

Environmental Health in Scotland  
and the  
Health Improvement Challenge

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**Professor George Morris & Mrs Ruth Robertson  
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George Morris  
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## Summary

From its traditional home in local authorities, Scotland's environmental health profession has played an important role in the nation's health. Its primary focus has been the pursuit of healthy environments normally through statutory means. Yet, whilst it remains vitally important to contain existing and emerging environmental threats to health, the profession has lost much of its status and influence. Environmental Health is seen by some external stakeholders and the profession itself as operating sub-optimally in a narrow statutory role governed by the demands of fulfilling performance criteria at a time when opportunities are opening up which might permit its return to a valued role, recapturing lost ground.

Foremost amongst the opportunities is Scotland's recently articulated Health Improvement Challenge <sup>(1)</sup>, which calls for a concerted multi-disciplinary effort to tackle ill health and inequalities in health. The skills of environmental health professionals are a huge potential resource to politicians, the public and the nation. However, the profession undoubtedly faces its own challenge, which can be seen as having two primary elements. One is about the need to re-energize a beleaguered profession, to propel it from its current dependent, reactive state to rival the most effective of modern professions. The second, and inter-related element is about rediscovering effectiveness as a force in public health. Much of the profession's task is about seeing the world in quite a different way. There is a need to create a clear statement of identity and to nurture the skills and maturity to work effectively in the new networks forming at local level to address the Health Improvement Challenge.

The task is significant and demands a concerted and organised campaign in which the whole profession and its component institutions must be partners. The campaign must succeed in a situation where the profession is institutionally fragmented and where the cohesive unifying force of concern for public health has been weakened.

## 1.0 Introduction

Environmental Health has always been a practical discipline. Hands-on and accountable, it has made a positive and identifiable contribution to the nation's health. The defining feature of the environmental health professional has been a focus on changing or preserving the physical environment\* as a means of achieving goals in public health. Almost uniquely amongst the many professions and groups who, through their activities, alter and shape the human environment, environmental health professionals do so solely in the interests of human health.

In recent times however, the profession has suffered diminishing fortunes, losing seniority and influence within its traditional institutional setting of local government. This is evidenced by reducing numbers of environmental health professionals heading up the composite departments that characterise today's local authorities. Environmental health is increasingly relegated to a rather narrow statutory role, driven by pressures to meet performance management targets which often relate only loosely, if at all, to Scotland's priorities for health. This situation coincides with arguably the clearest articulation from government for many years of the health challenge facing Scotland. The nation's health is poor, with an apparently intractable burden of chronic and infectious disease and enormous health inequalities between different sectors of society. It has been said <sup>(2)</sup> that what Scotland needs is a "step change" if it is to shake off this image. The Scottish Executive's response has been to present the circumstances as a Health Improvement Challenge defined within "Improving Health in Scotland – The Challenge" <sup>(1)</sup>. This is the latest in a succession of policy documents that reinforce the message that Scotland's poor health will not be

\* The Environment is the universal set of all things external to the individual and excludes self. In the socioecological model of health ( Evans & Stoddart) <sup>(3)</sup> the environment is seen to comprise two parts, the social and the physical environment. Thus, in this context, the physical environment is an inclusive concept, comprising the full spectrum of biological physical and chemical entities, whether natural or man-made but excluding the social environment whilst recognising that this closely inter-relates. Aspects of the physical environment may or may not be detected by the unaided senses.

changed by curative medicine alone but rather by redoubled efforts and new and imaginative alliances amongst the many agencies which influence life circumstances and lifestyles in the Scotland of the 21<sup>st</sup> century. The potential contribution of local government to addressing the health challenge is universally accepted yet the role that might be played by environmental health is much less commonly discussed inside or outside of local government.

We make no apology for placing a strong emphasis on conceptual issues in this report. We believe the profession needs a clear concept of what it is about, its modes of operation and what it can deliver. Only then can it develop strength, communicate its worth and gather the support necessary to achieve its potential.

Despite its theoretical underpinnings, the report is intended to be a working document used to inform action for a practical profession. It begins with a very brief sketch of the historical contribution of the profession to public health since its inception to the present day before offering some observations on the current situation. In Chapter 3, selected current policy documents including “Improving Health in Scotland - The Challenge” are described. These documents give the policy context in which any action must take place.

Consultation both within the profession and beyond has been a key feature in researching and preparing the document. Indeed many of the findings and recommendations have their origins in that consultation process. Respondents in this consultation have also offered a sounding board for ideas brought forward by the authors. The process is described in full and its findings distilled under a set of topic headings in Appendix 1. However, in the interests of continuity, reference is made to these findings at appropriate points throughout the text. The report ends with a proposed action plan for the profession in Scotland.

We believe that environmental health professionals can be central players in the multidisciplinary project to produce the step change needed in Scotland’s health. Indeed, if environmental health is not fully engaged, not just the profession but also the project will be undermined. The profession must however move from a reactive to a proactive stance, set clear goals and be focussed in its efforts to achieve them.

Crucially, it must restore some of the professional pride that has ebbed away in recent years as, only then, can the profession hope to be truly fit for the task which faces it. The need to confront these issues has driven the production of this report.

## **2.0 The Historical Context**

For as long as humans have seen links between their own health and their environment the manipulation of that environment has been a rational approach to preserving and improving health. It is unsurprising then, that across the globe; governments have embraced control of environmental hazards as a primary strand of public policy aimed at achieving a healthy citizenry. In the UK, control of the physical environment has been a key component of public health policy since the 19<sup>th</sup> Century. Indeed, the environmental health profession and the local government structures in which it principally operates, owe their origins in large part to the perceived importance of state intervention to secure a healthy physical environment.

Human understanding of the factors determining health has of course evolved over time and in response to a range of influences, not least advances in the various branches of science. For example, in the early 19<sup>th</sup> Century, it was widely held that many diseases were caused by exposure to noxious vapours, or “miasma” but with the discovery of the light microscope and the new science of microbiology, an amended causal paradigm emerged which sought to explain disease in terms of infection by minute pathogenic organisms. Under each of these paradigms the state of the environment was seen as an integral part of disease causation and environmental intervention, principally to deliver sewerage systems, wholesome water supplies and healthy housing, was indicated. Environmental measures were targeted at populations and, in addition to providing tangible health benefits; they accorded status and relevance to those responsible for pursuing them. Amongst this group were the predecessors of today’s environmental health professionals.

Infectious disease remained the principal target for public health measures well into the 20th Century but, whilst physical environment was still accorded importance (for example, support for slum clearance was frequently justified by reference to rates of tuberculosis in a specific locality), strategies such as immunisation and isolation denoted an increasingly individualistic approach.

Mainly due to the success of measures to counter infectious disease, the health fears of the post 2<sup>nd</sup> World War population shifted to what were seen as the new epidemics of cancer, heart disease and strokes which epidemiology increasingly associated with aspects of individual behaviour and lifestyle such as smoking, diet and lack of exercise <sup>(4)</sup>. Initially at least, many of these statistical associations were demonstrated in the absence of any real understanding of causal mechanisms. Perhaps inevitably, the indicated interventions were targeted towards the behaviour and lifestyle of the individual as though these existed independently of any social or environmental context. Even as underlying causal mechanisms began to emerge, these seemed to reinforce the notion that a direct assault on lifestyle was the only logical approach. This is not of course to deny the importance of environmental interventions for health in the post war era. The Clean Air Acts, enforcement activity in relation to food safety and the local authority contribution to safety and health at work, stand out as examples of environmental measures driven by health concerns and delivering real health dividends. Increasingly however, physical environment was regarded as less important in relation to the big health issues of the day than the association between lifestyle and health. Unsurprisingly, the favoured preventive interventions were targeted towards improving knowledge and changing attitudes and behaviour without reference to the social or environmental context.

This uncoupling of environmental issues from human health was reinforced at an institutional level when, in 1974, health service reorganisation in Scotland removed the post of Medical Officer of Health from its traditional home in local government to re-emerge in a rather different form within the area Health Boards. The term “environmental health” first came into common usage with local government reorganisation in 1975, to describe the residual component of the MOH-led local government health partnership. This was to remain in its original local government home where its health dimension was consistently underplayed. Activity centred on enforcement action in relation to food standards, water, housing, air quality etc. Whatever benefits may have flowed from these changes, NHS reform in 1974 and Scottish local government reform the following year had profound implications for public health. Public health medicine was placed in organisations where it was required to compete for resources and influence with curative medicine. The

perceived status of local authorities as players in the nation's health was also undermined.

For environmental health, a group historically characterised by the disparate nature of its activities and approaches, a focus on securing population health had provided both cohesion and purpose. If not entirely abandoned, this perspective certainly became subordinated to other concerns. The profession drifted to its current position where it is to a large extent anchored in a narrow statutory role, performing enforcement duties, which local authorities conduct on behalf of the UK government, the Scottish Executive and a number of agencies. The absence of a unifying thread provided by the theme of human health also left the service vulnerable to the fragmentation which has occurred during local government restructuring at national level, management driven internal restructuring within councils and the creation of new agencies to deliver aspects of the environmental health function. Today, those who direct the activities of environmental health professionals frequently lack a public health perspective and have little or no conversance with the discipline of environmental health and its contribution within the public health family. References to the diminution of the environmental health function, to achievement being measured in terms of compliance with best value and performance management targets, to the unremitting pressure to achieve these targets within the statute driven agenda of local government are now clichés in discourse between environmental health practitioners at all levels.

Whilst the above is a simplified and selective analysis of the history and current circumstances of environmental health as a discipline in the UK, it does sustain certain observations. The first is that environmental health practitioners are most valued when they are seen as relevant and effective in the context of contemporary health concerns of the public and politicians. This certainly has a lot to do with whether there is a scientifically plausible contribution from environment to the incidence and severity of the diseases people fear. It is also about the more fickle issue of the public perception of risk, which heightens fears regarding certain issues whilst reducing concern over others.

The second observation is that quiet vigilance in containing a threat, e.g. the infectious pressure on food supplies from agricultural and estuarine environments, is unlikely to sustain a high profile with the public and the media. Attention is attracted only when the protective envelope is breached and illness occurs. Much traditional environmental health activity relates to the containment of threats.

### **3.0 The Modern Policy Context**

#### **3.1 Introduction**

It was observed in the preceding section that environmental health practitioners appear to be most valued when they are seen to be relevant in the context of the current health concerns of the public and politicians. This was seen to be a function of prevailing paradigms about how disease is caused and also perceptions about risks and their prioritisation. Against this background, Scotland's environmental health professionals might profitably consider three key questions: (i) Which are the big health issues of today? (ii) Can they make a contribution to tackling these? and (iii) How can they convince policy makers that they have something valuable to offer in the context of the problems they have prioritised? To answer these questions it is essential to review the current understanding of health, the factors contributing to it and the particular health issues faced by the policy makers in Scotland.

#### **3.2 An Evidential Basis for Policy**

Currently, the socio-ecological model of health represented by the Evans Stoddart model (see Figure 1) provides the basis for much of the thinking behind policy initiatives in the area of health and health improvement in Scotland.

