ScotPHN report

NEW WAYS OF WORKING:

DEVELOPING PUBLIC HEALTH FUNCTION STANDARDS FOR SCOTLAND: EMERGING THEMES AND PROSPECTS

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1 Introduction

We set standards in health and healthcare to be able to ensure that patients and the wider population receive services which are of high quality, are effective, and are safe. They provide a way in which the assurance or governance of services and their providers can be carried forward in a robust and transparent manner.

However, setting standards for the business of health and healthcare has become something of an industry. In recent years standards have been set for educational attainment, professional competence, occupational definition, service quality, scope and effectiveness, individual clinical practice, team clinical practice, service (re)configuration, and workforce planning to name just a few. Essentially standards are set to provide a benchmark against which the presence or performance of an individual, team or service can be assessed to be operating at some pre-determined level of acceptability.

Standards sets fall into four broad categories. Standards which apply to the:

- individual health or healthcare worker / professional;
- the composition and function of service teams;
- the scope and performance of service activities; or
- the outcomes associated with service delivery.

In the real work these categories are not independent and there are clear inter-relationships. The presence of a specialist nurse in a clinical team may relate to both professional nursing standards that permit nurse to be employed in a particular role, and to standards for the composition of the specialist team. However, whilst standards may be recognised as being related to one another other, it is usually the case that the sets of standards themselves remain independent and are assessed independently. Thus a nursing professional standard will be considered independently of a service team composition standard. This independence of standards can be a source of uncertainty. For example, it is not impossible to imagine circumstances when a professional standard of competence is achieved on the part of an individual who is working in a service that is considered to be sub-standard.

Meeting a required standard generally means that the individual, service or outcome has attained an agreed threshold / level. In other words the standard has been “met”. Such threshold standards have their use, especially when related to individuals. However, in more complex situations, it can be difficult to be categorical that a standard has been met. In such circumstances it has become customary to establish ways of or determining if the standard is “fully met”, “partially met” or “not met”. Such gradation can be useful to highlight where progress has been achieved, but which

remains short of the standard having been met. Clearly such approaches remain somewhat subjective and only of use within the specific circumstance applied.

2 Standards for Specialist Public Health Practice

2.1 The United Kingdom

In the UK, the focus of standard setting for specialist public health practice has tended to focus on the individual professional and the team in which they work. In part this reflects the early work on professional quality assurance led by the Faculty of Public Health in setting educational standards for professional training[1] and setting the standards for continuing professional development and the revalidation of its members[2] . This approach to accrediting the individual has been followed by other professional bodies, notably the United Kingdom Public Health Register[3], the Nursing and Midwifery Council[4], and the UK Faculty of Dental Surgery.[5] Most recently the Royal Pharmaceutical Society launched its professional standards for public health practice[6] and work on public health practitioner standards are being developed in other professional organisational and agencies. Standards for effective public health teams have also been discussed in the UK, though only one formal statement seems to have been drafted by the Faculty of Public Health.[7] This document, which considers standards for effective public health team practice across the three domains of public health, also seeks to determine a minimum standard for minimum team scope / membership. More recently the FPH has set out a description of the Local Public Health Function, aimed at specifying the scope of public health service within the context of English Local Authorities.[8] However, it is specifically

[1] See: http://www.fph.org.uk/training.

[2] See: http://www.fph.org.uk/professional_standards

[3] See: http://www.publichealthregister.org.uk/specialist

[4] See: http://www.nmc-uk.org/Documents/NMC-Publications/NMC-Standards-of-proficiency-for-specialist-communicty-public-health-nurses.pdf

[5] See: http://www.rcseng.ac.uk/fds/jcptd/higher-specialist-training/higher-specialist-training-docs#dental-public-health

[6] See: http://www.rpharms.com/unsecure-support-resources/professional-standards-for-public-health.asp?

[7] See: http://www.fph.org.uk/uploads/Public%20health%20teams%20%20resourcing%20Draft%2010%20-%20Jan2012%20(2).pdf

[8] See: http://www.fph.org.uk/uploads/Functions%20of%20the%20local%20PH%20system%20FINAL%20200514.pdf

noted that these are not to be seen as standards, rather simple descriptions of the functions. One final initiative worth commenting on is the proposal to develop a set of Health Protection Standards as part of the implementation of the Scottish Health Protection Stocktake. At this time it is unclear if these will form a formal service standard set or be a description of functions carried out at differing nodes of the obligate network.

In the case of professional standards, the standards focus on both knowledge and practice delivery. These are usually externally assessed in a range of ways, linked to, but not assessed on the basis of, reflective practice. No formal approach to assessing standard attainment was specified for the FPH team standards.

2.2 The United States and Europe

Outside of the UK, the focus for public health standards has been more on the effectiveness of public health services provided. Whether this primarily reflects the different configuration of "public health" provision or the absence of professional public health specialty training / credentialing, standard sets from the US and from Europe focus on the characteristics of services which are meeting public health needs.

In the United States of America, standards for the effective delivery of public health services were initially developed by the National Association of County and City Health Officials and further developed by the US Centers for Disease Control (NACCHO/CDC) as a way of assessing the performance of public health departments in delivering service outcomes at county and state level. These were subsequently developed by the Public Health Accreditation Board (PHAB) as a means of accrediting public health systems in cities, counties and on a state-wide basis. The PHAB standards[9] are designed to be used by a public health system as a means of self-assessment, based on documentary evidence. These self-assessments are then appraised by a visiting panel which accredits the public health system over a seven stage process.

