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### **Interface with Primary Care**

There are considerable challenges facing primary care and Trusts in relation to Public Health. In the first place, there need to be greater opportunities for the various disciplines to work together. In the rest of the United Kingdom where robust primary care organisations have developed, primary care professionals work alongside Public Health professionals to assess local health needs and develop services, and health improvement initiatives accordingly. However because of the current comparatively limited scope of local Health and Social Care Groups in Northern Ireland, the same opportunities do not exist.

'Caring for People Beyond Tomorrow', the DHSSPS Strategic Framework for the development of Primary Health and Social Care offers real opportunities for multi-disciplinary teams to work together in the treatment and care of the communities they serve. The Strategic Framework proposes a primary care service which is of a 'high quality, seamlessly integrated, responsive' and organised to 'provide effective, and immediate, access to a wide range of services close to where people live'. This strategy describes a long-term 20 year vision; the challenge is to put in place the proposed arrangements which establish both quality primary care services and multi-disciplinary teams in the community.

Overall, providers of health and social care need to see themselves as Public Health organisations and should strive to develop the capacity and expertise within their organisations to fulfil that role.

### **Screening**

While Northern Ireland does have regional arrangements in place to coordinate screening programmes at Board level, it is agreed that the arrangements for regional coordination of screening need to be strengthened and streamlined. More robust regional arrangements would accommodate the significant effort required to develop new programmes and monitor existing programmes; work currently divided across the four Public Health Departments and the DHSSPS. Enhanced regional coordination would achieve efficiencies in terms of effort as well as providing an opportunity to pool relevant information and expertise. The work of the Director of Public Health and Consultants in Public Health across Northern Ireland would be supported by any enhancement of regional coordination with the possibility of developing regional expertise/ leads in each of the screening programmes.

#### *3.2.4 Main Considerations – Health Improvement*

<p><i>Health Improvement</i></p>
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| <ul style="list-style-type: none"><li>• <i>The role of Public Health in delivering the health improvement agenda needs <b>strengthening at both regional and local levels to address the</b></i></li></ul> |
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**determinants of health** influenced by government policy and the implementation of policies and strategies at a local level.

- Strengthen approach of **local solutions to local problems** – more opportunities to work in local community through coordinating structures such as HAZ and IFH partnerships.

Primary Care

- Facilitate **greater opportunities for the multi-disciplinary teams to work together in primary care** to reduce health inequalities.

Screening

- **Screening requires more effective management at the regional level** with support from sub-regional Public Health staff, with the need for standardisation of protocols and generally a more cohesive approach.

### 3.3 People, Capacity and Accountability

#### 3.3.1 Introduction

The theme of 'People, Capacity and Accountability' has been organised into a series of related topics. These are:

- Leadership and Accountability;
- Roles and responsibilities;
- Multidisciplinary Working, Skills and Training; and
- Performance.

#### 3.3.2 People, Capacity and Accountability

##### **Leadership and Accountability**

Political leadership is critical in influencing policies relating to the public's health. Public Health should be addressed as a priority by every government department, agency and local authority. The Ministerial Group for Public Health has a critical role to play in influencing the policy agenda across all the key government stakeholders.

Well organised and strategically positioned leadership is fundamental to Northern Ireland's Public Health function. The Directors of Public Health are acknowledged as fundamental to the leadership of the Public Health function as it operates through the Boards. However, it is recognised that Public Health involves the contribution of the many: medical and non-medical; statutory, voluntary and community; in providing services to improve the health of the population. As a result leaders will come from a range of professional backgrounds and sectors.

Leadership Programmes such as those run by the Institute of Public Health, Belfast Healthy Cities (e.g. Equity in Health – Tackling Inequalities in Health) and the Health and Social Services Management training unit increase the capacity of those working to build a healthy society from different sectors. It also endorses the view that there needs to be flexibility in who leads on Public Health.

Accountability arrangements need to be clarified in those key existing organisations, from policy setting to delivery, which provide fundamental services across the three Public Health domains of health protection, health improvement and service development.

### **Performance**

The overall aim of the Public Health function is to prevent disease, prolong life and promote health. In order to do so, performance management should ensure that Public Health and health outcomes are on all key contributors' agendas. It also requires that all the constituent parts of the Public Health function are engaging in monitoring and evaluation processes to regularly assess performance.

The performance agenda of the Public Health departments is determined by Priorities for Action (PFA). The implementation of *Investing for Health* is based on objectives and targets towards which all contributors work. The targets focus on the main determinants of health and measure progress towards reducing health inequalities. Targets were chosen which could mobilise action, generate data to measure progress and which were consistent with *Investing for Health* principles.

Health impact assessments (HIA) on all public policy or, at the very least, a clear focus on Public Health outcomes for all new public policies / strategies is fundamental. *Investing for Health* gave a commitment to develop a methodology to enable Departments to identify and evaluate the health impacts of new policies to maximise positive impacts and minimise negative impacts on health. Through MGPH, the Institute of Public Health in Ireland has provided advice, produced draft guidance for policy makers and facilitated HIA awareness training. The draft guidance is being piloted in a small number of policy areas during 2004. The draft guidance will be reviewed following the pilot exercises and it is anticipated that the final guidelines will be issued early 2005.

### **Roles and Responsibilities**

A key issue for Public Health and Public Health departments in Health and Social Services Boards is to create sufficient critical mass to deliver services across all three Public Health domains. Critical mass facilitates the development of expertise, investment in a multi-disciplinary approach and ensures adequate staff resources to meet current priorities with the capacity to respond to critical issues e.g. emergency planning.

The complexity and increasing range of organisations and people involved in direct and indirect health related provision requires clarity on organisational and staff accountability arrangements, procedures and roles and responsibilities. Lack of clarity in relation to roles and

responsibilities can lead to duplication of effort or gaps in service provision.