## Socio-ecological Model of Health (Evans and Stoddart)

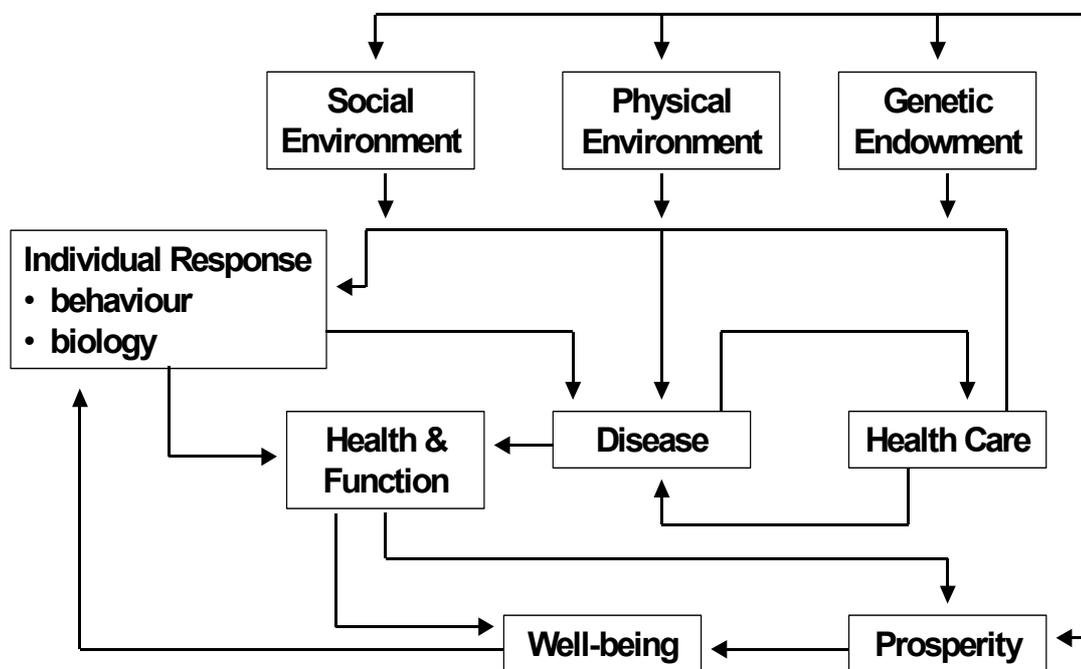


Figure 1 A Sociological Model of Health –Evans and Stoddart <sup>(3)</sup>

This model conceives health as extending well beyond simply the absence of disease to encompass function, wellbeing and inter-related factors. Importantly, from the environmental health perspective, the physical environment is placed alongside social environment and genetic endowment, as a primary driver of health. The model does not underestimate the impact of individual behaviour but portrays this as very much a dependent variable within a complex causal web. Implicit in the model is the recognition that good health (and not just the removal of illness) might be achieved by appropriate interventions. Thus, if health improvement is about developing ways of preventing ill health, protecting good health and promoting better health, action on physical environment must be central to its delivery. An important observation is that, in terms of the socio-ecological model, physical environment may act directly, indirectly and in association with other factors to influence many aspects of health

and wellbeing. However elegantly the socio-ecological model may set the context, progress is only likely to be achieved if it is matched by initiatives on the policy side.

The challenge set out by the Scottish Executive is characterised by the following statements:

- Scotland has poor health by UK and European standards
- Scotland has high levels of inequality in health outcomes for different socio economic groups
- There are strong cultural influences on health that have to be confronted
- Health improvement requires change by both society and individuals
- Poverty, in a broader sense, is a central feature of the problem
- History demonstrates that societies can adapt to meet new threats and challenges

Thus the challenge is all-encompassing in its nature and if it is to be successfully tackled, demands a multi disciplinary approach reinforced by national and local partnerships involving local authorities, NHS Scotland, the voluntary sector and local communities.

Inequalities in health between different communities in Scotland are an enduring concern and any health improvement in absolute terms ought to be accompanied by a reduction in health inequalities between sectors of society. Inequalities are evident across the spectrum of health outcomes, e.g. in relation to life expectancy. For example, the average life expectancy for men in affluent areas in 1990-91 was 76.7 years whilst in deprived areas it was 68.9 years. Similarly the average life expectancy for women in 1990-91 in affluent areas was 80.7 and 75.9 years respectively <sup>(1)</sup>. A report from the Public Health Institute of Scotland suggests, that, if Scotland is to catch up with comparable countries in Europe, life expectancy needs to improve at a much faster rate <sup>(2)</sup>. The Institute called for a ‘step change’ in Scotland’s health. However, there is acceptance that a ‘step change’ can only be delivered through the formulation and implementation of effective policies.

### **3.3 Key Drivers for Health**

It is useful to examine some the key policy drivers for change alongside other current influences on the environmental health profession in Scotland.

#### **3.3.1 Towards a Healthier Scotland** <sup>(5)</sup>

Published in 1999, this important White Paper on health in Scotland was arranged under three key themes:

##### *Life Circumstances*

These are external factors, which impact on health and wellbeing and can affect health directly, or indirectly by limiting choice and opportunity. They include factors such as unemployment, poverty, poor housing, limited educational achievement, the environment and social networks. The text recognises the need to address these underlying determinants if the health of the Scottish population is to improve.

The explicit references to environment and to housing, an integral component of it, and their relevance to health are important for environmental health professionals.

##### *Lifestyle*

This is the label given to the health relevant behaviours adopted by the population. Reference is made to both positive health enhancing behaviours e.g. physical activity or healthy eating and to negative and health threatening behaviours such as smoking and alcohol abuse. The text recognises the existence of significant barriers to choosing a healthier lifestyle, which may exist in many cases. Hence life circumstances, which include physical environment, can act to make it much more difficult for individuals to make healthy choices in their lives.

The document projects an explicit role for environmental improvement in making healthy choices easier.

### *Health Topics*

These are areas regarded as important targets if the health of the population is to improve. The list of health topics in the White Paper include Child Health, Dental & Oral health, Sexual health, Coronary Heart Disease and Stroke, Mental Health and Accidents and Safety. Significantly, the White Paper makes a clear reference to the capacity of interventions on Life Circumstances and Lifestyle to impact on health topics.

Appropriate action on the physical environment has the potential to impact positively in respect of several of these “health topics”.

### **3.3.2 Improving Health in Scotland: The Challenge<sup>(1)</sup>**

Amongst the current policy documents, *Improving Health in Scotland: The Challenge* is the principal reference. It proposes a framework for action built in part on the past successes in improving the health of the people of Scotland. The Challenge is to accelerate the improvement in the nations health by focussing policy and activity on priority areas. Recognising that everything cannot be achieved simultaneously, for the first phase, concerted action is recommended in relation to health improvement in the **Early Years**, the **Teenage Transition** period, in the **Workplace** and in **Communities**. The action will relate to both lifestyle and life circumstances and target risk factors have been identified. These are tobacco, alcohol, low fruit and vegetable intake, physical activity levels and obesity.

There are some important elements in the “Challenge Document” for environmental health professionals. The document makes specific reference to the need to improve the physical environment of Scotland’s most deprived areas. Clearly the profession’s role in relation to physical environment affords great capacity to influence life circumstances through statutory and other means. Specific mention is made of the need to involve local government in the thinking, the development and the delivery of strategy and policy for health improvement. There is a clear implication that good ideas from whatever source will receive a listening ear. Thus, changes to environment, which influence health directly and indirectly, are considered an important key to addressing the Health Improvement Challenge. These are the very

changes a motivated and innovative environmental health profession can help to engineer.

Notably too, environmental health professionals operate in workplaces and communities where not only can they work to change the physical environment but they might also be advocates for messages about lifestyle. The issue of whether environmental health professionals should become involved in generic health promotion is revisited in Chapters 4 & 5.

References within health improvement policy to the need to develop the public health workforce to maximise public health potential also have relevance to environmental health professionals. Developments in this area offer significant opportunities and we return to workforce matters at various points in the text, notably in Appendix 2.

### **3.3.3 Health Protection in Scotland - A Consultation Paper <sup>(6)</sup>**

The 2001 Review of the Public Health Function in Scotland <sup>(7)</sup> defined health protection as those activities that protect health and prevent ill health. Environmental health professionals have a historical commitment to these objectives. The functions include control of environmental hazards to health and management of public health emergencies. “Health Protection in Scotland – A Consultation Paper” considers the current arrangements for health protection in Scotland, and how the various organisations can best continue to work within a UK but also international context on health protection issues. The primary aim of the consultation is to assess the relative merits of 6 options for organisational change. These options are assessed on how they would or could:

- Improve the coordination and implementation of the required range of health protection measures
- Improve the effectiveness and efficiency of the key health protection functions of surveillance, investigation, risk assessment, management, communication and managing emergencies

- Enhance the accountability of health protection services in Scotland by more closely aligning policy, resource allocations and performance management functions
- Facilitate collaboration with UK, European and international counterparts in protecting health, especially in securing the best possible specialist advice and in recognising and responding promptly to emerging infections and the deliberate release of biological and chemical agents
- Provide incentives for people working in health protection to improve their individual and collective performance through a continuing process of personal, professional and organisational development.

It is clear on reading the document that “Environmental Health Officers” are seen as important players in Health Protection. This is entirely appropriate as health protection activity, although not always labelled as such, lies at the core of the professions traditional role. The document was not explicit on how environmental health professionals will operate within amended health protection arrangements.

*N.B. At the time of completing this report, the Scottish Executive has just published the responses to, and outcomes of, the consultation process. There are two main elements to the proposed future arrangements. Functions currently discharged by the National Radiological Protection Board and hitherto by the National Focus for Chemical Incidents (and also the commissioning of an integrated UK poisons service) will become the responsibility of the Health Protection Agency (for England and Wales), subject to the passage of new legislation.*

*The functions of SCIEH, the health surveillance elements of the Information and Statistics Division of the Common Services Agency (CSA), and the current responsibilities of the National Services Division of the CSA in relation to Scottish National Reference Laboratories will be brought under a new Scottish health protection organisation that will be a discreet division of the CSA.*

*Thus, the local authority environmental health function will not become part of Scotland’s new health protection organisation.*

### **3.3.4 Local Authorities as Health Improvement Organisation <sup>(8)</sup>**

This document carries the strong message that local authorities are key to the development and delivery of health improvement within the communities which they serve and is intended as a framework for local discussion and decision making on health improvement. There is emphasis throughout on the need for health improvement and tackling inequalities to be integrated into every aspect of local authorities - their thinking, their planning and their service delivery. Specifically the following characteristics are advanced as defining a local authority that is acting as a health improvement organisation:

- Health improvement should be integral to its internal corporate culture
- Health improvement should be accepted as a core function
- Staff should be supported and their capacity developed to advance the agenda
- Policies which support health improvement should be developed and implemented
- The transfer from policy to service delivery and practice should be ensured
- The impact of policies and practice on the health and well-being of communities must be critically reviewed
- Partnerships bringing value to the health improvement effort should be in evidence

### **3.3.5 Joint Health Improvement Plans (JHIP)**

The concept of Joint Health Improvement Plans is central to the effective operation of local authorities as health improvement organisations. Community Planning is the key framework for partnerships and initiatives at regional local and neighbourhood level and has a major theme around health. The process, which has statutory underpinnings, requires health boards and local authorities to participate. The statutory responsibility that requires the creation of a Community Plan also places a duty on the local NHS Board and local authority to agree and produce a Joint Health Improvement Plan (JHIP). In essence, a JHIP sets out the health improvement challenges for the locality and identifies the contribution of the partners. In the case

of local authorities these include the contribution that individual departments can make to improve the health and well-being of the population.

The creation of the JHIP is an obvious opportunity for environmental health professionals to play a central role in their employer's efforts to engage with others in delivering health improvement. Anecdotally, it appears that, despite some notable and celebrated exceptions, environmental health professionals are frequently quite detached from the processes developing the JHIPs at local level and unsurprisingly are being regarded as not central or even particularly relevant to their delivery.

### **3.3.6 NHS as Public Health Organisations<sup>(9)</sup>**

This paper was produced as a result of work undertaken by the Directors of Public Health in Scotland and the Public Health Institute of Scotland. It seeks to engage the NHS Boards by highlighting their responsibilities to undertake sustained work on combating the range of factors, which affect the health of the population and the inherent inequalities in health. The paper actively promotes effective working between partner agencies and the potential contributions to achieving health improvement in the population.

The Environmental Health profession working in a range of settings might use the paper as an opener for direct discussions around partnerships with NHS Boards.

### **3.3.7 Partnership for Care<sup>(10)</sup>**

This Government White Paper centres on the National Health Service in Scotland. The Paper tries to promote a culture of continuous improvement in the NHS including the modernisation of services to provide high quality care. Importantly, it also describes the devolving of power and the involvement of people in an attempt to ensure the right changes for health care. The Paper aims to provide an NHS, which gives the patient a quicker and better service. It also emphasises the need to tackle health inequalities and the importance of partnership working to change unhealthy lifestyles and circumstances. Actions include reducing waiting times and providing

better health information and advice. It is also clear that patients should be partners in decision-making.

The White Paper highlights the importance of “Health Improvement Challenge” and the role of local authorities in addressing it.

### **3.3.8 The Local Government in Scotland Act, 2003 <sup>(11)</sup>**

This recent piece of legislation is important in the context of this report not because it explicitly deals with the environmental health function of local government, but rather because there is to be found, within each of its 3 principal parts, provisions which are relevant to the role of local authorities in public health.