In Europe, the WHO has adopted a set of what has been termed Essential Public Health Operations (EPHO) standards has been developed by a team of academics. The EPHO standard set[10] describes ten core areas where national health systems need to ensure effective capacity to deliver public health for their populations. These standards, which are described in terms of service outcomes, have been used for an

[9] See: http://www.phaboard.org/accreditation-process/public-health-department-standards-and-measures/

[10] See: http://www.euro.who.int/__data/assets/pdf_file/0007/152683/e95877.pdf

independent analysis of the public health capacity in European nation states, based on documentary analysis augmented by secondary evidence gathering.

2.3 Convergence

Whilst the standard sets noted here are diverse, there are a number of areas of convergence. This is most noticeable in the almost universal adoption of the 10 key areas for specialist public health practice / service. These remain constant across both individual and service based standard sets.

There is also a high degree of convergence on the need for external confirmation that a standard has been reached. However, the form of external confirmation differs from standard set to standard set.

One clear area of divergence is in the focus for the standards. Those which focus on individuals tend to look to establish knowledge and personal practice competencies as the standards. Service standards focus on the outputs from the service in terms of what it can deliver.

3 Why Standards for Public Health Functions in Scotland?

As part of the Scottish Directors of Public Health (SDsPH) / Scottish Public Health Network (ScotPHN) New Ways of Working initiative, it was determined that standards for the Public Health Function in Scotland would be desirable. In part this was seen as a logical extension of the work which had been historically undertaken in the occasional reviews of Public Health; however a number of specific issues became apparent suggesting a more timely development of standards. These can be summarised as the need to be able:

- to describe the capacity of a local public health function to delivery services on an everyday basis, those services which it will do at request or to meet an urgent need; and those which it can do, if specifically required and allowed to refocus resources to allow delivery;
- for a shared language in which to describe the delivery of the core public health function within and between health board areas and with differing approaches to public health service delivery;
- to have a mechanism for the quality assurance of distributed service configurations across local agencies or for formal collaboration across geographical or agency boundaries;
- to complete workforce reviews and service developments within a specific public health function in a manner which can be understood in the context of a the wider, core public health function; and

- to ensure that it is the public health function which is at the appropriate standard / is a competent service, rather than a continued reliance on the competent professional.

On the basis of these needs, it was recognised that the necessary development base for these public health function standards in Scotland was most likely to be the type of service standards developed in the US and for WHO Europe.

It was also agreed that this work would seek to explore the transferability of existing standards sets into the Scottish public health context rather than seek to redefine a new set of standards.

The approach was also recently discussed at a meeting on service standards and considered to be a useful “test-bed” for such an approach on other parts of the UK.

4 The Scottish Pilots

4.1 Using standards for workforce review

Whilst not technically part of the pilots, two NHS Boards in Scotland used the NACCHO/CDC standards to explore workforce development. These pilots generally used the standards as a means of describing the existing workforce deployment and consider how to reallocate work areas and fill gaps.

In NHS Greater Glasgow & Clyde, a form of the standards to help structure and inform a workforce review across public health and health improvement workforces. NHS Grampian used the earlier standards to review the overall balance of work within the Public Health Directorates across the domains of public health. In each case, they were used to highlight gaps and the relative capacity of the specialist workforce within and between domains. In NHS Grampian, they have been used in subsequent years to audit the overall Directorate workforce capacity to delivery annual work programmes.

Formal reports on these uses do not exist, but verbal feedback suggests that these approaches helped structure discussions and helped provide a focus for exploring solutions. However, in all cases there were reservations from some public health staff as to the desirability of such approaches to professional working. As a result of these reservations, the identity of the two NHS Boards has been removed and they are referred to as simple NHS A and NHS B.

4.2 Using standards for service specification & reconfiguration: self-assessment

NHS A used the NACCHO/CDC standard set to formally describe their existing public health function across the three public health teams, reflecting the three domains of public health. They then used the outputs from the process to develop a plan for reconfiguring the public health teams within their public health system.

The Directorate used a rapid self-assessment process to define their service outputs in terms of whether the service standards was “fully met”; “partially met” or “not met”. They could also describe an area as not within their area of responsibility. Teams were given three hours to complete this task. The outputs from this rapid self-assessment were subject to external review by a visiting team of public health experts. The visitors sought to confirm the accuracy of the self-assessment (how accurate was the final description) and to seek views on the overall processes.

It was generally found that whilst the rapid self-assessment approach was not a comfortable experience, the accuracy of the assessment itself was high. The teams found it relatively straight-forward to describe what service areas were covered, but were uncomfortable with the self-assessment of how far the standard was being achieved. They were also deeply concerned about how the findings from the self-assessment would be used by others. This despite continued reassurances that the findings would remain confidential within the Directorate.

Subsequently the self-assessment was used by the DPH and the top management team to redefine work portfolios as changes in consultant staffing allowed gaps to be filled. Job planning was used as a means of negotiating more specific changes in work portfolios over time.

When last assessed, the DPH noted that the self-assessment had allowed the Directorate to be refocused and the work load rebalanced across the domains of public health. As a consequence, healthcare public health was strengthened, health improvement delivery was streamlined and a revised skill-mix agreed within health protection.

4.3 Using standards for service accreditation: evidencing / documenting a self-assessment

NHS B pilot exercise set out to describe:

- the work encompassed by a general Public Health Directorate;
- the levels at which the service is delivered (local, regional, national, or a combination of these);
- the collaborations with other services and organisations that exist for the purposes of public health delivery; and

- the impact of the public health contribution.

To meet the above objectives, NHS B used an adapted ("tartanised") version of the PHAB standard set, selecting the three domains from the PHAB standards which aligned most closely to the core work of the NHS B Public Health Directorate. These were: health protection; health improvement; and access to healthcare services. Specialist Public Health and Health Improvement staff worked in small teams to compile an evidence log of the key work-streams that mapped to the standards in each of the chosen domains. The process was externally peer-reviewed through ScotPHN.

