 21st century.

5.2 That said, no clear view of what the future might hold emerged. Nor was there scope to consider what an optimal health promotion service for the 21st century might look like. The best we can do at present, therefore, is to ensure that we are equipped to address our current agenda effectively, and are well placed to respond to future changes and challenges.

5.3 **Our final recommendation**, however, is that the new health improvement organisation should lead a scenario-planning exercise which looks at models of health improvement, including those adopted in other countries, and builds on these to develop proposals suited to 21st century Scotland. In this way, we will help to shape the future.

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Standards for specialist practice in public health

AREA OF SPECIALIST PUBLIC HEALTH PRACTICE	SUB AREAS
1. Surveillance and assessment of the population's health and well-being	1.1 Manage, analyse, interpret and communicate information, knowledge and statistics about health and well-being 1.2 Manage, analyse, interpret and communicate information, knowledge and statistics about needs and outcomes of health and well-being
2. Promoting and protecting the population's health and well-being	2.1 Plan, implement, monitor and evaluate strategies for promoting the health and well-being of the population 2.2 Plan, implement, monitor and evaluate disease prevention and screening programmes to improve the population's health and well-being 2.3 Plan, implement, monitor and evaluate strategies for protecting the health and well-being of the population
3. Developing quality and risk management within an evaluative culture	3.1 Assess risks to the population's health and well-being and apply this to practice 3.2 Assess the evidence and impact of health and healthcare services and interventions and apply the assessments to practice 3.3 Improve the quality of health and healthcare services and interventions through audit and evaluation
4. Collaborative working for health and well-being	4.1 Develop and sustain cross-sectoral collaborative working for health and well-being 4.2 Advise others on health and well-being, related issues and their impact 4.3 Communicate effectively with the public and others about improving the health and well-being of the population
5. Developing health programmes and services and reducing inequalities	5.1 Enable inequalities in health and well-being to be reduced through planning and targeting services and programmes 5.2 Plan, implement, monitor and evaluate programmes and services to address health and well-being needs

AREA OF SPECIALIST PUBLIC HEALTH PRACTICE	SUB AREAS
6. Policy and strategy development and implementation to improve health and well-being	6.1 Shape and influence the development of policies to improve health and well-being and reduce inequalities 6.2 Implement strategies for putting policies to improve health and well-being into effect 6.3 Assess the impact of policies on health and well-being
7. Working with and for communities to improve health and well-being	7.1 Involve communities as active partners in all aspects of improving health and well-being 7.2 Empower communities to improve their own health and well-being 7.3 Enable communities to develop their capacity to advocate for health and well-being
8. Strategic leadership for health and well-being	8.1 Develop, sustain and implement a vision and objectives for improving health and well-being 8.2 Lead teams and individuals to improve health and well-being 8.3 Develop capacity and capability to improve health and well-being
9. Research and development to improve health and well-being	9.1 Appraise, plan and manage research related to improving health and well-being 9.2 Interpret research findings and implement them in practice
10. Ethically managing self, people and resources to improve health and well-being	10.1 Manage the development and direction of work 10.2 Manage services that are aimed at improving health and well-being

(National Standards for Specialist Practice in Public Health: An Overview – approved Draft, Healthwork UK 2001)