#### *The Duty of Best Value*

The concept of best value is now well established within local government. The Act places a duty on local authorities to make arrangements that secure continuous improvement in the performance of the authorities functions.

#### *The Duty of Community Planning*

This requires councils to plan and provide services together with other public bodies, which are termed “Community Planning Partners”, and also to involve the communities affected.

#### *The Power to Advance Well-being*

This gives councils the power to do anything they consider is likely to improve the well-being of their areas and/or its population. This is essentially a “power of general competence” in the pursuit of well-being.

That a local authority has power to do anything it considers is likely to improve the well-being of its area, and those who live within it, is a significant departure. Specifically it implies the strongest endorsement to the use of imaginative non-statutory initiatives to change the physical environment. The limitations of a statutory

approach to controlling physical environment for health are well recognised. The new power is both an opportunity and a challenge.

### **3.4 Conclusions**

This Chapter conveys something of the content of the more important inclusions in a burgeoning library of official publications. For further detail, readers are referred to the specific texts, however the message for the profession is clear. Everyone knows that Scotland has significant issues around the health of its population but no one, any longer, proposes simple quick fix solutions or suggests that individual players, working in isolation, can make the necessary difference. Planning and partnership are likely to be the keys and physical environment, as a huge component in the life circumstances of each of us, is repeatedly emphasised as being central to progress. Imaginative solutions are being sought and a legislative climate has been prepared creating flexibility and encouraging the partnerships around which success will be built. Environmental health professionals must prepare, and present themselves as a vital part of the solution.

## **4.0 The Challenge for Environmental Health in Scotland**

### **4.1 Introduction**

The foregoing indicates the challenge facing Scotland's environmental health community. We suggest it has two primary elements each of which must be addressed if the profession is to prosper. Emerging consistently throughout the consultation that informed the production of this report, was the need to revitalise a profession that is not enjoying good fortune. Busier than ever and operating under sustained and significant pressure, the profession seems nonetheless to be losing status and influence. Discontent is widespread and there is a belief that the profession is continuing to lose ground and miss opportunities.

It is almost as if environmental health were in a straightjacket, constrained to operate in a narrow statutory framework. This is not because the professionals involved at local level do not recognise that there is more to creating healthy environments than enforcement related activity or indeed reject new ways of working. Rather it is because the opportunity to work differently is often severely limited.

The second element of the challenge facing the profession, and a key driver behind the commissioning of this report, is the desire to place environmental health at the heart of the multidisciplinary effort to produce the "step change" in the nations health.

We are convinced the scale of the problem demands a concerted and organised response co-ordinated at national level. An action plan is essential and we present our proposals for this in the next chapter. However, it is clear that little will be achieved without the broadest possible consensus on what is required and a strong commitment to its delivery. This chapter sets out the theoretical basis on which the action plan has been developed.

According to one interpretation, the environmental health profession has reached its present less than satisfactory position largely as a result of external factors. However, some have argued quite forcefully that timely and appropriate action with targeted

lobbying by the profession in Scotland would have avoided or at least ameliorated the situation. We see little profit in engaging in any debate around what might have been done in the past, but the belief that environmental health as a profession has acquired an extremely reactive character is, we believe, sustainable. Such plaudits as are offered to the profession by external observers appear to centre around the idea that environmental health is “good at reacting”, e.g. to local problem, to a sudden demand or crisis, to a new policy or to a piece of legislation. However, the overarching impression is of a profession which is reliable, worthy and competent within surprisingly narrow parameters but which ultimately depends on others to create its agenda and to determine its priorities. Such dependence is unlikely to deliver the change in circumstances that many in the profession are seeking.

## **4.2 Shifting the paradigm**

Assuming there is sympathy for the above analysis, a move from a dependent stance to one that is markedly more independent is indicated and, we believe achievable, even within the constraints that apply. Another way of expressing this would be to say the need is for a “problem centred” as opposed to a “task based” approach. The benefits of this change are potentially significant, certainly in terms of restoring professional pride and giving the profession more say in its own destiny. Independence can also make environmental health professionals more effective, helping to create the profile necessary to re-establish them as key health professionals in local government.

One important strategy must be to emphasise, and re-emphasise whenever possible, the role of the physical environment in health by drawing on appropriate sources, notably the Evans Stoddart Model <sup>(3)</sup>, but also the scientific literature.

To be truly effective in the context of the Health Improvement Challenge, independence alone is unlikely to be sufficient. Here, the need is for effective multidisciplinary working which implies that the re-invigorated profession that emerges must work in interdependent partnerships. Covey <sup>(12)</sup>, addressing a rather different issue in the management literature (specifically the development of leadership skills in the individual) presents the concept of a “maturity continuum” in

which the individual moves from dependence to independence and on to an enhanced state of maturity termed interdependence. We believe that the concept of working through a maturity continuum from dependence to independence and on to interdependence is a useful model to apply to the environmental health profession in Scotland and can lead to quite a different profession. Critically, it has the capacity to address both elements within the “professional challenge”. Specifically, it can tackle the current diminished status of the profession and also equip it to play a leading part in producing the “step change” in Scotland’s health.

### **4.3 Creating the Foundations**

In earlier work by the authors <sup>(13,14)</sup>, four issues were projected as fundamental underpinnings for any professional grouping. These issues, namely Identity, Territory, Skills/Knowledge and Priorities were explored in the context of the environmental health profession in Scotland. We would argue that progress through the maturity continuum demands a solid foundation created from consensus on three of these areas, namely Identity, Territory and Skills/Knowledge. The issue of priority is important but is addressed subsequently when considering the processes necessary to move through the maturity continuum from dependence to independence. Reflecting their importance, identity, territory and skills/knowledge were central themes in the consultation exercise that informed this report. They appeared to win acceptance as a useful context within which to discuss a disparate range of factors.

Identity and territory are closely linked but are not interchangeable. Identity is about how the profession sees itself and we suggest that a profession’s identity should be defined in terms of its overarching aims. A clear identity can be a cohesive force for any group and can be unambiguously communicated to others. Thus, environmental health’s identity might be defined in terms its particular contribution to the nation’s health. Identity is likely to remain essentially unchanged over time. By contrast, territory, in this context, relates to the breadth of activities a profession embraces in pursuit of its overarching aims. It is important for there to be a broad consensus on territory at any point in time but the boundaries may shift in response to a range of influences. However, territory ought always to be consistent with the aims that identify the profession.

A third and closely related issue, is the skills and knowledge that underpin (or ought to underpin) the activities of a profession. Inevitably, skills and knowledge relate closely to territory. A profession must decide whether it has the appropriate blend (and depth) of knowledge and skills for the territory it wishes to occupy at any point in time. By extension a key question is whether the education and training strategies adopted by the profession are attuned to modern demands?

### 4.3.1 Identity

In a previous publication <sup>(14)</sup> the authors proposed that the identity of environmental health might be defined in the in the following terms.

**“That area of public health activity, which seeks to improve and maintain the public’s health and well being through action on the physical environment.”**

This was seen to relate well to the socio-ecological model of health (see Chapter 3) in which physical environment, broadly defined, is presented as one of the key drivers of health. It seemed also to be consistent with the historical role of environmental health. We have argued that this is clear, concise and specific to environmental health because, whilst many players can change physical environment and in so doing influence health and well-being, environmental health is unique in that it does so solely in the interests of human health. The views of consultees were sought on the above statement of identity.

There was support for the idea that any statement of identity should be clear, concise and unique to the profession particularly if it is to operate effectively in multidisciplinary partnerships. Although there was discussion around the issue, there was (ultimately) agreement that any statement of identity should not make specific reference to the day-to-day activities of the discipline or to its institutional home(s). A suggestion by one commentator that the statement should be amended to include specific reference to the health protection role of environmental health professionals is accepted as appropriate particularly in the light of recent developments in that area. Some respondents expressed concern over use of the term “physical environment”

suggesting that, at the very least, it required to be defined. We accept the need for absolute clarity but make the strongest plea for the retention of the term, “physical environment” within the statement of identity because it is a recognised concept within the socio-ecological model of health and is understood both by policy makers and the public health community. For a definition of physical environment, see Chapter 1.

It was also suggested that adherence to the draft identity statement, places any generic health promotion activity aimed at lifestyle issues beyond the remit of environmental health professionals and some respondents were uncomfortable with this. We believe that generic health promotion is primarily the domain of health promotion professionals and, anyway, the socio-ecological model illustrates rather well that changes to the physical environment may indirectly result in changes to health related behaviours. Accordingly, the most appropriate way for environmental health professionals to impact positively on behaviour is almost certainly indirectly through changes to physical environments. We, nonetheless, have sympathy with the view that environmental health professionals might be effective advocates on lifestyle issues in the settings in which they operate - the workplace, the community, pubs, clubs, restaurants, shops, the hospitality industry etc. Through such activity they might support the work of generic health promotion. In interviews with external stakeholders, it was suggested on more than one occasion that, not to use a large workforce with communication skills to reinforce generic health promotion messages where possible, would be an opportunity missed. It could be argued that the identity statement might be amended to reflect the generic health promotion role. Alternatively, it might be more useful to adhere to the draft identity statement based on physical environment yet still embrace activities which promote exercise, healthy eating and smoking cessation because would be pragmatic and politically advantageous to do so.

### 4.3.2 Territory

In earlier work <sup>(14)</sup> we observed that there is a set of activities, which must be ongoing if environments consistent with human health are to be pursued and maintained. It was proposed that these activities make up the wider “discipline” of environmental health as distinct from the environmental health “profession” in Scotland. The authors have subsequently used the term “the protective envelope” to encompass these activities<sup>(15)</sup>. The protective envelope can be said to comprise:

- a) Activities which explore the relationship between physical environment and health and describe, in respect of different aspects of environment, what is acceptable and what is not in terms of health, and
- b) Activities, which are concerned with controlling those environments to preserve, protect and improve human health.

The second set of activities is informed by the first, but both parts are necessary if the population is to be protected from the health damaging effects of physical environment. The integrity of the protective envelope is developed and maintained through input from of a number of players of which the environmental health professional is but one. The role played by environmental health professionals within this set of activities can for convenience be termed, their “territory”.

Expressed in another way the integrity of the envelope demands activities, which relate to research and the maintenance of the evidence base and activities that create and preserve environments which are consistent with human health.

Those who research and maintain the evidence base deal in “evidence” of two types:

1. Empirical Evidence (to assess the biological plausibility of a health impact from an exposure), and

2. Epidemiological Evidence (from which comes our understanding of how much an exposure might impact on the health of the population).

Those who shape and control environments require certain things too. These are not so much “evidence” as “tools”. These also come in two types:

1. Appropriate environmental control technologies and strategies, and
2. Appropriate legal administrative, fiscal or other means to ensure the technology or strategy is applied.

The concept of a protective envelope is illustrated in Figure 2 below

**THE PROTECTIVE ENVELOPE**

<b>EVIDENCE</b>		<b>CONTROL</b>	
<b>EMPIRICAL</b>	<b>EPIDEMIOLOGICAL</b>	<b>TECHNOLOGY</b>	<b>APPLICATION</b>
<b>Box 1</b>	<b>Box 2</b>	<b>Box 3</b>	<b>Box 4</b>

Figure 2: The Protective Envelope <sup>(15)</sup>

Thus, it can be appreciated that for any environmental exposure one would wish to see strong evidence in Boxes 1 and 2, an effective control strategy (technology) in Box 3, and lastly means to secure the application of that strategy (Box 4).

Using the example of elevated lead levels in drinking water, there is abundant empirical evidence that lead is a cumulative toxin (Box 1) and there is epidemiological evidence from many countries linking it to neurological dysfunction in populations and other serious health outcomes depending on dose (Box 2). There are various actions that can successfully reduce or remove or reduce the exposure to lead in water (Box 3). An evidence-based prescribed concentration value (PCV) exists which is given legal status under the Water Supply (Water Quality)(Scotland) Regulations (Box 4). Thus, whilst unsatisfactory exposures will inevitably arise in different localities at different times there is something approaching integrity in the

protective envelope for this exposure. Taking a very different exposure such as living under high voltage power cables, empirical evidence falls well short of proving a plausible link to the alleged health outcomes (cancers) at the measured levels of non-ionising radiation. Epidemiological evidence of health outcomes is weak and equivocal. A partial control measure is available but, in most cases, only at considerable cost and inconvenience. Finally, and unsurprisingly given the quality of evidence base, there is no legal or other mechanism by which to force removal or reduction of the exposure.