To keep the workload manageable, the approach taken in NHS B aimed to be illustrative rather than comprehensive. Public health staff were asked to nominate work-streams where their contribution was felt to be essential (the work could not proceed or would be much reduced without public health input) and then to consider the work against the relevant standards. What emerged were a series of worked examples that covered the main roles carried out in the department and that were indicative of the totality of the work that is carried out even if the list of items included was far from exhaustive. The outputs did not cover work-streams where the public health contribution is more *ad hoc*, of an advisory nature, intermittent, semi-dormant and it ignores the potential for serendipity and opportunism in public health delivery. Summary papers were derived from the detailed evidence logs that describe the core public health roles in each piece of work, the actual or expected public health benefits from the work and the actual or expected benefits to the organisation (mainly NHS B or NHS Scotland).

Generally it was found that it was feasible to provide evidence of work-streams that showed how the service standard was being met. However it was found that its takes considerable time and effort to produce this sort of high-level statement. Over the period of the pilot, the local team started to recognise that the importance of such a statement is underlined by the challenge in maintaining the visibility of the specialist public health function in the context of input across a range of professionals and agencies operating at different levels (local, regional and national). This is especially so when such work is often being carried forward with long timescales before objectives are realised in a meaningful and measurable way. This high-level statement may be considered a form of "soft knowledge" that many public health professionals carry around in their heads in any case; however the advantage of being explicit is that organisational and partner agency blind spots to the public health specialist contribution can be addressed and even transcended to the benefit of productive partnership working and effective public health delivery.

4.4 Using standards to describe national public health services to others

As part of its most recent External Audit, ScotPHN used the EPHO standard set as a means of describing its functions to the key stakeholders which were interviewed by the independent, external audit team. The standard set was edited down to those essential public health operations that ScotPHN wholly undertook on behalf of the public health functions nationally, and those to which is contributed. As such, this version of the EPHO standards could be considered as a description of the ScotPHN service.

The independent external auditors used this service description to explore which stakeholders what they understood to be the work of ScotPHN, what was essential as far as the stakeholder was concerned and what was unnecessary.

The general themes from this pilot suggest that:

- unless an individual is fully familiar with scope and breadth of public health services, using standard sets to describe a specific public health organisation is difficult and may be a barrier to understanding and not an aid;
- whilst the EPHO can describe – at the level of a national government – the public health services provided; it is less easy to use when describing the types of inter-agency collaborations that actually comprise service delivery; and
- most stakeholder's views of public health were "transactional" – in that it was based on a personal experience of what public health professionals and services were doing for them and their organisations, at the level at which the EPHO are set, such transactions are somewhat removed from the service outcomes described.

Overall, it was felt that the EPHO was of better in considering high level outcomes and not in relation to the specific activities of an agency or organisation, even one with national responsibilities.

5 Emerging Themes

5.1 Translating standard sets

The most striking theme to emerge from these pilots is the relative ease with which the NACCHO/CDC standard set or the PHAB standard sets can be translated into the Scottish public health context. The degree of amendment to fit local circumstances is very low (especially in the PHAB standard set) and the recognition of service standard statements by Scottish public health professionals is high. This was not the case for the EPHO standard set where the translation process for

Scotland was considerably higher and the recognition of service standard statements lower.

5.2 Describing public health functions

Using standards sets to describe public health functions, both locally and for different levels in the regional and national systems was possible. Using them to describe collaborations is also possible – provided that there is documentary evidence to support service description. Certainly the findings from the NHS B pilot provide a rich analysis of the work being undertaken in the three core service areas considered. (See annex)

Regardless of variations in the make-up and priorities of individual public health services and departments, the application of the PHAB standards can help to focus attention on the effective specialist public health function and effective public health service delivery through the combined efforts of a range of professionals and agencies.

However, whilst public health professionals can and will use such standards based approaches, they are uncomfortable with how they may be used, especially in times of increased efficiency requirements and the mentality of “do more, for less resource”.

5.3 Building public health professional solidarity

The external review process in NHS A and the development of an explicit high-level statement in NHS B was found to encourage a celebration and recognition of the specialist public health contribution across a range of themes and work programmes. It was felt that such approaches can help public health professionals to stay united in the face of challenges that emerge. Where budget cuts are necessary and agreed, public health staff can be explicit in describing the work outputs and contribution that will be lost or reduced in volume/value as a result. The approach also enables specialist public health functions to explicitly plan their work in a way that takes account of shared professional values and goals, particularly where these overlap with the goals of the wider NHS, Government policy and the priorities of partners.

5.4 Self-assessment and Peer-Review

Whilst NHS A was reassured of the accuracy of its rapid self-assessment process through its external review, and the benefits of the explicit high-level statement are well understood and appreciated in NHS B, neither pilot progressed to a formal peer

review. In developing the NHS B high-level statement, the input from ScotPHN as an external peer was helpful. In particular this helped with ensuring the consideration of all the relevant aspects of a rounded specialist public health function and supporting the consistent application of the standards across different work-streams and domains of specialist public health delivery.

However, it must be recognised that whilst progressing onto a formal or informal peer-review would have meant additional work, the risk of a loss of focus on the exercise, and the risk that gaming behaviour could be encouraged. The PHAB accreditation merely indicates that satisfactory attainment of the standards suggests that a public health service is likely to be doing more good than harm. Therefore the return on the additional time needed for a peer-review may be open to question. There is a need to be sure that taking this additional step is meeting a specific purpose, rather than simply an expected “next step” in a process.