### ***Multi-disciplinary Working, Skills and Training***

The delivery of Public Health is truly multi-disciplinary ranging from the professions of medicine (e.g. GPs, consultants in public health, epidemiologists), dentistry, nursing, pharmacy, social services, and professions allied to medicine to environmental health, statistics, sociology, anthropology and urban planning. One of the common themes amongst their diversity is the key contribution they have to make to the public's health. *Investing for Health* has written this broader Public Health contribution into its strategy through its action plans. In addition, these professions already interact on a daily basis with the public to deliver services, monitor performance and address health related issues.

In September 2002 the Health Development Agency (HDA) and the Chartered Institute of Environmental Health (CIEH) published a vision statement for the development of environmental health over the next ten years. Called 'Environmental Health - 2012 - A Key Partner in Delivering the Public Health Agenda', the report describes the work of a joint HDA/CIEH project to support the environmental health profession in developing a strategic vision for its contribution to health development and wellbeing. It explores the projected growth of the profession's role in improving the public's health and reducing health inequalities over the next ten years.

Research (Poulton *et al* (2000) *The Contribution of Nurses, Midwives and Health Visitors to the Public Health Agenda*. Belfast, DHSSPS) has shown that nurses, midwives and health visitors are most active in the areas of health education and primary, secondary and tertiary prevention. With approximately 16,000 nurses in NI, nurses are in a strong position to 'drive forward the Public Health agenda' in direct contact with service users and communities in homes, community centres, hospitals, schools and workplaces and by contributing to policy development and implementation.

Current objectives for dental public health are set out in *Investing for Health and 'Priorities for Action'*, as well as the current 'Oral Health Strategy'. The Community Dental Service is well positioned to carry out Public Health functions and staff from the service are actively involved in multi-disciplinary and multi-agency working.

One of the central aims of 'Making it Better – A Strategy for Pharmacy in the Community' (DHSSPS, 2003) is to improve public access to pharmacy services. In addition, the 'Building the Community Pharmacy Partnership' offers opportunities to establish stronger partnerships between local communities and community pharmacists, of which there are over 500 with a health service contract.

The Public Health Medicine Training Committee has overall responsibility for the recruitment, placement and training of Specialist Registrars in Public Health Medicine. The main training locations are the four HSS Boards with some specialist placements also available within Health Promotion Agency (NI), Institute of Public Health, DHSSPS, QUB etc. Training provision is subject to annual inspection by the Faculty of Public Health and reports to date have been excellent. In order for this to continue it is necessary that Public Health departments maintain sufficient critical mass both to support the breadth of training required and to provide experienced and accredited trainers.

Conversely, training arrangements for non-medical personnel seeking to develop a career in Public Health are less systematic. It is recognised that there is a need to develop a multi-disciplinary training programme which would formalise and strengthen the contribution from non-medical professionals and ensure all of them are adequately trained, accredited and undertaking continuing professional development (CPD). Such a move would have implications in terms of additional resources such as training placements, training coordinators and would require dedicated funding.

There are currently a number of under-graduate and post-graduate academic courses available in the University of Ulster which have a Public Health emphasis e.g. MSc in Health Promotion, Postgraduate Diploma in Education for nurses, mid-wives and health visitors, BSc in Health and Social Care Policy. Progress is also being made in developing a Masters in Public Health, expected to be available in September 2005. The Master's course will be run jointly by Queen's University of Belfast and University of Ulster.

A UK wide Voluntary Register of multi-disciplinary Public Health specialists was established in the UK in June 2003 to promote public confidence in specialist Public Health practice through independent regulation. The Register is for Public Health professionals from any background who have a common core of knowledge, skills and experience, and work (or have the ability and potential to work) at a strategic or senior management level. Registration is designed to assure the public and employers that multi-disciplinary specialists in Public Health are appropriately qualified and competent. The main concern in developing this voluntary register in Northern Ireland is the lack of a properly resourced training infrastructure.

Providing training and support for those who wish to access the UK wide Voluntary Register of multi-disciplinary Public Health Specialists is essential if Northern Ireland is to support professionals from a range of disciplines who want to pursue a career in Public Health.

A training scheme would also need to be established to enable non-medical professionals to undergo training of the same duration, content and quality as that of their medical counterparts allowing

them to achieve specialist status through achieving membership of the Faculty of Public Health by examination.

An important recent development has been the formulation of nationally agreed occupational standards for public health practice. These have been devised both for specialists and for others working more generically in Public Health. They clearly set out the competencies required for Public Health practice and detail the knowledge, skills and experience required to acquire them.

Ongoing workforce planning and development for Public Health would also ensure that there are the much needed skills to deliver the right services at the right time to those who most need them.

### 3.3.3 *The Challenges*

#### **Leadership and Accountability**

The Public Health leadership challenge is to acknowledge the greater range, complexity and evolution of individuals and organisations involved in the Public Health function. Public Health leaders must be able to address the multiplicity of Public Health issues which are often inextricably linked with social, environmental and economic problems.

Where they are not already in place, accountability frameworks need to be established in, and agreed between, organisations planning and delivering Public Health services.

#### **Performance**

Public Health delivery should be reinforced through a performance management system involving the setting of robust indicators. Such indicators should be clearly measurable and implemented across all disciplines. This should include local targets and the use of an evidence based approach to facilitate collaboration rather than competition between partners. Performance data should be presented to decision-makers in a timely manner and findings used to modify programmes, services and policy to improve health outcomes.

#### **Roles and Responsibilities**

The multidisciplinary, multi-agency and inter-sectoral nature of Public Health requires clarity of both individuals' and organisations' roles and responsibilities. Roles and responsibilities in key existing organisations and any consolidation of future structures should be supported by political leadership, appropriate statutory instruments, clear structures and lines of accountability and use of performance management indicators.

### **Multi-disciplinary Working, Skills and Training**

It is widely recognised that the Northern Ireland Public Health function needs to invest in systems e.g. voluntary register, multi-disciplinary training framework, postgraduate courses, ongoing workforce planning and professional development which will support the systematic development of a robust multi-disciplinary Public Health workforce.

The development of a multi-disciplinary training programme would formalise and strengthen the contribution from non-medical Public Health professionals and ensure that all Public Health professionals are trained, accredited and subject to CPD.