Overhead power cables are however a good illustration of an issue which is increasingly debated, namely the potential for environment to affect health through psychosocial mechanisms in addition to the more accepted infectious, toxic or allergenic routes.

Maintaining the integrity of the protective envelope as illustrated in Figure 2 involves input from many players. The authors consider that, viewed in aggregate, all such activity, whether directed towards improving the evidence base or whether related to developing or implementing control measures constitutes the totality of the “discipline” of environmental health. Thus, there is a distinction between the discipline and the environmental health profession in Scotland which comprises EHOs, and those non-EHO specialists who work alongside them\*. Traditionally, environmental health professionals have been primarily concerned with control issues (Boxes 3 & 4). The profession’s focus has been on removing or reducing threats from environment principally through enforcement or the threat of enforcement. Typically, the environmental standards enforced are devised without input from the profession. Frequently, of course, environmental health professionals have a strong appreciation of the science underpinning aspects of causality and control for a particular exposure, e.g. in relation to bacterial pathogens in milk and their control through pasteurisation. However, the statutory enforcement role is the one with which environmental health is most closely associated in the public perception.

\* This theme of a wider “family” of professions operating to create and preserve the integrity of the protective envelope is developed further in Chapter 5 Recommendation 16 wherein we consider its relevance to REHIS.

The debate about territory must follow agreement around identity but we would suggest there is an opportunity for the profession to develop a wider role extending into other parts of the protective envelope. For example, we would submit that there is an opportunity for environmental health professionals to engage more fully with the wider public health community to progress efforts in Box 2, i.e. developing and maintaining the epidemiological evidence. Specifically, environmental health can provide environmental exposure data either as part of one-off studies or on an ongoing basis e.g. through a strengthened Environmental Health Surveillance System for Scotland (EHS3).

They must also consider whether they see a role for themselves in changing environments that places less emphasis on statutory enforcement. The limitations of the statutory approach to controlling the physical environment are obvious and have been addressed elsewhere by the authors <sup>(14)</sup>.

Opportunities for advocacy and other non-statutory strategies for changing environments or influencing health-damaging behaviours clearly abound for any profession with such a close interface with the public. We accept that activity of this nature is conducted by environmental health professionals but discussion ought to take place on the benefits of emphasising and formalising it as part of environmental health role.

It is commonly held that the development planning process currently under-represents health concerns. Moves to address this situation allied to a greater formalisation of the Health Impact Assessment would be welcome and would constitute an opportunity for environmental health professionals.

### **4.3.3 Skills and Knowledge**

Appropriate skills and knowledge to operate effectively within the territory it has staked out for itself is vitally important for any professional group. The wider non-EHO cohort of environmental health professionals operating in the environmental health service in local authorities and elsewhere, acquires its skills and knowledge through a variety of routes and often prior to commencing work in the field of

environmental health. For Environmental Health Officers in Scotland, skills and knowledge are normally acquired through attendance on the BSc in Environmental Health Course at the University of Strathclyde and a period of accredited practical training with a local authority. There has always been a tradition in environmental health of attending post qualification courses to enhance or update knowledge or to support activity in an area of specialist environmental health practice. Comments regarding the relevance of existing education and training emerged from several quarters during the consultation exercise with one senior external commentator describing environmental health as a profession whose training is “old fashioned”. We consider an analysis of the content of the existing training to lie beyond the scope of this report and we believe any fundamental review should only take place in the context of a clear statement of the territory environmental health will occupy. However, considering in isolation, the education and training necessary to be effective players in the multidisciplinary effort to address the Health Improvement Challenge, we believe core knowledge and skills in public health are essential. We also consider that, whilst science and epidemiology may have their innovators, their commentators and their communicators, environmental health professionals should have a role at least in respect of the latter two. This has implications for education and training to support their public health practice. There is a huge job around communicating risk to the public. This is not just about conveying certainties, it is about responsibly flagging up uncertainties and gaps in the knowledge base, of being advocates for the appropriate research. This is a territory environmental health professionals can occupy but only if they maintain a conversance with the issues and embrace what is now a recognised skill set. In Chapter 5 we make certain recommendations with regard to the specific nature of these skills and the mechanisms through which these might be acquired.

Before leaving the issue of education and training we would wish to raise a further issue for discussion within the profession, that of postgraduate education. Whilst some environmental health professionals have engaged in postgraduate study, there is certainly no strong tradition of this. It seems that environmental health may lag behind other professions in this regard. We suggest that this has had some quite profound effects on the profession, some obvious and some, more subtle. The obvious benefit of postgraduate study, which normally has a narrower focus than

undergraduate study, is enhanced knowledge. If programmes are well formulated and carefully chosen, post-graduate education can pay dividends for employee and employer alike particularly in relation to areas of specialist practice. For many, particularly those undertaking doctoral studies or some Masters degrees, postgraduate study provides training in research that can be applied to subsequent projects in the workplace. It can also generate capacity to critically review and appraise research by others. Research training allows participation in, or leadership of, collaborative research studies and the evaluation exercises that are often so important to new initiatives in public health.

A less immediately obvious outcome of having significant numbers within a profession engage in postgraduate study is the development of an thriving academic community. This can extend beyond the University to include individuals working in service delivery settings. The authors have suggested that the environmental health profession in Scotland lacks an “academic hinterland” and have suggested this has impacted negatively on the profession’s capacity to conduct debates around key issues <sup>(13,14,16)</sup>. It probably also limits the capacity for discussion around what constitutes the boundaries of professional territory over time. Environmental health in Scotland does have an active academic community but it is small, fragmented and inconsistent with the size of the profession. The community needs to expand and form networks. A mature profession should have a very significant academic element. It is part of the job and enhances effectiveness. For a profession like environmental health, academic activity will frequently have a strong practical or applied focus but this is not incompatible with academic excellence. Equally, high calibre academic activity need not be full time.

#### **4.3.4 Summary**

It has been proposed above that identity, territory and knowledge/skills make up the foundation for progress. We believe there requires to be very full discussion of these matters within the profession and have introduced ideas to stimulate such a debate. Consensus will give a firm base from which to pursue agreed goals in the profession (see “A Clear Vision” below).

## **4.4 Dependence to Independence**

### **4.4.1 A Proactive Profession**

Having established the foundations for progress through reaching consensus on professional identity, territory and knowledge/skills base, the profession will have already taken a step on the road from dependence to independence, it will have shown that it can be proactive in pursuit of its goals. However, a proactive, “can do” perspective must become an enduring part of the professional character of environmental health. During the consultation exercise, many cited the example of Trading Standards Officers as a profession that had successfully promoted itself, an achievement variously attributed to energy, leadership, organisation etc. It could be argued however that these attributes are all products of a proactive professional character. Adapting Covey’s model, the paradigm shift that makes the profession believe it can influence its own destiny is the first stage in the maturity continuum. Actions, we believe are necessary to achieve each stage within a professional maturity continuum for environmental health are presented in Chapter 5.

### **4.4.2 A Clear Vision**

It has been stated at various points in the text that what the environmental health profession in Scotland needs is a clear statement of what it wants to achieve. The idea of producing a “vision” is, of course, an accepted element of the strategic planning process and is widely applied. It has the particular advantage of allowing a destination to be set without reference to the array of perceived impediments that inevitably impinge when seeking to achieve any significant goal. It allows the journey to be begun with a clear end in mind with all the clarity that implies for process planning. The authors have considered producing a draft vision statement for the profession in Scotland based on synthesis of the findings of the consultation exercise. We are persuaded however that this would be wholly inappropriate as, only by involving the wider profession in the creation and assimilation of the vision, can commitment to its delivery be achieved. It is likely that any vision would describe the profession its members would wish to be part of in, say 10 years time. It may well make reference to identity and perhaps territory but the latter only in the most general terms because, as has been previously stated, the territory will inevitably change over

time. It seems plausible that a vision would emphasise a wider role in public health and make reference to multidisciplinary networks. It may do all or none of these things but whatever it is, it should be the creation of the Scottish environmental health profession as a whole, avoiding a top-down approach at all costs.

#### **4.4.3 Setting Priorities**

In environmental health it is possible to identify two types of priorities. The first are health priorities and the second, priorities for the profession. These are not necessarily the same thing. In relation to the professional maturity continuum, the priorities are likely to be those that are consistent with the efficient delivery of the vision and may be, for example, to do with enhancing the skills base or developing a communications strategy. Health based priorities are likely to be important too however, and unless environmental health is to slip back into a reactive stance it needs to develop and offer opinions on which exposures to physical environment are priorities for policy and action. It is health based priorities which are important to politicians, the public and our health service partners and the profession requires to form and communicate views on these by reference to the available evidence of health impact, efficacy of available interventions etc.

It should be possible to identify health priorities, albeit imperfectly, based on objective criteria. However a chance event, a scientific discovery, an epidemiological observation or perhaps unattributable media interest all have the capacity to influence priorities. For example the perceived threat from mobile phone base stations moved to near the top of the agenda in recent years yet, arguably, this issue does not fulfil many objective prioritisation criteria for health.

#### **4.4.4 Summary**

If environmental health can develop a proactive paradigm, a clear vision of what it wants to achieve and identify and prioritise the actions necessary to deliver the vision it will have completed the move moved from dependence to independence. Delivering the vision is then a matter of managing and working to negotiate the impediments.

In justifying the adaptation of Covey's concept of a maturity continuum to the challenge facing environmental health (a very different application for which it was conceived), we made reference to the highest form of maturity being interdependence. This has particular relevance in the context of the environmental health contribution to multidisciplinary working to address Scotland's Health Improvement Challenge.

The terms "maturity" and "maturity continuum" are not commonly used in relation to a professional group. We have felt justified in adapting them for use in that context because, irrespective of the vision environmental health ultimately defines for itself the first stage of the journey to achieving it will certainly involve a move from dependence to the more mature state of independence. Few would argue that to be proactive, to have a vision and to pursue it in a prioritised way constitutes a higher level of maturity than does mere acceptance of unsatisfactory circumstances.

The above might, on first appraisal, appear condescending to the environmental health profession. It may fail to recognise the many pockets of activity in Scotland where practitioners are proactive within the constraints that apply, show initiative and exhibit excellent skills. There are examples of good practice, an aspect we will return to in the context of the action plan (Chapter 5). However, in applying the model of progression through a maturity continuum to environmental health, the purpose is to pursue maturity, not at the level of the individual officer, but at the level of the profession in Scotland.

## **4.5 Independence to Interdependence**

### **4.5.1 The Pre-requisites for Effective Working in Public Health**

Good public health practice, particularly at senior level demands knowledge and understanding, confidence, openness and a capacity to reflect but also judgement when confronted by an, often bewildering, array of options. Each of these is an attribute of maturity. It is not without reason that strategic and operational skills in public health are normally disseminated at post-graduate level. Medics, dentists, pharmacists and a range of other disciplines typically receive their primary public health education in Masters programmes having first qualified in their discipline.

Amended perspectives are necessary to recognise health and disease as attributes of populations rather than of individuals and to work effectively within that paradigm. Epidemiology, the underpinning science of public health is conceptually and operationally challenging particularly when applied to the links between environmental exposures and health outcomes. To understand risk and to be effective in its communication demands particular skills and carries responsibilities that must be fulfilled if trust is to be preserved. Working effectively with and for communities presents challenges for which education alone is unlikely to be adequate preparation.

Just as maturity is demanded for individual effectiveness at senior level in public health, it ought to characterise professions adopting a prominent role in the area. Perhaps the part of public health most relevant to professional groups and exerting the greatest demand in terms of maturity is working in multidisciplinary partnerships. Many have negative experiences of attempts at partnership working, recalling occasions on which different cultures clashed and individual players sought to dominate. Successful partnership working is time consuming and challenging and requires trust and patience on all sides. It requires the confidence to engage. In other work <sup>(16)</sup> the authors suggest some prerequisites for professions which seek to be effective in multidisciplinary partnerships. These are discussed briefly below.