5.5 Practicalities

Three very clear learning points emerged from the pilots:

1. A local lead person is needed to oversee and co-ordinate any attempt at applying standards to the work of a specialist public health department. This ensures that actions are assigned appropriately, completed, monitored and that the most uniform interpretation of the standards that is possible applies across the work of the department.

2. Care is needed to ensure that the whole workforce which is to be encompassed by the process has been involved in the set up process, have agreed any necessary ground-rules and are clear about ownership of outputs from the standards review.

3. The standards selected must be considered as core and integral to the work of the directorate and the overall purpose of the exercise clarified; either to produce a high-level statement or to progress on to a formal or informal peer-review against the standards’ criteria.

6 Prospects

The existing pilots have established the feasibility of adopting the PHAB standards in Scotland as the basis for a set of public health function standards.

For both NHS A and NHS B the outputs from their pilots were internally useful for planning the local directorate workplan, for addressing organisational blind spots to the public health contribution, and to foster more effective partnership working.

More widely NHS B is part of a three NHS Board audit process, an ideal forum for some detailed consideration of local practices and priorities in the context of the values and attitudes that are held across the wider profession. A proposal to extend this pilot across the three NHS Boards is being considered at present and could be a first step towards the wider application of these standards across the Scottish public health community.

The wider application of service level public health standards could lead to a call for the development of quality indicators for specialist public health practice. Some reliable progress markers or indicators would need to be developed that are known to relate to effective public health delivery in a complex operating environment – at present these do not exist. A possible pitfall with any type of regular formal or informal assessment is the danger of a gaming culture emerging; where the assessment process in itself starts to become a key driver of the behaviours and practices of individual practitioners, teams and services.

Revalidation of public health medical professionals is already underway and this approach to appraisal and assurance at individual practitioner level is expected to be applied more widely across the public health workforce in the future. Explanation of the specialist public health role to an appraiser from another discipline could be challenging but a measure of explicitness may help public health staff with getting genuine benefit from the time spent on the revalidation process.

7 Recommendations

It is recommended that:

1. an agreed set of PHAB based standards for use by public health functions in Scotland is now developed for further refinement in practice. Ideally these should also provide the basis for the development of the Health Protection Standards being proposed as part of the obligate Health Protection Network;

2. ScotPHN communicate the outputs, insights and potential applications of the NHS A and NHS B pilots and other pilot work extensively across the Scottish Public Health community and encourage other public health teams and services to consider some of their work-streams against the relevant domains of the PHAB standards to inform recommendation 1;

3. SDsPH encourage the participation of other Public Health Directorates in the three NHS Board audit process to pilot the peer-review of the standards and engage external sharing of findings, discussion and reflection within the confines of the audit process; and

4. the overall usefulness of the pilot outputs as a mapping tool and in the development of high-level statements should be fully explored and exploited to allow a careful consideration of their use in the context of a formal or informal peer-review to be undertaken.

Annex 1: NHS B service description high-level summaries

The health services summary paper describes a range of leadership and co-ordination/facilitation roles that are carried out by senior public health staff across a range of topic areas. Progress is reported against many public health challenges such as quantifying and addressing unmet need; identifying and addressing social, cultural and physical barriers to accessing care services; and earlier detection of illness to facilitate earlier intervention. Progress is also reported on a number of organisational priorities such as budget control, developing staff competence, managing reactive demand for healthcare, and progress against key Scottish Government targets.

The health protection summary paper describes a number of proactive roles that contribute to surveillance and improved understanding of illness patterns in the population, that contribute to improved preparedness, and that offer some assurance in relation to specific identified threats to public health. Some staff members are also heavily involved in more reactive work to manage incidents and threats in order to mitigate their impact. The main public health benefits are described in terms of limiting the spread of preventable illness and death in the community and developing the workforce capacity and capability to respond to future threats. The main organisational benefits are described in terms of defending and supporting the reputation of NHS B, NHS Scotland and potentially other agencies in the media and in the eyes of the public; along with the assurance that comes from the fail-safes and other measures that help to better co-ordinate the efforts of all agencies in managing identified threats to public health.

The health improvement summary paper describes the leadership role that senior staff take on in order to steer and co-ordinate the efforts of all relevant agencies towards specific health improvement goals. There is also a key operational and support role for other health improvement staff in ensuring that actual delivery is aligned to strategic objectives, to feedback on progress, and to ensure that the strategy is appropriately revised in accordance with the emergent challenges and opportunities.

8 Appendices – Domains 2, 5 and 7

Domain two: Investigate health problems and environmental public health hazards to protect the community

Standard 2.1: Conduct timely investigations of health problems and environmental public health hazards

The purpose of this standard is to assess the department's ability to conduct investigations consistently, to review practice against standard procedures, and to ensure a co-ordinated approach across the different services and agencies involved in the investigations. The focus seems to be more on the availability of written processes rather than on their execution.

Types of evidence (evidence that pre-dates April 2008 should not be included)

- **Protocols for recording and managing notifiable diseases and other public health hazards identified**
- **Processes for peer review and audit**
- **Processes to develop and monitor partnership working with other agencies**
- **If link from evidence to standard is not obvious then explain it in one or two sentences**

Rationale for this area of public health work

Standards procedures, assigned roles and responsibilities, and well-thought out co-ordination are necessary to ensure a timely response and thorough investigation in to the cause of a public health problem so that further disease and illness can be prevented.