While the development of a multi-disciplinary training programme has been widely supported, it is also acknowledged that this represents quite a radical shift in how public health professionals acquire skills and training to develop competencies in a diverse range of settings. Whilst nationally agreed occupational standards have been welcomed by those working in Public Health, further work needs to be done in respect of awareness of their existence and adoption and implementation.

#### 3.3.4 Main Considerations – People, Capacity and Accountability

##### *Leadership and Accountability*

- The Public Health leadership challenge is to **acknowledge the greater range, complexity and evolution of individuals and organisations** involved in the Public Health function.
- **Accountability frameworks** need to be established in, and agreed between, organisations planning and delivering Public Health services.

##### *Performance*

- If Public Health is to be a progressive process it must actively engage in **monitoring existing initiatives** on the ground, evaluating not just the inputs and outputs but also the **long term outcomes**.

##### *Roles and Responsibilities*

- The multi-disciplinary, multi-agency and inter-sectoral nature of Public Health requires **clarification of both individuals' and organisation's roles and responsibilities**.

##### *Multi-disciplinary Working, Skills and Training*

- A **multi-disciplinary training programme needs to be developed with a dedicated funding source that supports those from a wide range of disciplines** who wish to pursue a career in Public Health
- **Ongoing workforce planning and development for Public Health** to ensure that there are the much needed skills to deliver the right services at the right time to those who most need them.

### 3.4 Health Protection

### 3.4.1 Introduction

The effective functioning of Health Protection activities in Northern Ireland is a significant theme in this analysis. In this sub-section, there are three main areas that are assessed in terms of the Health Protection function:

- Health Protection;
- Environmental Health; and
- Emergency Planning.

### 3.4.2 How Health Protection is organised

In Northern Ireland at present, the provision of health protection services falls under the responsibility of a number of different public agencies, working in partnership. These agencies and the general organisation of the health protection domain are described briefly in this sub-section.

#### **Department of Health Social Services and Public Safety**

The DHSSPS, through the office of the Chief Medical Officer, takes the lead role in setting regional policies and standards for Health Protection and for co-ordinating efforts through the various public agencies.

#### **Health and Social Services Boards**

The Health and Social Services Boards, through the Directors of Public Health and their staff, work at the local level on Health Protection issues across the full spectrum of activities from prevention, screening and immunisation through to responding to specific incidents.

#### **Communicable Disease Surveillance Centre (CDSC)**

CDSC (NI), which provides a regional centre for the surveillance of communicable diseases, became operational in 1999 and entered into a five year service agreement with the DHSSPS. CDSC (NI) as part of the PHLS transferred to the newly established Health Protection Agency on 1st April 2003.

The CDSC (NI) offers specialist expertise to various stakeholders across the health protection environment in Northern Ireland. As a part of the Health Protection Agency, it is within an organisation which comprises the previous functions of the PHLS, the National Poisons Service, the Chemical Incident Response units, and from 1st April 2004 the National Radiological Protection Board.

The CDSC has provided operational support to Directors of Public Health in several major outbreak investigations. In addition CDSC maintains close working relationships with the DHSSPS Senior Medical

Officer responsible for Communicable Diseases; provides out of hours medical cover through the regional epidemiologist; contributes to undergraduate and postgraduate medical and nurse education and seminars for environmental health officers; is recognised by the Faculty of Public Health as an approved training location for postgraduate training; and is represented on the Regional Advisory Committee on Communicable Disease Control.

### ***Healthcare-Associated Infection Surveillance Centre (HISC)***

HISC was established in September 2001 by the DHSSPS in response to the need for accurate and timely data regarding healthcare-associated infection (HCAI). HISC is responsible for the collation and analysis of the regional data on behalf of DHSSPS.

The Department of Health's circular HSC 2000/002 and the DHSSPS document HSS (MD) 9/2000 made the Chief Executives of acute NHS Trusts responsible for instituting surveillance of HCAI. HISC enables acute Trusts in Northern Ireland to undertake HCAI surveillance and comply with HSS (MD) 9/2000 by facilitating the collection, handling, analysis and feedback of surveillance information. Infection Control Teams send data to HISC on behalf of Trust Chief Executives.

The DHSSPS's first priority in surveillance of HCAI in Northern Ireland was the establishment of a surveillance programme in elective orthopaedic surgery procedures. Data on elective orthopaedic surgery procedure SSIs is being collected by Trusts in Northern Ireland, Scotland, Wales and parts of England using the Healthcare Associated Infection Surveillance Steering Group Orthopaedic sub-group core data set.

HISC has a close working relationship with the CDSC (NI) and collaborates with surveillance centres throughout the UK, Republic of Ireland, Europe and USA and worldwide on surveillance programmes that foster harmonisation of protocols and standardisation of databases that permit the production of pooled risk-adjusted data.

### ***National Poisons Information Service (NPIS)***

NPIS is part of the Medicines Poisons Information Centre managed by the Pharmacy Directorate in the Royal Victoria Hospital. All Hospitals in Northern Ireland with casualty departments have access to Tox-base, the online database of the NPIS. Direct telephone enquiries are dealt with by staff in the Medicines and Poisons Information Service. Clinical enquiries may be passed up to a voluntary panel of medical staff who act as advisors. While out-of-hours calls are directed to the Casualty Department of the Royal Victoria Hospital where staff will access Tox-base, there is no formal out-of-hours cover.

The Service requires investment and reorganisation to address issues such as increased demand, appropriate cover for enquiries, maintenance of the current system, clearer operational structure (out

of hours cover, on-call, funding, governance and strategy arrangements).

In England and Wales, the NPIS has recently been relocated under the auspices of the Health Protection Agency where advice is given in relation to the management of individual cases of acute poisoning and also in the management of chemical incidents and deliberate chemical releases.

### **Environmental Health**

In Northern Ireland Environmental Health Services are delivered at three levels: regional, sub-regional and local.