#### **4.5.2 Project a Strong Sense of Professional Identity**

The driver behind the push for working across sectors and disciplines is the belief that no single group can produce the prescribed step change in Scotland's health. Implicitly it is about recognising and celebrating diversity. We believe that despite its position as a key driver of health within the socio-ecological model, there remains a tendency to underestimate the true importance of physical environment at operational level. There is an accompanying failure to recognise the capacity of environmental health to operate outside a relatively narrow statutory agenda. In short, a failure to see that environmental health can be key players in addressing Scotland's Health Improvement Challenge and active partners in developing and delivering Joint Health Improvement Plans. As a result, environmental health has often been excluded and (consultees have implied) has not in some instances fought hard enough for a seat at the table. Efforts to address this problem must focus on communication and

lobbying at local level but reinforced by clear and unambiguous statements from the centre about what environmental health is, what it can do and its unique contribution to these initiatives.

#### **4.5.3 An Abundance Mentality**

It was suggested above that many had negative experiences of partnership working and effort patience and skill must be applied if multidisciplinary working is to realise its potential. A common experience of multidisciplinary working <sup>(1)</sup> is the attempt by one group or individual to dominate. One possible reason for this ultimately damaging behaviour is the perception that the rewards are limited and partners must compete. When applied to Scotland's Health Improvement Challenge, the rewards in terms of success are potentially very significant. For any single member of the partnership to succeed it is not necessary for another to fail. When applied in a business situation those who recognise this abundance of reward are better able to negotiate so-called "win-win deals" <sup>(12)</sup>. This idea translates rather well to multidisciplinary partnerships in public health particularly when supported by a recognition that approached openly, relationships result in a synergy. The openness, trust and confidence to work in this way comes from a clear understanding of the role, skills and contribution of others and a confidence in the contribution of one's own profession. This is an example of interdependence, a high form of maturity.

#### **4.5.4 A Core Knowledge and a Common Language**

There is broad consensus in the public health community that there is a core set of knowledge which, if acquired to differing degrees by all those working in public health, will not only improve practice but will also facilitate communication between the key players. For professions such as Health Promotion, Medicine and Nursing with a tradition of Masters study in Public Health, these core skills are often absorbed through the core compulsory modular content on the programmes. The modules typically deal with the principles of public health, epidemiology and applied statistics, evidence-public health practice <sup>(17)</sup>. We suggest that "research methods" is also a core skill and ought to be included. Few in the environmental health profession have had the opportunity to undertake such modules placing them at some disadvantage

through lacking the core knowledge and also a shared common language to communicate effectively others in public health.

#### **4.5.5 Communicate Effectively in Partnerships**

Underpinning the best communication is not only a shared language but also a capacity to listen and understand the concerns and contributions of others. There are some encouraging signs that health improvement professions and groups in Scotland are developing the structures and habits of listening to one another. In this regard we would cite the Scottish Forum for Public Health, which seeks to provide a single unified voice for multidisciplinary public health in Scotland. It is proving an important focus for discussion and has initiated a sentinel project to map the skills and contribution of key players in the public health workforce in Scotland. Environmental Health is well represented on this group through REHIS and SCIEH and has the capacity to influence the agenda of the group.

A second body is the Healthy Environment Network (HEN). Co-ordinated and facilitated by NHS Health Scotland, this is an important forum that seeks to bring together representatives of public sector organisations, NGOs, professional groups etc. who, through their activities, can change environments for health purposes. Again environmental health professional are well represented and currently hold the Chair of the HEN Steering Group. Projects in which the Network is presently engaged relate to “Safe Routes to School” and the emerging issue of “Environmental Justice”. These have been selected to elicit the widest possible member participation.

#### **4.5.6 Efficient Dissemination of Good Practice**

There is an inevitable concern when it comes to multidisciplinary working to address the Health Improvement Challenge that there will be considerable rhetoric and insufficient action. The Joint Health Improvement Plan concept should do much to counter this risk but it is nonetheless important to disseminate examples of good practice and information on new and successful initiatives to the profession as a whole. A culture that encourages evaluation of initiatives is highly desirable and evaluative skills require to be nurtured. These can be applied not only to activity

related to the Health Improvement Challenge but also to the more traditional activities in environmental health.

#### **4.5.7 Conclusions**

Whilst some environmental health departments are active participants in the development and delivery of their local Joint Health Improvement Plans others are not. We would suggest that it is essential for them to make every effort to gain a seat at the table.

The profession at central level can assist the efforts of its members to engage in the Health Improvement Challenge by initiating a process which will lead first to independence and on to the interdependence required for effective partnership working. We regard the imminent publication by REHIS of “Environmental Health: Securing Safe Healthy Environments” as an important first step. Chapter 5 of this report contains a series of recommendation for action. We believe these will be important inclusions in any Action Plan for Environmental Health in Scotland. However, the final version of the Action Plan can only be produced against the background of broad consensus around a vision for the profession.

## **5.0 Recommendations and Proposed Actions**

### **5.1 Introduction**

A two-part challenge has been presented for the profession. The most immediately obvious part, and the driver behind the commissioning of this report, is the desire to see environmental health at the heart of the effort to address Scotland's Health Improvement Challenge. There is a need to ensure that that environmental health gets involved in the local networks formed address the challenge and to counter any perception by others that environmental health has no real role to play. The other part of the problem and the dominant and recurring theme in almost every conversation with an environmental health professional during the consultation, is the diminishing status of profession and the need to regain profile and influence both inside and outside local government. In reality the two parts are inextricably linked. Unless the profession is strong and influential it cannot hope to have a valued contribution in the multidisciplinary response to the Challenge. Yet the long-term future of the profession will not be secured unless it is seen to be playing a lead role in addressing the issues that the public and policymakers regard as important.

It was argued above that the profession in Scotland needs a vision of where it wishes to be within a set period. We were robust in stating that the creation of the vision is not the role of the consultants. The whole profession has to be closely involved in developing the vision to secure the commitment that will be necessary to achieve it. Obviously, the specific actions necessary, the methods adopted, the sequence of delivery and the times allocated to each task along the route to making the vision reality can only be finalised following a clear articulation of that vision. However, we believe that the consultation exercise has afforded sufficient insights concerning the salient issues and the type of profession many members would like to see. Based on this, we set out below, in approximate sequence, a draft action plan, with key recommendations and the actions necessary to fulfil these. This seems pragmatic at this stage and not to do so, an abdication of responsibility. The recommendations themselves are arranged within several overarching themes based on the arguments presented in Chapter 4. Revitalising the profession and embracing the challenge is a

complex task and there are many crosscutting issues. Thus an individual recommendation may be relevant to more than one part of the task and an individual action may serve more than one purpose. Essential to any action however is the creation of a mechanism for moving forward and hence the first recommendation is for the establishment of a Project Steering Group.

## **5.2 Create the Mechanisms for Delivery**

### **Recommendation 1: Establish a Project Steering Group**

If the findings of this report are accepted, the environmental health profession will embark on a campaign that will take it from its current beleaguered position to that of a modern high profile profession playing a central role protecting the population from the health damaging effects of their environment. It will play a key role in the delivery of stated objectives within the Health Improvement Challenge. The project must be expertly managed and subjected to periodic evaluation of both process and outcome. We believe it will be necessary to create a high profile Project Steering Committee (PSC). Whilst recognising the initiative taken by Royal Environmental Health Institute of Scotland (REHIS) in commissioning this report we believe that the Institute should at least consider forming and facilitating the PSC at arm's length. We suggest the PSC should be formed from representatives of e.g. REHIS, the Society of Chief officers of Environmental Health, the University of Strathclyde, an environmental health professional representing each common environmental health specialty in local government, environmental health qualified staff within the Scottish Environment Protection Agency, the Food Standards Agency and the National Health Service and the shortly to emerge, Health Protection Organisation for Scotland. We also believe representation from the student cohort would be valuable.

An independent, non-environmental health chair with a strong background across the range of public health competencies would be beneficial. Consideration should be given to providing an honorarium for the Chair of the PSC to reflect the commitment likely to be involved. The group must be supported by a strong senior secretariat.

In our view it is critical that any group formed is forward looking and does not degenerate into a forum for “bleating” over perceived injustices or apportioning blame for past action or inaction. Increasing the proportion of members from non-environmental health backgrounds might help to counter these tendencies, as might representation from key stakeholders. The choice of Chair is amongst the most important decisions that will be taken.

REHIS should obviously be a central player in any Project Steering Group. However, in our work we have encountered disaffection for REHIS in some quarters. It would be unfortunate if some sectors within the profession showed antipathy to the PSC and its recommendations because it was seen to be a creation of REHIS. Accordingly we recommend that the PSC be seen to be independent of any of the constituencies represented on it.

We fully accept that, to take this recommendation forward in the manner suggested, will give REHIS less control over subsequent events and yet not absolve them from responsibility for facilitating and supporting the process. For REHIS to embrace this model will be an act of courage which, we believe, will be ultimately be repaid by a much stronger profession to the great benefit of REHIS. We recognise also that on occasions the PSC will often consider issues in which REHIS has a historical and legitimate interest and already addresses through its own structures. Education and training is an obvious example. It is important that the protocols for working agreed at the outset respect and do not undermine the position of REHIS whilst preserving the independent model proposed for the PSC.

The role of the PSC is to ensure the implementation of the following actions according to an agreed timetable. A large number of actions are proposed. Some are intended to afford the profession the sound foundations to move forward whilst others relate to moving through the maturity continuum. Finally, a set of important but complementary actions is listed. The PSC can only hope to deliver on these actions by establishing defined subcommittees and drawing in support from across the breadth of the profession.

**Action: REHIS should identify a senior independent person with a broad knowledge across the spectrum of public health to chair the PSC.**

**Action: The independent Chair should consult with others before agreeing those organisations and constituencies that would be represented on the PSC.**

**Action: REHIS should provide the secretariat for the PSC. The Secretariat must have high levels of competence and a detailed knowledge of the field of environmental health.**

**Action: The Chair should convene an initial meeting of the PSC with a remit to take the project forward.**

### **5.3 Lay the Foundations**

#### **Recommendation 2: Agree a Statement of Identity**

In Chapter 4, it was argued that success for any professional grouping was unlikely to be achieved in the absence of a clear statement of its identity, territory, and skills and knowledge. These constitute the foundation from which the revitalised profession will be built. Attention to these issues underpins the move from dependence to independence and we recommend a very early task of the PSC is to consider these. In Chapter 4 we propose a draft statement of identity based on the overarching aims of the profession. This statement was floated during the consultation and certain suggestions were made regarding it. Based on the comments of consultees within the consultation process we suggest that the earlier draft Statement of Identity be amended to read as follows:

**“Environmental health is that area of public health activity which seeks to maintain, improve and protect health through action on the physical environment”.**

It is reasonable at least to debate an addition to the statement of identity to include the following phrase

**“ and in consultation with NHS Board Health Promotion Professionals, to exploit opportunities emerging through conduct of their core functions e.g. in workplaces and the community to reinforce generic health promotion messages”**

In practice we question the wisdom of this latter addition. We accept that it fits well with the power to promote well-being enshrined within the Local Government in Scotland Act but it does detract from the clarity of the message on physical environment, which aligns so closely with the socio-ecological model of health and is widely recognised in the public health community. Reference to health promotion renders the statement less appropriate to those working outside local authorities, e.g. in Scottish Environment Protection Agency.

**Action: The PSC should develop a draft Statement of Identity framed in terms of the overarching aims of the profession**

**Recommendation 3: Stake out the Territory**

In relation to territory, it was suggested in Chapter 4 that this would vary over time and in response to external influences. We believe the concept of a “protective envelope” as covering the entire field of environmental health as a discipline is important and that environmental health should establish a territory within this. In our view, the territory should extend to active involvement in developing the evidence base in epidemiology principally through contributing exposure measurements. We recognise that for a variety of reasons, environmental health professionals have become focussed on a statutory agenda. This carries two inherent problems: (i) It limits the professional involvement to those which are the subject matter of statute and (ii) It places too much emphasis on enforcement which, whilst it has a very important function, is incapable of addressing the wider spectrum of health threats from physical environment.

