1. Organisation name

Royal College of Physicians of Edinburgh

2. Title |Forename | Surname

Dr	AD	Dwarakanath

3. Postal Address

9 Queen Street, Edinburgh
Post Code| EH2 1JQ

4. Phone Email address

0131 247 3658	s.collier@rcpe.ac.uk

5. I am responding as a group/organisation ☒ and note that the response will be shared with the public health review group[i].
The name and address of your organisation will be made available to the public (e.g. if the Scottish Government publishes a report on behalf of the review group or if responses are published on the Scottish Government website).

Are you content for your response to be made available?
Please tick as appropriate ☒ **Yes** ☐ **No**

6. I am responding as an individual ☐ and note that the response will be shared with the public health review group[ii].
Do you agree to your response being made public? (e.g. if the Scottish Government publishes a report on behalf of the review group or if responses are published on the Scottish Government website?)
Please tick as appropriate ☐ **Yes** ☐ **No**

Where confidentiality is not requested the Scottish Government can make your responses available in one of the following basis please tick the one that applies.
Yes, make my response, name and address all available ☒
Yes, make my response available, but not my name and address☐
Yes, make my response and name available, but not my address ☐

7. Public Health Division of the Scottish Government (SG) will share your response internally with other SG policy teams who may be addressing the issues you discuss. SG may then wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this engagement exercise
Please tick as appropriate ☒ **Yes** ☐ **No**

---

[i] Review Group membership available by contacting the publichealthreview@scotland.gsi.gov.uk mailbox
[ii] Review Group membership available by contacting the publichealthreview@scotland.gsi.gov.uk mailbox

1. **How can public health in Scotland best contribute to the challenges discussed? Specifically, what is your view and evidence of the Strengths, Weaknesses, Opportunities and Threats (SWOT) to the contribution of the public health function in improving Scotland's health and reducing inequalities?**

Strengths

- **Independent voice of Public Health locally**

  Scotland has retained the independent role of the Area Director of Public Health (DPH), who has sole editorial responsibility for the area DPH Annual Report. This locally recognised role and responsibility must not be lost, rather, it should be strengthened. It is complemented by strong national networks which facilitate the sharing of good practice.

  In many local departments staff also contribute to national level work or roles across all domains of public health. The close links between the challenges of local delivery and national input are highly beneficial in development of policy.

- **Advocacy roles nationally**

Scotland has a world class reputation for public health research, education and practice as well as a long history of medical and public health innovation and intervention. Scottish Physicians have made an impressive contribution to public health e.g. Sir Douglas Black, FRCPE, author of the Black report on inequalities in health.

Advances in advocacy and policy influence, for example, in relation to tobacco and alcohol related harm, rely on authoritative and collaborative leadership encompassing the Faculty of Public Health, other Medical Colleges in Scotland and organisations such as ASH and SHAAP (the latter hosted by RCPE). RCPE will continue to support work to improve public health and wellbeing and reduce health inequalities.

- **Public Health Intelligence and Inequalities**

Without public health research, information skills and enquiry the current situation regarding inequalities would not have been described.

- **Trust**

There is a strong sense of trust in professional institutions and local public health activities in Scotland. This has been built up through responsible stewardship over time, and is in contrast to experience elsewhere in the UK where multiple changes have created organisations perceived to be more distant and less credible. This is evidenced through the generally positive response by the public to approaches by public health and health protection in Scotland and is profoundly important in response to any major threat, as evidenced internationally with respect to Ebola.

Weaknesses

There are gaps in capacity to take on national pieces of work, for example by Scottish Public Health Network or on behalf of Directors of Public Health. There are

also gaps in public health advice to health services in some areas. Progress on socio-economic inequalities may be limited but many levers are political and rely on areas such as progressive taxation. The emphasis on socio-economic inequalities is essential but this can occur at the expense of others domains, for example, the life expectancy gap for those with physical, learning disability and mental health problems. Cross-sectoral engagement including the private and third sector could be strengthened in some areas.

Opportunities

The appointment of the DPH with an emphasis on health policy across local authorities (LAs) is to be further promoted, and this is obviously easier where the LA and Health Board are coterminous e.g. Fife, Borders. LA staff should be frequently in council and partnership meetings as often as NHS.

With Health and Social Care Integration the emphasis should also be on joint working by the DPH. The size and number of LAs in Scotland does not lend itself to smaller PH departments which would in effect result in lack of critical mass and professional isolation. This did not work with primary care trusts in England. The DPH should continue as Executive member of the NHS Board to which integration bodies are accountable, with access rights to the Board of the integration body. The emphasis on prevention and early intervention under Integration mean that public health skills are essential in meeting the challenges of service and health improvement which can be achieved by increased capacity where more than one LA is involved.

The advocacy role of the Faculty of Public Health (FPH) in Scotland could be strengthened to give a more visible profile in conjunction with the Medical Royal Colleges. The recommendations of the Marmot Review could be implemented more visibly and widely by professional organisations and local health systems, and reports on these produced by community planning partnerships to build emphasis on reducing inequalities.

Threats

There are direct reports from England that employment either in a local authority or Public Health England as an Executive Agency of Government restricts the independence and advocacy function expected of a Public Health Department, Director of Public Health and Consultants. This should be avoided in Scotland.

Examples include being unable to sign petitions relating to public health and advocacy, being unable to deliver communication to the staff and public in an effective and timely manner e.g. blogs, newspaper articles, internet, without civil service media approval; and to challenge decisions or communicate public health messages which are not fully supported and approved by the local authority.

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

Independent professional advice is essential to inform and engage with the Government and other elected representatives. The leadership role of Directors of Public Health and future Directors of Public Health could be more positively supported.

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

Public Health is integral to working locally within Community Planning Partnerships and the new integrated health and social care bodies. Local leadership capacity should be strengthened to deliver this successfully.

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

While some local authorities in England have positively embraced public health, in others staff feel demoralised, undervalued and sidelined. For example, both non-medical specialists and medical consultants are being employed by local authorities on inferior terms and conditions. As a result of this and the many re-organisations, PH staff have left or moved to other sectors. Support staff in local authorities have also been reduced or downgraded resulting in poorer quality information on public health. If the career path for public health doctors or specialists is perceived to be unstable and unrewarding, the specialty will not be attractive to the best candidates.

<u>Risks of Fragmentation of the speciality</u>

The division of roles, employers and fields of public health in England has led to differentiation of roles, in contrast to Scotland which has integrated departments working across all domains of health protection, health services, health intelligence and health improvement. Complemented by national specialist units, the geography of Scotland lends itself to local departments of public health working with community planning partnerships at one level, supported by a multi-disciplinary team delivering across all PH functions. Any loss of local leadership relevant to all domains of PH e.g. the DPH role, would be detrimental to delivery of the PH function.

The current system in Scotland has resilience such that generalist consultants are competent to manage health protection situations should the need arise in a larger incident. The principle challenges in these situations involve managing and delivering Incident Management Team (IMT) actions in the local system – this is not a function of an ‘expert’ organisation in relation to the technicalities of incident management, already given by Health Protection Scotland (HPS).To quote from a recent high profile incident “the challenge is people, not processes or policy”.

Employment within the local health system allows influence well beyond that system and high local credibility. It provides a stable governance structure which is of significant importance. It allows professional development where relevant alongside clinical colleagues which is important in retaining parity of respect for public health as a medical speciality, given the importance of the protection and promotion of population health.

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

These are well supported in some departments at present but perhaps not in all and sharing good practice would bring benefit.