Area of work	Summary of evidence log	Comments	Public health value	Organisational benefit
Joint Health Protection Plan (JHPP)	JHPP describes the key roles for all agencies in the area in managing incidents	If all agencies sign up to it then its contents are part of the workplan for each agency (NHS, LA, others).	Helps to develop partnership working. Consistency of process	Scottish Government requirement
Recording of notifiable illnesses	SOP has been developed	This is largely a support staff role.	Surveillance of health and illness patterns	Meets a legal requirement
Checklists to help with managing common notifications	Checklists available for common reported illnesses.	CPHM role to develop and review checklists – CPHM and HPNs use the checklists.	Fewer people get ill Fewer deaths Consistent process	Reputation (manage media coverage) Manage demand for healthcare

Control of infection manual	This has been developed and gets reviewed and updated by the Health Protection Team	Roles are carried out by HAI staff, clinical staff, and care home staff. How do we monitor compliance?	Prevent illness in vulnerable people Fewer deaths Consistent process	Reputation (manage media coverage) Manage demand for healthcare
Questionnaire for GI outbreaks or incidents	Questionnaire developed, reviewed and updated by Health Protection Team	Questionnaire used by EHOs, CPHMs and HP Nurses. How do we monitor compliance?	Prevent illness Fewer deaths Consistent process	Reputation (manage media coverage) Manage demand for healthcare
Contingency plans	Pandemic influenza preparedness plan (PIPG) Waterborne Hazards Plan (WHP)	PIPG development, review and updating along with relevant exercises are led by the Health Protection Team. HPT contribute to the WHP, which is led by Scottish Water.	More likely to respond effectively to a pandemic or major water incident leading to fewer people getting ill or dying.	Scottish Government requirement Reputation (less likely to have negative media coverage of response to a major incident)
Specific audits	Large outbreak reports, investigation reports, SBAR reports on untoward incidents, and routine audits of HP practice.	CPHMs produce reports that cover lessons learned and other issues that help to improve service quality	Continuous quality improvement in the response to health protection incidents.	Workforce competence Aids communication across the organisation on major health protection issues.
SHPIR and other national guidelines for more rare incidents (usually developed by Health Protection Scotland).	For rare incidents it is appropriate that guidance is developed and reviewed at national level.	HPS might lead these processes but what input do NHSB staff have. How do we know how well we apply these resources locally?	Prevent illness Fewer deaths	Reputation Manage demand for healthcare Staff competence enhanced

Comments on standard 2.1 – There is a need to clarify the CPHM role (lead development and review of JHPP and other major documents, manage complex incidents, develop procedures and review these for HPNs and support staff), the HPN role (manage incidents) and the support staff role (log incidents, maintain databases etc).

Standard 2.2: Contain/mitigate health problems and environmental public health hazards
This standard is more about the procedures that enable effective response and containment of a threat. It is more about the live operations whereas the previous standard 2.1 was more about the protocols being developed in the first place.

Types of evidence (evidence that pre-dates April 2008 should not be included)

- **Protocols to manage incidents (outbreaks and environmental incidents)**
- **After Actions Reports (AARs)**

Rationale for this area of public health work - This standard seeks to assess the ability of the PH department to respond to information about a public health hazard and to contain it

Area of work	Summary of evidence log	Comments	Public health value	Organisational benefit
Health Protection Manual	The HP Manual provides updates on live HP incidents and with links to support resources across a wide range of topics	The HPT have led the development, review and updating of the HP manual.	Consistency of process Fewer people get ill Fewer deaths	Reputation (manage media coverage of HP incidents)
HP risks entered on DATIX	Risks are described, scored and management plans have all been put on DATIX and these are reviewed at the PHWP group.	The HPT update and review their own risks. The wider risk process is led by a non-health protection CPHM.		Proactive management of prioritised risk areas - this is an organisational priority
CPHM day rota and sub-specialist roles for health protection CPHMs	Systematic approach to managing all new incidents. The response may be led by a CPHM with particular expertise, if it relates to an existing major work programme.	HP nurses log all new incidents and discuss management with the CPHM on duty. A CPHM with prior expertise in an area may take over the management of a particular incident as relevant.	Less illness Fewer deaths	Reputation – manage media coverage Manage demand for healthcare
Database of blue form incidents and weekly monitoring	Weekly emails from support staff with a summary of that week's activities.	This is largely a support staff role.	Surveillance for patterns of health and illness	Intelligence gathering

Standard 2.3 – Capacity to investigate and contain public health problems and threats – this standard focuses on capacity and therefore the emphasis will be on number of staff, staff training and competence, and the design of rotas.

Types of evidence (evidence that pre-dates April 2008 should not be included)

- **List Health Protection Team staff and support resource**
- **Surge capacity process (NHS B staff and mutual aid with other boards)**
- **Joint exercises with other boards and agencies**
- **If link between evidence and standard is not obvious then briefly explain it (one or two sentences)**

Rationale for this area of public health work

Good access to laboratory testing and epidemiological advice can determine the capacity of a HPT to respond rapidly to a public health threat, investigate it and act effectively.