**Action: The PSC should explore strategies to enable the profession to present itself as a valuable partner in environmental epidemiology.**

**Action: The PSC should emphasise the importance of continuing to support the EHS3 initiative co-ordinated by SCIEH in which all local authorities are currently partners.**

**Action: The PSC should consider how best to develop clear and readily communicable ideas concerning non-statutory approaches to changing environments for health.**

**Action: For pragmatic reasons, environmental health professionals should consider using their interface with the public in various settings as an opportunity to convey health promotion messages. The PSC should develop a clear policy on this.**

**Action: The PSC should elicit the views of the Scottish Executive Health Department before opening a dialogue with NHS Health Scotland and local NHS Boards on the role of environmental health professionals in generic health promotion.**

#### **Recommendation 4: Define the Requisite Knowledge and Skills for the Profession**

The correct blend and depth of knowledge and the possession of the relevant skills were presented in Chapter 4 as fundamental for any profession. These must be sufficient for the profession to be effective and credible within its chosen field of operation that we have termed the profession's "territory". Just as territory will shift over time, so too must knowledge and skills be subject to regular review in terms of its relevance to territory. Certain suggestions regarding the appropriate territory of a revitalised modern environmental health profession have been included in Chapter 4 as a stimulus to debate. These have been discussed in Recommendation 3 above. This involves an extension of core knowledge and skills for the profession as a whole and may exert further demands on the component specialties. Even were the profession to seek to occupy a rather different territory from that suggested, there is likely to be benefit in acquiring the core knowledge and skills of public health, i.e. basic epidemiology, research methods, elementary statistics and the principles of

public health (see Recommendation 9 below). We consider that expertise in the field of risk communication and generic principles of exposure measurement are also desirable. Beyond these, individual specialties in the profession may identify specific demands for enhanced knowledge and skills. If the profession elects to embrace a more generic health promotion role in the settings within which it operates, this too needs to be matched to skills and knowledge

There is a role best fulfilled at national level, in drawing up, for the new era, the core generic competencies for environmental health and for its component specialties. The role must extend to considering how best the skills and knowledge and training necessary to fulfil the competencies can be acquired. This is likely to require both formal and informal education and perhaps training placements but flexibility and accessibility for the whole profession (and not just the existing undergraduate student cohort) must be a feature of any arrangements.

**Action: The PSC should establish a subgroup to agree generic and specialist competencies for environmental health for the new era.**

**Action: A PSC Subgroup should liaise closely with those involved in developing health protection competencies in the wider field of public health.**

**Action: The PSC should liaise closely with the CIEH on issues of professional competency.**

**Action: A PSC Subgroup should identify skills and knowledge deficits and bring forward proposals to address these.**

#### **5.4 Dependence to Independence**

##### **Recommendation 5: Promote a Shift in the Professional Paradigm**

In the analysis in Chapter 4 it was proposed that a shift in the professional paradigm from “reactive” to “proactive” is central to moving the profession from dependence along the maturity continuum. Simply to declare that the professional personality

will henceforth be different is very unlikely to be successful. However, we believe that, the establishment of the PSC and the work around identity, territory and knowledge/skills will help establish the pattern that will shift the paradigm. Perhaps the most important act in developing and sustaining a proactive character will be the creation of the vision. At every stage the message put across by the PSC should be that the profession is capable of influencing its own destiny.

**Action: The PSC should use the consultation to develop and agree the vision statement (see Recommendation 6 below) to promote positive messages regarding the capacity of the profession to influence its own destiny.**

**Action: The PSC should regularly revisit, and revise as necessary, arrangements to ensure communication with the profession over the project.**

**Recommendation 6: Develop a Vision for Environmental Health Professionals in Scotland**

It has been emphasised above that the Vision Statement must be the product of the widest possible consultation within the profession. From involvement comes commitment. Thus while we would regard the PSC as the engine of change and the forum in which the real work is done, when it comes to developing the vision, the Committee's role must be that of facilitator. The PSC may wish to apply qualitative research strategies using focus groups to help develop the vision. It may be useful to engage consultants skilled in the specialist area of qualitative research to assist in this task.

**Action: The PSC should design a consultation strategy to produce the profession's vision for the future**

**Recommendation 7: Agree Professional Priorities and Develop and Publicise Public Health Priorities for Environmental Health**

In Chapter 4 it was suggested that priorities for the environmental health profession came in two types. Priorities for public health are certainly important, partly because to present views on the public health priorities of environment health professionals would be present the profession as serious, reflective and campaigning around the issues of importance.

The second set of priorities relate to the delivery of the vision. Each must be unambiguous and be supported by a specific action or actions. In the best traditions of business planning each action should have a date for completion. Individuals must be held accountable for delivery. We suggest that most of the recommendations and actions in this Chapter should feature in the final Action Plan.

**Action: Following the consultation process to generate the profession's vision, the PSC should review the recommendations and actions within this chapter and from these and any others that appear appropriate for delivery of the vision, prioritise these within a final action plan.**

**Action: The PSC should establish strategies for identifying and reviewing public health priorities. In this connection consultation with Scottish Centre for Infection and Environmental Health and the Scottish Executive is likely to prove valuable.**

## **5.5 Independence to Interdependence**

Covey <sup>(12)</sup>, addressing personal development and leadership issues, states that the individual can only become truly interdependent after first becoming independent to a high degree. This observation translates well to the environmental health profession. Recommendations thus far relate to developing independence for the profession. We now move to the second element of the task, specifically the move independence to interdependence.

**Recommendation 8: Project a strong sense of professional identity**

It has been suggested in Chapter 4 that multidisciplinary working is most likely to succeed and develop synergistic partnerships when the individual contributors develop skills in partnership working but continue to project a clear sense of identity. Accordingly, we believe that unambiguous statements of identity and the unique contribution of participants is an aid to successful multidisciplinary working and gives the participants the confidence to participate fully in the pursuit of shared goals. Thus, the need to develop a clear statement of identity is not only essential to underpin the move from a dependent to an independent profession, it is the basis of communication within the interdependent relationships necessary to multidisciplinary working. It is the “shorthand” for what the profession brings to the table. The importance of these and how these might be developed are discussed elsewhere. This recommendation differs from Recommendation 1 in that it relates not only to the development of the identity but also to communication to the wider world.

Thus, if as we suggest, the statement of identity is couched in terms of a commitment to controlling physical environments for health this should be communicated widely whilst simultaneously reinforcing the pivotal role of physical environment as a key driver of health and well-being and the numerous references to the importance of physical environment within policy documents.

**Action: The PSC should institute a campaign within the profession to reinforce its agreed statement of identity.**

**Action: The PSC should organise a series of road shows for the profession to reinforce identity and to deal with theoretical issues around the relationship between physical environment and health.**

**Action: The PSC should reinforce the importance of communicating the identity statement in partnerships and generally**

**Action: The PSC should produce, under the title of e.g. “Your Environmental Health Partners”, material distilling character, identity, knowledge and skills and why the unique environmental health contribution is vital in any partnership to address the Health Improvement Challenge.**

**Recommendation 9:            Develop the core knowledge and understand and use the common language of public health.**

Central to the development of the public health workforce is the belief that, irrespective of the diversity of skills and knowledge amongst public health practitioners, it is possible to identify a set of generic competencies. This thinking is reflected in proposals to enhance the skills at the practitioner level and in the accreditation arrangements for Specialists in Public Health (see Appendix 2). Development of the educational content of the new Masters programmes led by NHS Education <sup>(15)</sup> centres on the need to provide practitioners with these competencies.

Whether or not environmental health professionals join these and other relevant courses as Masters students or seek other routes, they should embrace a common skills set and common language if they are to be effective in multidisciplinary partnerships to deliver the Health Improvement Challenge

**Action: The PSC should engender discussion within the profession on the issue of core competencies for public health practitioners to ensure the profession is aware of these, their relevance and the ways in which they may be acquired.**

**Recommendation 10:            Be a Listening Profession**

It is a basic principle of effective communication between individuals that participants should be good listeners. In multidisciplinary working the first instinct for each participating profession is almost certainly to make itself understood. Indeed we have emphasised the need to communicate a clear statement of identity and territory to others. It is equally important however to have a clear understanding of the skills, the contributions, and even the concerns, of other professions entering partnerships with environmental health. The profession has made much of the failure of those outside the profession to understand its importance and its position. It seems important that if this is to be expected of others, then environmental health should actively seek to learn about its partners. One function of the Scottish Forum for Public Health (see

Recommendation 11 below) is to create opportunities for better understanding within the family of public health professions.

**Action: The PSC should organise joint seminars to explore areas of common interest and discuss joint approaches to aspects of the Health Improvement Challenge.**

**Action: In consultation with others, the PSC should identify specific questions related to the Health Improvement Challenge, which imply the need for a multidisciplinary approach. These should be developed and solutions explored in brainstorming sessions and workshops. We believe these might be useful at national level, between leaders in each of the participating professions or groups. This would give the exercise status and exert pressure to deliver reinforced by a commitment to produce recommendations (an obvious pairing for this type of exercise would be health promotion and environmental health). This type of activity would almost certainly find favour at the level of the Scottish Executive if practical recommendations were forthcoming.**

#### **Recommendation 11: Participate in the Relevant Forums**

A number of multidisciplinary forums have developed in recent years, which have direct relevance to both traditional environmental health activities, the enhancement of the evidence base and the Health Improvement Challenge. Of particular note are the Healthy Environment Network (HEN) and the Scottish Forum for public Health (SFPH).

The Healthy Environment Network is a multidisciplinary network of government agencies, professional groups and voluntary sector bodies whose activities can influence the physical environment in the interests of human health. HEN was formed and is facilitated by the Public Health Institute for Scotland (now NHS Health Scotland). The Network Steering Group currently has two main project themes relating to “Environmental Justice” and “Safe Routes to School”. The Network is

currently chaired by an environmental health professional. Both REHIS and the SOCOEH are members and the latter is also represented on the HEN Steering Group.

The SFPH aims to provide an independent voice for multidisciplinary public health in Scotland and closely mirrors the Multidisciplinary Public Health Forum in England. Current projects relate to mapping the public health workforce and organising a seminar on multidisciplinary working on public health in Scotland in early 2004. Chairmanship of the SFPH affords a seat on the Scottish Affairs Committee of the Faculty of Public Health Medicine. The Forum currently has environmental health professionals in the role of Chair and Executive Secretary. REHIS is independently represented on the Forum.

**Action: The PSC should encourage representatives of the profession to seek membership on relevant multidisciplinary forums relating to public health. They should use the opportunities provided as platforms for raising the professional profile both as a key player in public health and in the development of the evidence base on environment and health.**

**Action: The PSC should ensure succession planning to maintain environmental health representation on all relevant committees.**

**Recommendation 12: Develop Strategies for The Dissemination Materials to Support the Health Improvement Role and if Possible, Examples of Good Practice**

From the consultation exercise described in Appendix 1 it is clear that most environmental health professionals recognise that physical environment can act not just through toxic, allergenic or infectious mechanisms but also through a psychosocial route to influence psychological wellbeing and behaviour. Nonetheless there was a strong feeling that some practical guidance was necessary in order to apply such insights in day-to-day activities to address the health challenge. In short, support is necessary to assist the profession to make the case for a place in the partnerships emerging to formulate and deliver the Joint Health Improvement Plans.

In addition to accessible education and training consistent with a new and extended role, there was a call for basic guidance material and examples of relevant activities and good practice.

**Action: The PSC should commission the production and ensure the distribution of concise guidance notes suggesting partnerships and appropriate environmental health input to address the Health Improvement Challenge through partnership initiatives, e.g. in transport and local estate planning.**

**Action: The PSC should create a library of examples of good practice involving environmental health professionals across the field of health improvement.**

## **5.6 Complementary Activities**

### **Recommendation 13: Communicate with Stakeholders**

Environmental health in Scotland has many stakeholders with which it ought to maintain an active dialogue. Such a dialogue would enable the profession to better understand the views and concerns of these stakeholders and to convey important messages relevant to the public health and professional priorities. A list of stakeholders should be produced. In some cases, e.g. local government in Scotland, SEPA, the HSE there may be obvious routes for communication and, indeed these may already produce effective 2- way communication to the benefit of the profession. In other cases, the Scottish Executive, Public Health Medicine, the wider public health community or indeed the public at large, the most effective routes for communication may require a little more thought. In every case careful consideration must be given to the messages that the profession wish to convey and to how the communication can be mutually beneficial.

**Action: The PSC should form a “Communications Subgroup” to advise the Steering Group**

**Action: The Subgroup should create a list of stakeholders.**

**Action: The Subgroup should include at least one individual with media relations expertise.**

**Action: The Subgroup to devise a communications strategy for approval by the PSC.**

**Recommendation 14: Agree and Implement Sentinel Projects**

We believe that the profession would benefit from being strongly associated with a limited number of topical projects. An example of such a project might be a professional response to the Children’s Environmental Health Action Plan for Europe.