At the regional level, the main Government Agencies which share a role with District Councils are the Food Standards Agency (FSA), the Health and Safety Executive (HSENI) and Environment and Heritage Service (EHS). These agencies focus on very specific areas of activity and have a significant impact on the delivery of the local Environmental Health Service in these areas. DHSSPS also has a Chief Environmental Health Officer who works closely with the Chief Medical Officer on relevant cross-cutting issues.

At the sub-regional level, four Group Environmental Health Committees (Northern, Southern, Eastern and Western Groups) support, monitor and coordinate Environmental Health activity across the 25 District Councils outside of Belfast. As the Groups' major customer, District Council Environmental Health Departments use the specialist skills offered by the Groups to support the services they deliver. The Groups and Belfast City Council also provide agency services on water quality to the Environment and Heritage Service, to the Northern Ireland Housing Executive on housing matters, and to the Health and Social Services Boards in relation to communicable disease and port health.

At the local level, the 26 District Councils currently deliver an Environmental Health Service to business, organisations and the public. These services cover the wide remit of health and environmental issues from food control, consumer protection and health and safety, to Public Health, housing, environmental protection and pollution control.

Environmental Health acts as a regulatory body in a number of key areas to protect the public's health and seeks remedies for problems experienced by communities and individuals. For example, EHOs collect and submit environmental samples including food, drinking water and swimming pool water for analysis by the Public Health Laboratory Service.

In an advocacy role, Environmental Health Departments are involved in a significant number of important partnership initiatives which seek to tackle health inequalities and wider quality of life issues. Some examples include the World Health Organisation Health Cities initiative

in Belfast and Londonderry, Health Action Zones in North and West Belfast and in Armagh and Dungannon, Healthy Living Centres and, most recently, the *Investing for Health* Partnerships.

The *Investing for Health* Strategy has been strongly welcomed by many working in environmental health because it refocuses efforts on the local Public Health agenda. This focus on Public Health outcomes has resulted in many Environmental Health Practitioners (EHPs) suggesting an expansion of their role in delivering the Public Health agenda.

### **Emergency Planning**

Under current arrangements, emergency planning relating to Public Health issues tends to be approached on a collaborative basis involving professionals from a variety of agencies and units within the Health and Personal Social Services and from elsewhere in the NI public sector. These include (but are not necessarily confined to) the following:

#### **HPSS:**

- Consultants in Public Health Medicine
- Chief Medical Officer and staff
- Other DHSSPS staff
- NI Ambulance Service
- Clinical toxicologists
- Health Protection Agency
- Acute hospital HSS Trusts
- National Radiological Protection Board
- Medical Physics Agency

#### **Others:**

- Central Emergency Planning Unit, OFMDFM
- NIO
- Police Service of NI
- District Councils
- NI Fire Authority

The arrangements for managing emergency planning responses for Chemical, Biological, Radiological and Nuclear (CBRN) threats need to be strengthened at the regional level to ensure sufficient specialist capacity. A regional response to CBRN also needs to have access to national resources which could not be replicated in Northern Ireland e.g. expertise in relation to chemical incidents, some incidents relating to poisons and also radiation. The current arrangements for advice on chemical agents have included 'contracted in' expert support from organisations situated within the University of Wales previously known as CIMSU (Chemical Incident Management Support Unit) and the National Focus. These specialist organisations are now part of the Health Protection Agency in England and Wales.

The Emergency Medical Assistance and Rescue Team (EMART) consists of approximately one hundred Doctors and nurses and other relevant health professionals. This team was formed following the 9/11 attacks and fulfilled the desire to recreate locally what had been learned from USA experts. These volunteers will be alerted to respond to work with the emergency services staff at the incident site and to provide additional assistance at receiving hospitals. The Office of the CMO has

driven and championed this project which is seen as innovative at a national level and one that considerably enhances Northern Ireland's capacity in relation to Health Service Emergency Planning measures particularly those relating to CBRN incidents.

The Northern Ireland Regional Medical Physics Agency (NIRMPA) is a specialist agency of the HPSS and provides services and advice on a range of issues relating to radiation protection, radiology and nuclear medicine. NIRMPA would have an important role in the initial response to an incident involving radioactive material in Northern Ireland.

Given the multi-dimensional threats posed to the health and well-being of the population from various sources, it is quite appropriate that emergency planning work is undertaken on a collaborative, multi-agency basis; much of this tends to come under the overall direction of DHSSPS, although some elements of emergency planning in its broadest perspective may operate under the jurisdiction of other agencies outside the health service.

However, two aspects of the current approach arising from the analysis are its dynamic nature and its relative lack of structure, with the result that there is reportedly some absence of clarity regarding roles and responsibilities. In Northern Ireland, there is no single agency or individual with sole executive authority over emergency planning matters, as would be the case in some other locations, and one stakeholder made the comment that *"often these new priorities need expertise over and above that which can be replicated within each Board separately.... a clear regional lead and links nationally are needed."*

It was also reported that as a consequence of the lack of clarity, there are overlaps and gaps appearing in the work being taken forward by various agencies on emergency planning matters.

### 3.4.3 The Challenges

#### **Organisation**

One of the most critical issues to have arisen during the consultation process, and which has formed a central aspect of the analysis, is the location of the health protection function within current public service structures. At a time in the post-9/11 environment when external threats to the health of the population have never been higher, there is a clear need for the health protection function to be strengthened in order that a fully coordinated prevention and response programme can be planned and delivered. Specific issues which emerged during the consultation process included:

- The desirability of creating a single, unified centre for health protection in Northern Ireland, in which resources and expertise from various public agencies would be pooled to create a centre of excellence;

- The need for health protection to have both a coordination mechanism at the centre, and local units of delivery to ensure that issues on the ground are effectively covered;
- The need for multi-disciplinary teams to be engaged in health protection on a dedicated basis, including medical, nursing (particularly infection control nurses), environmental health and other staff;
- Central expertise on a Northern Ireland-wide basis was considered to be very important in areas such as disease surveillance, communicable disease control, and management of infrequent events requiring specialist knowledge such as chemical incidents;
- The need to steer away from the tendency to create highly specialised service "silos" for functions such as health protection, as this would tend to reduce the existing collaboration between professionals engaged in health protection, health improvement, service development and environmental health work – it is believed that health protection should remain part of the mainstream of Public Health in order to provide a more integrated and cohesive level of service.