Area of work	Evidence Log	Comments	Public Health value	Organisational benefit
NHS B 24/7 response	Daytime and out of hours CPHM rota.	There will always be at least one CPHM available to respond to a particular incident 24 hours a day, seven days per week.	Fewer people become ill Fewer deaths	Reputation (manage media coverage on the front foot)
Major emergency plan (MEP)	HPT maintain the NHS B Major Emergency Plan contacts list	Emergency Planning Officer manages the NHS B contacts list for the MEP		Preparedness
Surge capacity among public health staff	Public health support staff contact details held centrally to be contacted at short notice out of normal hours MOU agreed with PH Departments in other boards agreed by Director of PH	Normally only one or two public health staff are contactable out of normal hours for emergencies. This can be escalated at short notice for a major incident.	Fewer people become ill or die when an incident occurs outside of normal office hours.	Reputation Preparedness

Surge capacity across the organisation.	Training staff across NHS B on health protection and developing a process to call on them at short notice.	CPHMs and HP nurses train staff across NHS B so that their additional support can be called upon for surge capacity.	Preparedness to respond to major incidents enhanced	Better prepared for major incidents Staff competence Reputation
Health Protection Scotland 24/7 response	A CPHM is contactable 24/7 for specialist advice, support and details of the bigger picture across Scotland.	HPS can offer a second opinion out of hours and expert advice depending on the individual's area of expertise.	Better management of HP incidents outside of normal hours	Reputation
Regional exercises	Exercises that simulate major incidents such as Exercise Senator held in September 2011.	Exercises can highlight the current state of preparedness and any additional measures that need addressing	More organised response to a major incident.	Preparedness Scottish Government requirement

Standard 2.4 – Urgent and non-urgent communications with partner agencies and the public				
Types of evidence • **Test contact lists** • **Routine and emergency communications with the public** • **Communication with NHS B and partner agencies**				
Rationale for this standard – effective communication promotes a more coherent multi-agency response and a more coherent response across the wider community.				
Area of work	**Evidence Log**	**Comments**	**Public Health value**	**Organisational benefit**
Contacts list	Reviewed every 3-6 months for accuracy and update	Support staff role	Supports effective communication to enable a better response to a PH threat	Preparedness Reputation
Communication of out of hours rotas for public health, executive directors, NHS managers, and environmental health officers.	PH out of hours rota shared with relevant staff in NHS B and partner agencies. PH staff can access the other rotas.	Promotes communication out of hours.	Fewer people become ill Fewer deaths	Reputation - facilitates an organised response to incidents
Health Protection Scotland national guidance on communication of risks to the public	Is there any evidence of the application of this HPS guidance in NHS B?		Promotes an effective community-wide response to a public health threat	Reputation
Communication with NHS B services and partner agencies	Appropriate lists of people and posts are being developed for specific types of communications.		Promotes a more effective response across agencies and within NHS B to a PH threat.	Reputation
The general public contacting the NHS B PH department.	Phone number is on the NHS B website and an automated message in place to re-direct out of hours calls		More coherent community-wide response to a PH threat	Reputation
Use of other media to communicate public health information	NHS B communications department co-ordinates the wider media messages. During a major incident algorithms are developed for NHS 24 staff to manage calls.		More coherent community-wide response to a PH threat	Reputation (prevent panic in the community).

Domain five: The development of policies and practices to support the health improvement department in being systematic in its approach to addressing the main public health challenges, to act as a vehicle for effective community engagement (share responsibility for health improvement with the general public), and to ensure that policy makers and the general public have access to sound public health evidence when considering all policies (whether these impact directly on public health or only in a peripheral way).

Standards 5.1, 5.2 and 5.3: These cover the general influencing role of HI staff, which requires staying abreast of a wide range of policy areas and issues, and good communication/networking skills and use of communication tools to influence the debate and decisions that are made. They also cover the specialist health improvement role in leading and developing strategies and plans for specific health improvement initiatives such as tobacco control and child healthy weight etc; this involves asset-mapping, sharing of relevant data and ensuring that agreed actions feature on the relevant plans of all agencies. The standards also cover the role of other HI staff in supporting the operational delivery of initiatives and the monitoring, evaluation and feedback. Finally there is the need to ensure that sound public health advice is available on a range of policy issues that might only impact on health in a more peripheral way (transport policy etc).				
Types of evidence - Health assessment reports or other reports; Emails or notes of meetings to show collaborative approach; plans and strategies that are led by health improvement or where HI staff support their implementation; evidence of impact of HI initiatives.				
Area of work	**Summary of evidence log**	**Comments**	**Public health value**	**Organisational benefit**
Community Plan and Single Outcome Agreements.	LA Partnership Board minutes Notes from a range of performance monitoring committees Local area partnership action plans	HI staff lead the development, monitoring and feedback on the health and wellbeing aspects of the Single Outcome Agreements in each LA patch. HI staff also support the development and implementation of the health and wellbeing aspects of locality-level plans.	Systematic approach to ensuring that resources are targeted at locally-identified health issues that are married to national priorities	Scottish Government requirement Partnership working
Tobacco control	Notes of multi-agency meetings and email correspondence with staff from a range of agencies, and evidence of consultation with the general public.	HI staff lead the key strategic planning processes such as developing, implementing and revising the NHS B no-smoking policy. Other HI staff support the operational	Greater awareness of the health risks of smoking and how to seek support to quit Reduction in long-term conditions related to	Scottish Government requirement Manage demand for reactive healthcare

		implementation of this work.	smoking	
Child healthy weight	Notes of multi-agency meetings and feedback from Scottish Government through audits and evaluation.	Some HI staff lead the development and evolution of the multi-agency child healthy weight strategy and some HI staff support its operational delivery.	Influence attitudes and behaviours of parents re the health of their children	Scottish Government requirement
Early Years	Early Years Collaborative multi-agency strategic planning group notes and emails to staff across a range of agencies.	Some HI staff contribute to the development of strategic plans and lead/support the operational implementation of parenting initiatives and other programmes to support the health of young children.	Improved awareness of health-promoting approaches to parenting	Scottish Government requirement
Mental health (the Mental Health HI lead is actually based in the clinical mental health service but his remit largely relates to the broader health improvement aspects of mental health)	Notes of national policy making groups on mental health that include input from NHS B HI staff. Presentations and support to a range of local multi-agency services to incorporate national policy on mental health in to care systems and processes. Awareness raising with members of the public.	HI staff contribute to the development of national policy and support its local implementation via influencing, awareness-raising and direct support with integration of mental health issues in to routine practice (development of protocols, care pathways etc)	Increase awareness of mental health issues among staff from a range of agencies and the general public. Specific protocols and pathways in place for people that are especially vulnerable to mental health problems (homeless etc).	Scottish Government policy in relation to “A Mentally Flourishing Scotland” and SG targets on specific aspects of mental health such as suicide prevention etc.
Health and wellbeing of children and young people	Health as a topic in the curriculum for excellence that is delivered through schools. Notes from a range of multi-agency meetings and attendance at youth groups	HI staff support the implementation of initiatives to support greater knowledge and awareness of health in young people. The leadership and planning functions are	Increased knowledge and awareness of key health issues among school children	Delivery against the objectives for NHS B in the SOA.