**Action: A short life working group of the PSC should make recommendations on criteria, which should be fulfilled by any sentinel project chosen.**

**Action: Based on these criteria, a working group should recommend one, or at most two, sentinel projects, decide outputs and produce clear plans and timescales for delivery (see Recommendation 13).**

**Action: The Communications Subgroup should advise on a strategy for communication of output from sentinel projects including dissemination of the report, media issues etc.**

**Recommendation 15: Nurture the Academic Hinterland**

In Chapter 4, the view was put forward that the environmental health profession in Scotland would benefit from the development of an “academic hinterland”. This is not to say that there is not academic activity. Indeed, valuable teaching and research is conducted by environmental health qualified academics in the University of Strathclyde, the University of Edinburgh and elsewhere. By engaging as partners in research alongside e.g. medics, statisticians, bioscientists, engineers and statisticians etc the small band of academics in Scotland have garnered credibility and respect for the profession in areas such as parasitology, epidemiology, particle research, waste management and food. The status this activity has afforded the profession is

important for the future. It should now be supplemented by academic activity and philosophical debate around key aspects and issues for the profession including the identity, territory and knowledge base. This type of academic activity is evident in the most influential professions and extends beyond the boundary of the university campus. The academic activity is of a different sort but must be of a comparable standard.

**Action: In liaison with the REHIS Education Committee, the PSC should encourage and support postgraduate study amongst members of the profession.**

**Action: The PSC should foster an academic community, e.g. by commissioning editorials on key issues affecting the profession and the relationship between health and, environment.**

**Action: The PSC should encourage debate around the Health Challenge and strategies for engagement.**

**Action: The PSC should enter into a dialogue with the editors of key publications relevant to environmental health to better understand their requirements in terms of papers, articles etc.**

**Action: The PSC should, in consultation with others, identify key research questions and engage partners to develop research proposals and seek funding.**

### **Recommendation 16: An Inclusive Professional Body**

When discussing the issue of the “territory” for environmental health professionals in Chapter 4 we introduced the concept of a “protective envelope” (see Figure 2, Chapter 4). We used this term to describe all activities to develop the evidence base on physical environment and health and to develop and implement control measures. We suggested that, taken in aggregate, these activities represent the “discipline” of environmental health. Environmental health professionals in Scotland to whom this report is directed must stake out a territory within this wider discipline.

Implicitly, others, e.g. public health doctors, chemists, microbiologists, epidemiologists, legislators etc. occupy different, perhaps overlapping territories within the discipline of environmental health and make their own contributions to the protective envelope. Many of these contributors have defined professional homes (even if the emphasis of their work would mark them out as highly specialised when viewed alongside colleagues in their own profession). Thus, a chemist working in, say, particle speciation or in toxicology, would still regard him or herself as a chemist but their work would fall within the wider “discipline” of environmental health. In many cases, they would legitimately be termed “public health practitioners”.

Competencies have been defined for public health practitioners and work is underway to develop this sector of the workforce in Scotland. Indeed, at UK level, there is a feasibility study currently underway to explore whether it will be possible to have a branch of the Voluntary Register of Public Health Specialists (see Appendix 2), reserved for “defined specialists”. Those achieving registration would exhibit particular strengths in certain of the competencies for specialist practice in public health but might not have sufficient depth in one or more to achieve registration as a “general” Specialist. If the Board of the Voluntary Register embrace this concept and ultimately implement it, then many groups across the “discipline” of environmental health, and health protection, perhaps including EHOs, may seek registration. It must of course be emphasised to gain entry to the register, even as a defined specialist will still require seniority and a high level of knowledge, skills and understanding in the wider discipline of public health.

Whilst no decision has been taken as yet, it is plausible that there will be a defined specialty in “Health Protection”. Accordingly, membership of the Voluntary Register may become an aspiration for some epidemiologists, chemists, microbiologists, statisticians etc. working in the wider discipline of environmental health, e.g. within the new Health Protection Agency or in Scotland’s own health protection organisation. Having enhanced their skills across a wider range of public health competencies, some of Scotland’s senior EHOs might also seek membership as a means of demonstrating broader public health credentials.

However, the status of a “defined specialist” in health protection within the Voluntary Register would never be the same thing as being the member of a professional body. It would not, for example offer CPD accreditation or professional development opportunities. Importantly too, those operating at practitioner level would be unable without embracing further skills, to gain access. There would appear to be a need for a professional body to represent the disparate group of professionals who will be charged with delivering the health protection function and who, unlike EHOs do not presently have a professional body. We believe this may constitute an opportunity for REHIS. The individuals concerned are not EHOs and, in most cases, are not seeking to be so. Mainly, but not exclusively, they are from scientific backgrounds, working, for example in SCIEH, perhaps in SEPA, in the FSA, universities, public analysts and elsewhere.

We believe REHIS could perform a very useful service for this group by creating a special category of membership for non-EHOs operating across the broad discipline of environmental health. We recognise of course that REHIS already has many non-EHO members. The difference with this new group is that they would be actively recruited and a concerted attempt made to address their specific needs. The group would benefit from having an established professional body sympathetic to their activities in the public health sub-discipline of environmental health with all that implies and which could offer CPD and the other benefits of professional membership.

For REHIS, the benefits of having such an able group of high calibre individuals, many of them likely to be employed in Scotland’s health protection organisation, are obvious. We believe that if REHIS does not move to fill this void and to support professional colleagues, additional professional bodies will emerge to fulfil their needs. For REHIS this would be an opportunity missed and it would additionally have the potential to limit REHIS and environmental health professionals to their existing remit.

**Action: REHIS should establish, as a matter of urgency, a subcommittee to consider the implications and opportunities of the emergence of a new “health**

**protection profession". This may have relevance to the work of many existing REHIS members.**

**Action: The sub-committee should consider the opportunities and implications that would attend the emergence of an enhanced sense of common cause amongst the disparate professions across the discipline of environmental health .**

## APPENDIX 1

### The Consultation Process

The consultation process was conceived, firstly, to gauge the views of those working within environmental health, the “**Internal Respondent Group**” on what they consider to be key issues facing their discipline. A further objective was to explore opinions around the Health Improvement Challenge, its relevance to environmental health and the profession’s capacity to engage with others in addressing it.

In a parallel exercise opinions were sought from a rather disparate group comprising individuals outside the profession, but whose activities bring them into contact with environmental health professionals. It was expected that this group might have an interesting and perhaps a more objective perspective. No attempt was made to include members of the general public in this “**External Respondent Group**”. Respondents were invited to express their personal views rather than attempt to represent their employing organisation. Amongst those included were some with a role in policy formulation and with responsibility for delivery of the health challenge in government. Senior representatives of the public health community at NHS board level, both medically and non-medically qualified were interviewed as were individuals engaged in the education and training of Scotland’s environmental health workforce.

The primary strategy adopted was to conduct face-to-face interviews structured around specific themes whilst allowing ample opportunity for interviewees to offer opinions on any issues they considered relevant. Commonly termed a semi-structured interview technique, this approach was universally adopted for the External Respondent Group. Consultation with the Internal Respondent Group involved a combination of semi-structured interviews, discussion of themes in small groups and a formal consultation event attended by about forty environmental health professionals. The event included both presentations and a significant workshop element.

Most consultation exercises are by their nature selective and the one reported here is no exception. We would submit however that individuals in the External Consultation Group were approached to participate because they were believed to offer a particular perspective and were likely to have views on the profession, its work and its capacity.

For the Internal Respondent Group the aim was to reach a representative cross-section of the profession. It may of course be claimed that those attending the consultation event were self-selecting and perhaps unrepresentative. For example, the event may have attracted those with a particular concern or viewpoint that is not widely held. They may also have had an atypically strong interest in the health improvement agenda. We can offer no evidence to counter such assertions save to observe that a range of views was forcefully expressed and there was some interesting debate. The consultation process took place over a period of approximately six months and the authors are grateful to all those who participated.

In reporting the outcome we have adhered to a commitment made to all respondents, specifically that anonymity would be preserved and no comments attributed to individuals. Whilst it is accepted that this does on occasions reduce the value of the exercise, we believe the outcome of the consultation is useful and includes many helpful, if occasionally unwelcome, observations.

### **External Respondent Group - Outcomes**

A striking feature of the External Respondent Group was the extent to which, despite offering some criticisms, there was goodwill towards the profession. This group came from a disparate range of backgrounds and it was perhaps unsurprising that on occasions there was a failure to grasp the full breadth of the environmental health function, even as it currently operates. The interviews comprised open-ended questions loosely grouped around the following themes although scope was afforded to respondents to pursue any issue they believed relevant.

*Issues relating to identity, territory, skills, knowledge and to how the profession is perceived by others*

Most of the External Respondent Group had independently formed the impression that the environmental health profession is not enjoying good times. Some felt that there had been a “golden era” but times had moved on and the profession had lost both status and influence. Respondents seemed genuinely well disposed towards the profession and implied it deserved better than its current worthy but rather low profile image. Unsurprisingly the “Life of Grime” programme was mentioned on more than one occasion and was regarded as damaging to the image of environmental health.

Insofar as many external commentators were concerned, the identity of the profession seemed to be defined in terms of what they considered to be its day-to-day functions or its institutional base rather than any overarching purpose. When probed further and presented with the draft statement of identity discussed in Chapter 4 (which referred to the environmental health role being about the control of physical environments for human health) most could see benefits in such a statement, particularly those who had a concept of a “socio-ecological model” of health. Such a concept was more evident in those with a background in public health at NHS Board level.

The profession was seen to operate within rather narrow confines and to be primarily bound up in statutory activity. Some respondents even had a somewhat narrow view of the extent of this activity, regarding food safety and environmental health as synonymous. A few had little concept of the role of environmental health in the field of pollution of occupational health and safety. One individual recognised and evidently valued role played by environmental health was as part of a multidisciplinary team involved in outbreak investigations.

The failure of the profession to emphasise its health credentials in recent times was seen as contributing to its frequent exclusion from local initiatives to address the Health Improvement Challenge. The loss of the health dimension was also believed by some to have been instrumental in placing environmental health outside the debate on policy and strategic issues at nationally. However, encouragingly it was widely accepted that the situation is unsatisfactory and requires to be addressed. Gratifyingly,

those operating in the field of policy or operational public health seemed particularly to regret the position of environmental health, perceiving environmental health as a national resource, not optimally deployed in relation to the recently articulated Health Challenge.

No respondent in this group was critical of the profession in terms of its competence and expertise but again this view seemed to be formed in the context of a rather narrow view of the profession's role that emphasised technical and enforcement skills. Several commentators remarked that the profession has become rather marginalized and does not articulate well with other parts of the public health workforce.

### *Education and Training Issues*

Commentators with knowledge of, or involvement in, the education of environmental health professionals pointed out that only 7 students had entered the BSc course in Environmental Health at the University of Strathclyde during the current academic year. Issues were raised around the viability of the course in the longer term. Those who offered an opinion suggested that the decline in popularity of the course related directly to the poor standing of the profession and a failure across the spectrum of the profession to promote environmental health as a career. Employers were not absolved from criticism in this regard.

Some commentators contended there was a lack of relevance and direction in the current education and training programmes. Notably, one influential commentator observed, "environmental health is a profession whose training is old fashioned". Another commentator alluded to disagreements between "governing bodies" as being a factor in the failure to sort out its education and training problem. On further probing this was explained as a reference to what the commentator regarded as separate and uncoordinated approaches to professional concerns by REHIS and the Society of Chief Officers of Environmental Health.

More than one interviewee expressed frustration that the profession seemed to "lack a single central governing body" which they perceived as leading to a lack of strategic direction for the profession and its training and educational arrangements.

A view emerging from those with a wide public health perspective was that the failure to change and embrace more generic public health skills and in particular epidemiology had been to the detriment of the evidence base which underpins much of environmental health activity. One remarked that it was implausible that a profession of the size and importance of environmental health would not be closely involved in work to improve the evidence base that underpinned its activities.