From the analysis of the current situation pertaining to health protection, it is clear that there are significant issues to be addressed. The present system appears to be somewhat fragmented, and although relationships and collaborative endeavours between the various responsible agencies are generally positive, it lacks clear accountability and focus. Internationally, it would appear that there is an increasing tendency in many countries to centralise all health protection functions within a single accountable organisation, particularly in the context of the upsurge in global terrorism and the threat from nuclear, biological and chemical attack, and in the light of risks posed by virulent infectious diseases such as SARS and avian flu.

A number of issues require specific consideration in the case of Northern Ireland. In the first place, the analysis has pointed to an effective balance being struck between a centralised, regional focus on health protection, and the local Public Health and other staff who will be engaged in various aspects of health protection work. The clear consensus is for regional coordination of health protection services while maintaining and strengthening local resources which by their nature are closer to the relevant health protection issues in the geographical areas and which are better placed to deliver effective local services. This is also important if multi-disciplinary working is to be achieved across professional groupings, including nursing staff, environmental health officers, and others.

Secondly, the coming into being of the Health Protection Agency and its assimilation of the NI Communicable Disease Surveillance Centre in 2003 must be taken actively into account. The rise of global Public Health threats creates the clear necessity for strong linkages to be

reinforced between NI Public Health professionals and their UK and other European colleagues. The role of the HPA and the CDSC must therefore be considered when new arrangements are being devised, as it would appear to offer an existing (though recent) model in which key specialist skills and resources are centralised to provide an effective health protection service.

Thirdly, the role of other professionals aside from doctors must be invested in and supported. Nursing and Environmental Health staff, amongst others, have a valid role to play in all aspects of health protection work, and the fact that they are spread across the health and local government systems, close to the communities they serve, argues in favour of health protection being a regionalised service which is supported by locally delivery.

### **Environmental Health**

The core issue affecting Environmental Health, arising both from the consultation process and from the analysis, is how to ensure that more effective and more structured collaboration is organised between EHPs working in the local authorities and Public Health staff working in the health and personal social services (HPSS).

Under current arrangements, there is regular cooperation between EHPs and their HPSS counterparts, on both strategic/regional issues (for example, policy and service planning) and operational matters (for example, responding to certain incidents). However, the general belief amongst EHPs consulted with was that the Environmental Health service is not sufficiently part of the mainstream of Public Health, and that a more structured approach would be desired – up to and including having Environmental Health and Public Health co-located within a single organisation, or under unified managerial control and accountability structures.

Some schools of thought believe that local democracy would be better served by placing Public Health under the control of local authorities, providing a platform for Environmental Health and Public Health to be combined within local government structures.

While there is considerable benefit to be obtained from having closer working relationships between EHPs and the Public Health colleagues working in the HPSS, this can still be achieved through the existing structures in which local government and the HPSS are separated (or through whatever changing administrative structures emerge from the Review of Public Administration). The analysis is based on several key considerations:

- Most of the tasks undertaken by local authority EHPs are of a local, operational nature (for example, inspections of premises, pollution monitoring and investigation, etc);

- Many of the functions carried out by Public Health staff working in the HPSS are integral to the HSS Boards and Trusts, and are not of immediate relevance to EHPs working in district councils (for instance service development issues);
- Overall, whilst it is clear that there are many areas of common interest between EHPs and Public Health staff, we believe that greater benefit can be obtained from closer interface between staff from within their own agencies and the organisations themselves, for example secondments between organisations and EHP posts in regional organisations with responsibility for health protection and health improvement, rather than aiming to merge all Environmental Health and Public Health activity within a single structure;
- Our assessment is that the wider interests of Environmental Health would not be served by placing this function within the HPSS – as evidenced by the current position in the Irish Republic, where Environmental Health Officers are employed by the Health Boards but work on an agency basis to the local authorities, suggesting strongly that Environmental Health as a professional discipline is more properly located within a local government setting. Within a local government setting, the role of district councils to promote health and wellbeing could be strengthened in a similar manner to the general power of competence available to local authorities in Great Britain;
- Equally, we conclude that the wider Public Health interest is better served by having these activities located within the HPSS, providing for better integration between Public Health and front-line care delivery;
- Finally, the role of the Chief Environmental Health Officer (CEHO) to advise the Chief Medical Officer on relevant cross-cutting environmental health issues could be further developed at a policy and strategy level with the CEHO providing the link between the DHSSPS, regional and sub-regional bodies and the Environmental Health service.

As with Health Protection, the Environmental Health function operates at both central and local levels, and it will be important to develop future structures which can maintain and strengthen the working relationships between Public Health and EHP staff both locally and centrally. For instance, there is considerable merit in having experienced EHPs involved with the Communicable Disease Surveillance Centre, in wider aspects of Public Health planning, and in other work to improve the general health and well-being of the population. On this basis, a key consideration to emerge from our analysis is the need for effective, multi-tier working relationships to be developed involving Public Health staff and EHPs, in a structured manner as well as facilitating more informal approaches.

### ***Emergency Response Planning***

Emergency response planning is undertaken in a highly dynamic and rapidly-changing environment, in which the diversity of emerging threats (SARS, avian flu, bio-terrorism, and others) requires a flexible, immediate and non-bureaucratic response from those agencies with a professional interest in, and responsibility for, the health and well-being of the general population.

Although there are legitimate concerns regarding the lack of clarity in roles and responsibilities, the imposition of a highly structured, bureaucratic model to manage emergency response planning matters would be somewhat counter-productive, as it would effectively remove the capacity of key professionals to be flexible in their response to emerging threats, and would tend to paralyse the system at a time when it could least afford it.