	outside of the school setting.	carried out elsewhere.		
Gender-based violence	NHS B gender-based violence plan. Notes from a range of national committees and policies and processes to support the care of victims and address wider social attitudes.	HI staff lead the NHS B planning process and support its implementation through training of staff in relevant service areas and by seeking to explore and influence broader social attitudes.	More awareness of the effects of gender-based violence and the underpinning social attitudes. Improved clinical response	Implement Scottish Government policies on "routine enquiry" and other aspects of gender based violence
Alcohol licensing	Notes from a range of multi-agency meetings. Responses to consultation on applications for a new licence to sell alcohol.	DPH is a statutory consultee and has an active advisory role in relation to all new applications for an alcohol licence. HI operational staff member to support this work.	More control over number and location of outlets that sell alcohol. More awareness of the public health implications of alcohol.	Implement Scottish Government policy on alcohol licensing procedures.

Standard 5.4 - Maintain an All Hazards Emergency Operations Plan				
Types of Evidence • **Collaborative planning across agencies** • **Multi-agency exercises and shared learning** • **Debrief after incidents** • **Contact lists**				
Rationale for this standard: Advance planning and exercises can enable a more effective multi-agency and community-wide response to a major threat.				
Area of work	**Evidence Log**	**Comments**	**Public Health value**	**Organisational benefit**
Collaborative planning	The Major Emergency Plan, Joint Health Protection Plan and the Pandemic Flu plan.	Health Protection CPHMs lead the development, review and updating of these plans across a range of services and agencies.	Partnership working	Scottish Government requirement Preparedness
Multi-agency exercises,	PIPG (pandemic flu) exercise	Health Protection CPHM led	Partnership working	Increase staff competence

testing of plans	September 2012 CBRN plan tested September 2011 (Exercise Senator) Foodborne plan tested March 2011	PIPG and Foodborne plan multi-agency exercise. Police led CBRN exercise and CPHMs, HP nurses and PH support staff all contributed to this.		Reputation Preparedness
Debrief reports after multi-agency exercises	Clarifies the roles of different agencies and enhances the overall response	Do the HPT lead on writing the debrief reports?	Partnership working	Reputation Preparedness
Major Incident Plan	This gets tested on hospital sites in NHS B	What is the HPT role in this?	Fewer ill people and deaths in a major incident.	Reputation Preparedness

1. How do we share learning across Scotland after incidents?
2. How do we horizon scan to see what threats may emerge in the future?

Domain seven: Promote strategies to improve access to health care services – to keep the evidence list to a manageable level this paper only covers pieces of work that require substantial input from senior public health staff (the work would not proceed without public health input).

Standard 7.1: Assess healthcare capacity and access to services - Conduct a health needs assessment and communicate the findings - **Identify barriers to access (patient and carer consultation etc)** - **Identify service gaps (geography, finances, lack of skilled staff etc)**				
Types of evidence - Health needs assessment reports or other reports - **Emails or notes of meetings to show collaborative approach**				
Rationale for this area of public health work **To develop an understanding of the population's access to healthcare services by looking at the capacity of the healthcare system, barriers to healthcare (as perceived by patients/carers), and gaps in access to healthcare (financial, geographic, service capacity etc).**				
Area of work	**Summary of evidence log**	**Comments**	**Public health value**	**Organisational benefit**
Caldicott Guardian	Information Assurance Committee minutes. Caldicott Guardian Approval forms. Caldicott Guardian Approval process.	DPH role to vet research, audit and service evaluations and other requests which use patient identifiable information.	Assurance for the public that NHS safeguards their personal information.	UK and Scottish Government requirement. Reputation
Disinvestment in homeopathy services	Health needs assessment report to inform further action. NHS Board papers to inform the public and media interest.	DPH role to chair the SLWG meetings; lead on collation of data and preparation of reports for the main planning committee and the NHS Board.	Clarifies the population health impact of homeopathy	Budget control
Promote greater clinical effectiveness in a targeted group of service areas across NHS B	Identified some service gaps and areas for improvement to be taken forward by people with expertise in those service areas.	DPH chaired the clinical effectiveness sub-group and co-ordinated its workstreams – individuals with expertise in the field then took those workstreams forward.	Improved care pathways for certain clinical conditions	Recommendations to improve quality of care in selected clinical service areas.