Some of the key issues to be addressed in relation to emergency planning in Northern Ireland are:

- A clear(er) definition of what emergency response planning constitutes in NI – for example, where are the boundaries between the HPSS agencies and other emergency services/agencies outside the health service?
- The need for a clear(er) definition of what NI's strategic response is to the challenges posed by major threats, and how this response integrates with UK- and EU-wide approaches.
- The need for Public Health professionals' input into emergency response planning work to become a more dedicated function for which time/resources are specifically allocated rather than being "tagged on to the day job".
- A general desire for clear policies and procedures to be developed and circulated regarding emergency response planning matters.

Overall, emergency response planning work undertaken by Public Health professionals needs to be accounted for separately, and resources allocated to ensure its effective discharge as an important, core element of their work. Given the significance and scale of the threats being planned against, nothing short of a regional approach, linked in with wider UK and EU plans, will suffice.

Whilst a multi-agency approach is extremely important, effective and successful emergency response planning will require the appointment of a single, nominated manager at senior level in the health and social services sector to drive the process forward and to take cross-cutting responsibility at a high level for making sure that resources are released, that organisations co-operate, and that the necessary work is done to protect Northern Ireland from all identified threats.

#### 3.4.4 *Main Considerations – Health Protection*

Organisation

- There is an **increasing tendency in many countries to centralise all health protection functions** within a single accountable organisation.
- **An effective balance must be struck between a centralised, regional focus on health protection, and the local Public Health** and other staff who will be engaged in various aspects of health protection work.
- The coming into being of the **Health Protection Agency and its assimilation of the NI Communicable Disease Surveillance Centre in 2003** must be taken actively into account.
- **Nursing and Environmental Health staff, amongst others**, have a valid role to play in all aspects of health protection work, and the fact that they are **spread across the health and local government systems, close to the communities they serve**, argues in favour of health protection being a regionalised service which is supported by locally delivery.

#### Environmental Health

- **Closer working relationships between EHPs and the Public Health colleagues working in the HPSS can still be achieved through the current structures in which local government and the HPSS are separated** (or through whatever changing administrative structures emerge from the Review of Public Administration).
- It will be important to develop **future structures which can maintain and strengthen the working relationships between Public Health and EHP staff both locally and centrally.**

#### Emergency Response Planning

- **There needs to be a clear(er) definition of what emergency response planning constitutes in NI** – for example, where are the boundaries between the HPSS agencies and other emergency services/agencies outside the health service?
- **There is also a need for a clear(er) definition of what is NI's strategic response to the challenges posed by major threats**, and how this response integrates with UK- and EU-wide approaches.
- **Emergency response planning undertaken by Public Health professionals needs to be accounted for separately**, and resources allocated to ensure its effective discharge as an important, core element of their work..
- **Given the significance and scale of the threats being planned against, nothing short of a regional approach, linked in with wider UK and EU plans, will suffice.**

### 3.5 Service Development

#### 3.5.1 Current Arrangements

Although arrangements vary from Board to Board, many Public Health staff within Boards are involved in activities such as:

- Quality;
- Clinical effectiveness;
- Efficiency;
- Service planning;
- Audit and evaluation; and
- Clinical governance.

Generally, there is no precise definition of the boundaries of the role of the Public Health practitioner in respect of the above activities, and the extent of their involvement tends to vary between individuals depending on such factors as workload, specialism, seniority and interest, amongst others. Thus, whilst one Public Health practitioner may have a significant involvement in, for example planning, the configuration of acute care and auditing its clinical effectiveness within their Board, another practitioner in a similar post elsewhere may have little or no such involvement.

Many Public Health professionals accept that there is substantial merit in their playing an active part in service development. It is argued, for example, that the three interlinked strategic approaches to Public Health (health protection, service development and health improvement) are all essential components of an effective Public Health function, and are both complementary and inter-dependent; health improvement in particular being closely linked with service development. This being the case, it is suggested that the Public Health function must be located where it can influence all available approaches to protect and improve health, and the leader of the Public Health function for a defined population should be able to effectively use all three strategic approaches to ensure maximum health protection and improvement and should be supported by a team of sufficient critical mass.

Supporting this argument, the Health Board Chief Executives and the Directors of Public Health have put forward strong cases for service development to continue to be an integral part of the role of Public Health. From their viewpoint, Public Health professionals within the Boards play an increasingly important role in evaluating, planning and critically questioning a wide range of service development opportunities, bringing an independent medically-qualified perspective to bear and enabling Boards to reach informed choices

based upon a sound assessment of the health and social care needs of the population.

However, others who do not work within the area of service development would argue that it is not germane to the core work of Public Health and that it requires significant time, energy and resources that might be otherwise allocated to health improvement issues e.g. obesity, sexual health, alcohol and drug abuse.

### 3.5.2 *The Challenges*

Outside of the Health and Social Services Boards, there is some divergence of opinion in relation to service development, and whether it constitutes a task which Public Health staff (especially doctors) should be pursuing. The availability of resources to undertake service development, at a time when other demands in the areas of health protection and health improvement are increasing, is a difficult balance to achieve.

Within the Public Health departments, Public Health Doctors are keen to continue their contribution in service development. The challenge is primarily resource-related. Public Health Doctors want to continue their valuable contribution in service development. However, it is acknowledged that additional health improvement and health protection activities could not be met without a commensurate increase or redistribution of staff resources.

Central to our analysis is the fundamental recognition that the Public Health function operates best when the three core activities of service development, health improvement and health protection are undertaken in an integrated manner. They are mutually dependent and international best practice suggests that a silo-based approach would be significantly less successful.

Within Northern Ireland, research has shown that many senior Public Health staff (doctors and others) are playing an ever more important role at the centre of planning, evaluation and decision-making within their Boards. This includes their participation in top level management decisions on resource allocation, service evaluation, and safe clinical systems. In many cases senior Public Health staff act as the senior medically-qualified adviser to the Chief Executive and Board, independent of Trust-based clinicians involved in service provision. The Board Chief Executives, making use of such support from their Public Health staff, were very supportive of this role, regarding it as a shift away from a functional or service delivery model towards one where the Public Health Department is involved in both service delivery and provision of wide-ranging advice and guidance to the corporate organisation.

Other activities, in which Public Health professionals are either currently involved, and/or where they wish to develop their role, include such matters as needs assessment, planning, service commissioning, clinical governance, service evaluation, and information management.

It would appear that a strong service development component within Public Health is likely to add significant value to the working of the Health Boards, continuing in similar fashion in whatever new HPSS structures emerge from the Review of Public Administration. However, as with other activities, finding the resources to enable service

development to take place as an integral aspect of Public Health will continue to be a major challenge for Boards.

### 3.5.3 Main Considerations – Service Development

- **The Public Health function operates best when the three core activities of service development, health improvement and health protection are undertaken in an integrated manner.**
- Public Health Physicians should **continue to contribute to the quality development of health and social care services** in Northern Ireland.
- **Resources must be examined to ensure that an integrated approach can be maintained**, in which Public Health professionals continue to play an active part in service development activities.
- **Notwithstanding this consideration, it will also be important to draw some boundaries around what “service development” constitutes**, in order that it does not become a catch-all for Public Health staff to become overly drawn into operational issues which are the responsibility of other Health Board departments or of other agencies.

## 3.6 Managing Public Health Knowledge

### 3.6.1 Introduction

How the Public Function is organised to manage information and how it uses information and research to assist in planning its activities have been major themes in the analysis. In this sub-section, there are two areas which are assessed in terms of how Public Health knowledge is managed:

- Health Information and Intelligence; and
- Research and Development.

### 3.6.2 Managing Health Information and Intelligence

#### **Health Information and Intelligence**

Knowledge management is an essential component in supporting the overall objectives of improving the health of the population and reducing health inequalities. Information is a valuable resource in Public Health for a number of reasons:

- Active surveillance of Public Health to identify and respond to issues of concern and to monitor the impact of Public Health interventions.
- Gathering, analysing, synthesizing, reporting and storing information on the population's health and the determinants of health both routinely and on specific issues.
- Building, using and storing evidence bases.
- Cataloguing and making widely available local, regional, national and international sources of health intelligence and research.
- Awareness raising, education and training in the use of sources of information about health.

- Carrying out research and development activities.
- Comparing local information with regional, national and international trends.

There are significant strengths in information processes in Northern Ireland to support Public Health functions. For example Public Health has benefited from the experience gained through the Monica Project (Multinational Monitoring of trends and determinants in Cardiovascular disease) and the Health Promotion Agency is a WHO Collaborative Centre for CINDI - the Countrywide Integrated Non-communicable Diseases Intervention Programme.

Some of the organisations which provide health related information in Northern Ireland are described briefly below:

#### ***The Northern Ireland Cancer Registry (NICR)***

NICR is an example of an established information resource targeting a particular Public Health issue. The NICR provides accurate, timely information on cancers occurring in the population of Northern Ireland to enable research, education and planning of services to reduce disease.

#### ***The Northern Ireland Statistics and Research Agency (NISRA)***

NISRA provides statistics and social research in order to inform government policy and helps plan public services such as health and education. Regional surveys provide valuable information on health behaviours. The Agency also provides statistical information to District Councils and businesses and the General Register Office, which is responsible for the registration of births, marriages, deaths, is also part of the Agency.

#### ***Information and Analysis Directorate (IAD) - DHSSPS***

The Information and Analysis Directorate's central goal is the provision of an effective, impartial, statistical, research and economic data analysis service. It provides high quality, timely and accurate advice to a wide range of internal and external customers, much of the information is collected from numerous HPSS Trusts and Public Health sources throughout Northern Ireland. The Regional Information Branch, DHSSPS is one of seven Branches that make up the IAD and furnishes core departmental interests with statistical information about activity within the HPSS.

#### ***The Research & Development Office (R&D)***

The R&D Office is a directorate of the Northern Ireland Health and Social Services Central Services Agency which promotes, coordinates and supports Research and Development activities in health and social care. The Office has a strategic and operational role.

At a strategic level the Office provides an overall strategic direction for Health and Personal Social Services research and development and liaises with national, statutory and health related organisations including the Department of Health. At operational level the R&D Office supports a wide range of research and development issues from education and training to direct commissioning. *Investing for Health* was one of the R&D Office's directly commissioned research programmes.

While the organisations described above and others provide an important function in information gathering, there is little co-ordination and a general lack of analysis. Some of the limitations of the current fragmented nature of information gathering in Northern Ireland would be:

- Lack of systematic processes in some areas to study the information, analyse it and report on the implications for Public Health.
- No 'one-stop-shop' for potential users of Public Health information and a resulting possible duplication of effort in bringing information together from different sources.
- A limited pool of individuals who are skilled in Public Health analysis and who currently work in disparate organisations.
- A tendency for excellent initiatives to be on an ad hoc basis rather than building on them to develop long term sustained health monitoring.
- Lack of clarity as to who is responsible for Public Health knowledge management.

### ***Growing demands for information and emerging sources***

The *Investing for Health* agenda is being actively taken forward on a wide range of fronts. This is creating demands for information to support health development processes at all levels and a common desire is emerging for strong, easily accessible sources of reliable information to maintain these efforts. Emerging processes including Community Health Impact Assessment are hampered by the lack of readily available health profile data. Local Health and Social Care Groups are seeking to carry out needs assessment work and again are facing data issues. Against this background, there remains a clear need for a sustained effort to ensure comprehensive health surveillance is maintained.

New sources of potentially valuable information to support Public Health functions are emerging. In particular the new GMS contract is stimulating a major effort to improve GP information on morbidity. Northern Ireland has a strong track record in this area through the work of the Data Retrieval Project and should be well placed to use the data to help identify and monitor health trends. Broadband technology is spreading rapidly and will enable fast access to a vast

array of information on the internet. It also provides the potential to build better systems for disseminating local information to users such as through the Geographic Information System established by NISRA.