Increase awareness of oral health and dental services among expectant mothers	Produced a DVD and included information on oral health and dental services in the Improving Maternal Health resource pack.	CDPH advised on the survey method and content used in the initial survey of expectant mothers that informed the subsequent development of information materials.	Better knowledge of oral health in pregnant women; less dental illness	Reduced demand for reactive dental care (in the future)
Needs assessment on restorative dentistry services across Scotland	Report shared with relevant stakeholders across Scotland	CDPH chaired the group. The main recommendation was for a MCN to be established.	Better treatment service for restorative dentistry	NHS B involved in the piloting of a new restorative dentistry patient pathway led by the West of Scotland Dental Consortium.
Implementation of Best Possible Start Programme	Guidance document for PH nurses on the new 27-30 month health check, training needs analysis, and an evaluation framework for Best Possible Start.	PH Specialist contribution was mainly on the evaluation of BPS and supporting PH nurses with the new health check	Surveillance of health and illness in children More timely intervention for children with developmental problems	Staff competence improved Scottish Government requirement to monitor Best Possible Start Less reactive demand for healthcare (in the future)
Redesign of traumatic brain injury rehabilitation services	Set up a new community rehabilitation service to replace previous dependence on out of area services	Lack of NHS B locus of clinical expertise in brain injury meant that this workstream was initiated, led and implemented by a CPHM.	New service to help address unmet need	Improved budget control Staff competence improved (develops expertise in NHS B)
Local evaluation of Keep Well programme	Comprehensive evaluation of Keep Well as a health improvement pilot and as a means to address the inverse care law	CPHM role was to chair meetings and co-ordinate the evaluation work programme that was carried out by a dedicated Keep Well research officer.	Improved understanding of how to address barriers to accessing services in deprived areas.	Informed the mainstreaming of Keep Well across the NHS B area
Promote uptake of breast cancer screening in targeted population sub-groups	Identify areas and population sub-groups with low uptake and avail of national resources to inform the approaches to improving uptake	CPHM role to chair the group, oversee work and lead on the evaluation.	Earlier detection and treatment of breast cancer Address health inequalities	Scottish Government target re uptake of breast screening

Implementation of bowel cancer screening programme and ongoing monitoring	Developed the business case and led on the measures needed to address service gaps identified, wider consultation and ongoing monitoring	CPHM role to oversee the implementation of bowel screening in line with the national specification, ongoing monitoring and governance of the programme.	Earlier detection and treatment of bowel cancer	Bowel screening programme delivered within budget and operating in accordance with the national specification Scottish Government requirement to implement bowel screening programme
Development of NHS B blood borne virus service plan.	Multi-agency stakeholder event, focus groups with clients, use of stage drama and formal needs assessment with ethnic minority groups.		A more holistic pathway of care was developed in collaboration with all parties	Improved management of demand for care

Standard 7.2: Identify and implement strategies to improve access to health services **Produce a strategy in collaboration** **Strategy implementation group** **Specific initiatives to address language, literacy, ethnicity etc**
Types of evidence (evidence that pre-dates April 2008 should not be included) • **Strategy report with recommendations** • **Minutes of strategy implementation group meetings** • **Record that the strategy is on the work programme of each relevant agency** • **Audit work to inform implementation** • **Initiatives to promote service usage in specific population sub-groups**
Rationale for this standard – Collaborative development of strategies to increase access to healthcare for people that experience barriers (culture, language etc) and to address gaps in access to healthcare (service capacity, geography, finance etc).

Area of work	Evidence Log	Comments	Public health value	Organisational benefits
Address variation in access to 6-week child health surveillance checks	Action plan developed in conjunction with GPs and PHNs to address variation in access	PH Specialist chaired the planning group, authored the guidance document and leads on monitoring	Health inequalities Timely intervention	Reduce demand for reactive healthcare (in the future) Scottish Government requirement.
Implementation and evaluation of aspects of the Detect Cancer Early Programme	Chairing oversight and planning groups to ensure the local health system could cope with extra referrals and to maximise the impact of awareness-raising activities.	CPHM role to oversee the process of the awareness raising campaigns and to evaluate their impact; also to contribute to acute division planning for extra referrals with suspected cancer.	Better awareness of cancer Earlier detection and treatment of cancer	Better cancer treatment pathway Scottish Government targets
In response to the evaluation of Keep Well, some specific initiatives emerged to address barriers to access	An outreach service to contact non-attenders and a bus offering health checks in a manner sensitive to people from ethnic minority groups.	CPHM role to facilitate introduction of interventions to address barriers and to oversee their evaluation and evolution.	Overcoming barriers to accessing services. Health inequalities	Less reactive demand for healthcare (in the future) Scottish Government target
Increase uptake of dental services among children in deprived areas	Childsmile service agreement with dental practices and Childsmile early years pathway developed	CDPH chaired the Childsmile group and co-ordinated its work	Overcoming barriers to services Health inequalities	Improved treatment pathway
Improve uptake of dental services in drug users	Develop a poster to raise awareness and a leaflet on methadone and oral health	CDPH chaired the Dental Resources and Services for Addictions SLWG and co-ordinated its work.	Better awareness of oral health in drug users Health inequalities	Manage reactive demand for dental care among drug users
Lead on the delivery of Equally Well	Strategic framework for Equally Well and refreshing of health inequalities work through the main public health planning group	DPH led on the development of the strategic framework, oversaw its implementation and leads on the refreshing of health inequalities work.	Health inequalities Partnership working	Scottish Government requirement
Contact tracing of notified TB cases	Written process for contact tracing and management of contacts.	CPHM co-ordinates local activity and ensures alignment with TB action plan for	Control of TB in the population	Reputation Manage demand for

	Identification and management of a TB cluster in 2011.	Scotland. TB nurses contact trace and advise on the management of contacts.		reactive healthcare.
Development and implementation of NHS B blood borne virus plan	Blood Borne Virus and Sexual Health Delivery Plan with a range of resources targeted at specific sub-groups across NHS B (ethnic minority communities, people with learning disabilities, young people).		More inclusive approach to service delivery and to information resources for people vulnerable to blood borne viruses.	Scottish Government requirement Better management of demand for healthcare

ScotPHN report

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