Creating the network of Public Health Observatories (PHO) in Great Britain has been an effective way of drawing together information from a diverse range of sources to build a more robust knowledge base. The recent grant from the Health Research Board and matched funds from the DHSSPS will be used to set up the all-island web-based Public Health Observatory (PHO).

The aim of the PHO will be to meet the information needs of users and to support the activities of partner organisations by linking available information resources. It will consist of various sections, reflecting different types of health information such as health status, services available and health policies.

### 3.6.3 *Research and Development supporting the Public Health function*

#### **Research and Development**

In Northern Ireland, the Department of Epidemiology and Public Health within Queens University (QUB), Belfast provides a strong academic base for research, for which it has achieved the five star rating. The key areas of research within the Department in QUB are:

- Genetic epidemiology;
- Health epidemiology;
- Clinical epidemiology and decision sciences;
- Cancer Registry; and
- Cardiovascular.

Income is generated from international, European and local sources e.g. Wellcare, European Union grants, Research and Development Board and Health Research Board in the Republic of Ireland.

The University of Ulster (UU) has strong links to Public Health; including midwifery, social policy and health promotion; the University offers BSc (Hons) and Masters degrees in Environmental Health, is home of the Environmental Health Protection and Safety Centre (EHPaS) and is involved in the publication of the Journal of Environmental Health Research.

The University has also developed research on key issues such as nutrition, physiology and exercise. Research interventions are widely acknowledged as being powerful tools in working towards greater improvements in the health and wellbeing of the population.

The academic departments in QUB and UU also contribute to the evidence base through research interventions.

There is a vast array of work relating to Public Health practice which is not published in academic journals. This is usually conducted by professionals in a range of settings, for example the community, in trusts and health boards.

Examples of this are an assessment of health needs, an evaluation, audit or other types of research. Much of this is potentially very useful for others working in the same field and is often conducted to rigorous standards. There has been a great deal of discussion about how an easily accessible repository for such material could be made available to public health professionals.

An attempt to provide a single source for unpublished literature has been through the development of the Good Practice Database on the HPSS Extranet. This provides a searchable dataset and has a facility for professionals to send in their work for inclusion. Other discussions to develop an all Ireland resource are being led by the Institute of Public Health. It has been suggested that this could be achieved through the development of a website which would facilitate awareness, access and use of unpublished literature and other sources of information.

However, as is often the case with projects such as this, dedicated time is needed to develop and maintain the resource and ensure it is used to maximum effect.

### **Building the Evidence Base**

In Northern Ireland, significant resources have been targeted at developing action plans to reduce health inequalities. Action plans need to be developed using a quality evidence base.

Northern Ireland Public Health has some work to do in establishing an effective evidence base. There is no organisation within Northern Ireland that mirrors the functions of the Health Development Agency (HDA). The HDA is the 'national authority on what works to improve people's health and reduce health inequalities (gathering) evidence and (producing) advice for policy makers, professionals and practitioners to get evidence into practice.' It has made some strides in systematically reviewing and synthesising the evidence related to interventions aimed at improving Public Health, and disseminating practical guidance on interventions shown to be effective.

Collaborative efforts have been started between the Institute of Public Health and the Health Development Agency (HDA) where the Institute is developing evidence briefings using the HDA's methodology. Exercises such as these developed with the HDA are seen as mutually beneficial; both in terms of the learnings gained in process and the information shared.

#### 3.6.4 *The Challenges*

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**Health Information and Intelligence**

Activity in improving the public's health and reducing health inequalities must be underpinned by evidence and the availability of sound health intelligence. Currently there is no regional information infrastructure drawing international, national, regional and local information together in Northern Ireland.

The all-island web-based Public Health Observatory (PHO) which is being developed as a network of public health information agencies should go some way in redressing the absence of a regional information resource. The challenge is to develop a high quality, accessible knowledge management system which can draw from established evidence bases and measure impact and outcomes of Public Health activity over a period of time. It must also provide accurate, relevant and timely information on key Public Health issues in order to improve public understanding and aid decision making.

**Research and Development**

It is critical that Northern Ireland has a good quality Public Health evidence base that can be used to develop action plans in line with priorities. Experience has shown that working in partnership with established national and international organisations to complement and contribute to common aims can result in mutual benefits.

The challenge is to build capacity within Northern Ireland to disseminate available evidence, translate it into practice and policy and address regional needs and local priorities. It is critical that information is accessible, timely and up-to-date; that is based on best practice guidelines and standards. While it makes sense to collaborate with national and international organisations such as the HDA, it is also important that Northern Ireland builds its own capacity and capability in building and disseminating research and evidence in Public Health. In addition, Public Health related Research and Development activities should be discharged in close liaison with the Research and Development Office.

The challenge for academic Public Health departments is to meet their overall research objectives, which are often linked to quality ratings and external funding, as well as addressing the research priorities of the broader Public Health community. Succeeding in both these areas requires sufficient capacity within the departments.

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**Building the Evidence Base**

It is recognised that along with information, research and evaluation, evidence is a fundamental tool in planning for critical health interventions. Collaborative exercises with national organisations such as the HDA are particularly advantageous to Public Health in Northern Ireland where they stretch Northern Ireland beyond its own borders in terms of working alliances; focus activity on structured methodologies for developing evidence briefings; build UK-wide capacity for developing Public Health evidence; and strengthen Northern Ireland's links with the established knowledge and evidence base of the Health Development Agency.

**3.6.5 Main Considerations – Managing Public Health Knowledge****Health Information and Intelligence**

- Develop a **high quality, accessible knowledge management system** which can draw from established evidence bases and measure impact and outcomes of Public Health activity over a period of time. **It must also provide accurate, relevant and timely information on key Public Health problems in order to improve public understanding and aid decision making.**

**Research and Development**

- Achieve a balance between academic Public Health departments providing research to meet their overall research objectives and **address the research priorities of the broader Public Health community.**

**Building the Evidence Base**

- Build capacity within Northern Ireland to make available **evidence that addresses regional needs and local priorities.**