There was limited awareness of curricular developments in England being brought forward by the Chartered Institute of Environmental Health that reflect a more broadly based public health approach. It would be reasonable to say however that, amongst respondents, there was an appetite to learn more, and a view that Scotland should not be left behind in these matters. Postgraduate education, as a route to raising knowledge and skills within the profession, was explored with interviewees. There was general interest and some were aware of the Common Masters Programme in Public Health targeted at the practitioner level and being driven by NHS Education. However, the general view was that by whatever means they are delivered, the profession needs flexible and accessible programmes to enable it to be address the Health Improvement Challenge and capitalise on new developments in health protection.

### *The Future Role of Environmental Health*

When the interviewers explored the issue with them, most External Respondents felt that environmental health professionals should, and could, play a fuller role in public health in areas such as the Health Improvement Challenge. Some pointed out that the development of the Specialist in Public Health role would be a route for some environmental health professionals to occupy senior generic positions in public health. However, this was regarded as a likely option for only a relatively few. Several respondents emphasised that the profession's role within the partnerships to meet the Health Improvement Challenge should be specific, unique and should centre on the physical environment. Such involvement should not however be at the expense of the traditional health protection function with which environmental health has been historically associated.

One senior commentator observed that, through the nature of their traditional activities, environmental health professionals operated in a wide range of workplace and community settings. In these settings they can, not only enforce healthy environmental standards, but might also pursue environmental change through non-statutory routes to make healthy lifestyle choices more possible. Perhaps more controversially, they might also be advocates for healthy lifestyle choices. The same commentator made reference to the “challenge document” and projected a number of situations where environmental health activity could impact positively on the early years and teenage transition. They further suggested that the profession ought to develop concise material illustrating quite specifically how environmental health professionals could contribute positively in these areas. This would have the benefit making a very overt statement that environmental health is willing and able to engage the Health Improvement Challenge.

#### *The Institutional Home for Environmental Health*

Probably due to its diminished status in the local government setting, the possibility that environmental health might be better situated elsewhere is often discussed within professional ranks. Opinions were sought on this from the External Respondent Group.

The historical links between the environmental health profession and local government were considered by most of the External Respondent Group to be important. Several mentioned the close interface between the profession and the communities it served and felt this could be diminished were the profession situated outside local democratic control. Others claimed that placing environmental health in NHS Boards, as has often been suggested, might help emphasise the profession’s health credentials. A downside of such an arrangement was seen to be the bias of the NHS towards curative medicine and the lack of any enforcement culture in the Boards.

Fragmentation of the environmental health function amongst local authorities, Scottish Environment Protection Agency and the Food Standards Agency was

regarded by some as regrettable but there was no strong claim that this had been to the detriment of the service delivered overall.

Arguably the most telling observation regarding the profession's institutional home was that the profession has no real capacity to engineer a change anyway. The same commentator expressed the opinion that there is little point in the profession pursuing an objective it is powerless to influence and the advantages of which are probably questionable in any event. It was suggested effort would be more profitably directed towards creating the best possible networks and communication systems to facilitate working across and within institutions.

### *The Contribution of REHIS*

The Institute was seen as one of the main contact points for the profession in Scotland. However, several commentators expressed the opinion that it needed to be more vocal and “publicity aware” than currently. In some quarters, it was felt that the Institute was not capable of adequately representing the profession due to a lack of resources and profile.

More than one respondent suggested there might be advantage in a merger between REHIS and the Chartered Institute of Environmental Health. The perceived advantage was the creation of a stronger, better-resourced, professional body, which would be better able to address current challenges. However, most external commentators showed little interest in, and had limited knowledge of, the professional structures in environmental health. Generally they regarded such matters as important only in so far as they might be important for the profile of the profession or its capacity to organise. Most did however believe that responsibility for publicity and the raising of the profession's profile rested squarely with the professional body.

### **The Internal Respondent Group - Outcomes**

How a profession sees itself is clearly important and influences among other things the image it projects to others. Gaining some feel for this was regarded as a key aim of the consultation as were professional perceptions of the Health Improvement

Challenge and how the profession might engage with it. A number of strategies were adopted to elicit views from the Internal Respondent Group. These included themed semi-structured interviews with individuals from REHIS and the International Federation of Environmental Health. These were similar to the interviews used for the External Respondent Group. A meeting was also held with a group of student Environmental Health Officers and included a limited workshop session. Some less formal discussions relating to the Health Improvement Challenge were held with small groups of environmental health professionals when the opportunity presented itself. Lastly, a one-day consultation event was arranged involving several presentations followed by workshop sessions on themes relating to the status of the profession and the Health Improvement Challenge. The following seeks to distil under appropriate headings, the views emerging from Internal Respondent Group.

Unlike the External Respondent Group, the Internal Respondent Group shared a common professional background and were considered to be rather closer to the issues. This clear difference between the groups led to the adoption of an amended form of consultation. The themes used within the consultation were also slightly amended and this is reflected in the reporting format.

#### *Issues Relating to Identity, Territory, Skills and Knowledge*

As with the External Respondent Group, the issue of identity was explored in some detail with certain common issues emerging. The first was that, again in common with the External Respondents, the environmental health professionals were initially inclined to define their profession in terms of day-to-day functions, statutory duties and their institutional homes rather than an overarching theme. Many seemed to approve of the simple statement of identity proposed in Chapter 4 when this was presented for comment. Some however were initially rather uncomfortable with the concept of “physical environment” suggesting it would certainly benefit from definition. Few had encountered the concept of a socio-ecological model of health and after some discussion around this, most saw merit in an identity framed with some reference to this.

Discussion regarding the appropriate territory for environmental health professionals was often dominated by expressions of frustration because officers saw themselves as locked into programmes of work whose only function was the fulfilment of statutory performance criteria. Many saw this as detrimental to their status as professionals. A fair proportion of those who held this view saw little prospect of a profession, thus constrained, ever having any prospect of taking on new work and new challenges. A number of possibilities for extension of the environmental health role either into improving the evidence base relevant to its more traditional function or, through partnerships, to address the health challenge were explored. Whilst there was interest and some enthusiasm, there were seen to be real practical difficulties. The impression conveyed was of a profession that had lost much of its opportunity for independent action and was frustrated by this.

Views on education were many and varied. Many students and recently qualified officers particularly, felt there was an urgent need for a root and branch review of this area to ensure it aligned much more closely with the professions needs, now and in the future.

### *The Profession and Health Improvement Challenge*

Following a brief outline Scotland's Health Improvement Challenge and the policy drivers behind it, the following questions were posed:

“What are the strengths and weaknesses of the environmental health profession when it comes to seeking a prominent role in addressing the Health Improvement Challenge?” and

“What opportunities and threats does it pose for the profession?”

### Strengths

The strengths of the profession were seen as many and varied but certain aspects were repeated again and again. The participants felt very strongly that they are excellent communicators who on a daily basis communicate effectively with a wide variety of individuals from professionals to local politicians to members of the public. They

believed themselves to be ideal candidates to move the Health Improvement Challenge forward with their extensive networking and problem solving skills already in place. Environmental Health staff also considered themselves to be respected by the general public and at least in terms of their stock with the public, able to face the challenge from a position of strength.

### Weaknesses

Just as the group was happy to identify its strengths, it was also willing to accept weaknesses in its capacity to address the Health Improvement Challenge. A recurring theme amongst those consulted was that their activities went largely unsung and they were very weak in the area of self-promotion with environmental health receiving little publicity. As stated above when addressing the issue of territory, there was a frustration that they are statute driven which allows little time for a more proactive role and involvement in the Health Improvement Challenge. A further weakness was seen to be future capacity with real concern that the numbers of people entering the profession is dropping significantly. The existing environmental health workforce in Scotland was described as “an aging population”. A staffing crisis was seen as inevitable in the near future and some felt it is already evident. The current training programme is regarded by many, particularly in the student cohort, as not relevant to the modern era with issues such as the Health Improvement Challenge not being covered in education or workplace training.

REHIS came in for some criticism and its perceived shortcomings in some areas were identified as a weakness in the context of the Health Improvement Challenge. It was asserted that perhaps only around half of Scotland’s environmental health professionals are members of REHIS, which was seen to undermine its effectiveness and authority as a voice for the profession.

Some were confused by the specific roles of the Society of Chief officers of Environmental Health (SCOEH) and REHIS and saw the current arrangements as contributing to disjointed management of the profession as a whole. For those who perceived this as a problem, it was seen an obstacle to progress for the profession. Some observed that often, chief officers are somewhat “removed” from the issues of the new public health agenda and are reluctant to embrace change of priority. It was

conceded that this might be due to political constraints and other pressures. Respondents were frequently vociferous (if a little unfocussed) when apportioning blame for what they saw as the profession's problems including its perceived lack of preparedness in the context of the health challenge document. Many saw the predicament of the profession as being linked to a lack of input to the policy and strategic decisions which influence the profession which in turn they blamed on a failure of the profession to "get its act together" and be forward looking.

### Opportunities

Paradoxically, when it came to discussing opportunities, many of the same individuals who had presented the weaknesses of the profession so graphically in interviews, workshops and plenary discussions seemed to have hope for its future. The Health Improvement Challenge was seen as an opportunity to raise the profile of the profession and secure its future. Home safety and involvement in community planning were cited as possible expansion areas.

The new commitment to health protection and the forthcoming Health Protection Organisation in Scotland were welcomed as opportunities and some believed that environmental health has sufficient public trust to fulfil an important role in the communication of risk. This was seen by some as another field in which to develop the role of environmental health. Importantly, many discerned opportunity in what they identified as a new sense of purpose in the profession and a wish to see it playing a much more influential role in future. For some commentators, it was almost as though the groundswell of frustration in the profession might be harnessed to positive effect to deliver the desired outcomes.

### Threats

The group perceived many threats but felt that these would not inevitably lead to long term damage if urgently addressed.

The diminishing number of recruits was seen as a threat to the profession's long term survival as was its diminished status in local government. The lack of involvement in policy making (and what some perceived as the failure of REHIS to secure influence in this area) was regarded as leaving the profession vulnerable and dependent. REHIS

was seen by some as failing to create a public profile for the profession which again left it vulnerable to fragmentation. Other commentators saw responsibility for this problem as being more widely distributed across the whole profession and employers. Some claimed that the profession is regarded as old fashioned and not relevant to the Health Improvement Challenge. This they felt was a huge threat in a time of significant change and shifting emphasis at national level. Perhaps more due to its visibility as a target than anything else, REHIS came in for criticism on a number of issues. Even so, there was willingness amongst many, to concede that there is real apathy in the profession and that this was a big obstacle for any group seeking to engineer change. Some felt that many colleagues (not just senior staff) do not seek a role in public health issues at local level and that there is an ignorance of the changing agenda.

#### *REHIS, local authorities and the Health Improvement Challenge*

An attempt was made to elicit views on the potential role of REHIS and of employing authorities by seeking answers to the following question:

“What actions would you propose at the level of employing institution or indeed for REHIS in order to embrace the Health Improvement Challenge and create a more effective valued profession?”

There was a consensus that there must be an increased involvement of the profession in the themes of the Health Improvement Challenges. Indeed there was felt to be an urgent need to identify and prioritise actions in this area to lift the profile of the profession. The need for a national campaign to raise the profile of the profession was seen as necessary with a particular emphasis on raising the professions profile with policy makers. A role for REHIS in this activity was seen as important as the issues were seen to urgently require a co-ordinated national response and REHIS is a national body.

Managers in environmental health were seen as having responsibility to raise the profile of their departments in their own workplace by becoming more involved in new policies such as Community Planning and Joint Health Improvement Plans

(JHIPS). Environmental health professionals in authorities such as North Lanarkshire were applauded for achieving a prominent role in creating and influencing the local JHIP. It seems the profession is expecting their leaders at local level to “elbow their way in” to networks to produce JHIPs and generally to engage in addressing the health challenge. It emerged strongly however that success was seen as much more likely when backed by a supporting campaign at national level. There was a call for appropriate information and training to support local demands for “a seat at the table” and subsequently to ensure effectiveness.

Communication was seen to require attention at all levels to ensure that environmental health is aware of all the issues in their field of work in a timely manner. Interestingly, there was a real interest in working more closely with external consultants and realising the potential of all environmental health professionals from whatever background.

Workshop groups and interviewees were surprisingly enthusiastic in their support for research generally but specifically where it enhanced the evidence base for environmental health action. There was support for joint working on surveillance and the development of an evaluative culture particularly in relation to environmental health input to the Health Improvement Challenge. There was enthusiasm for the development of educational material to nurture the skills base in core public health issues such as epidemiology and an awareness of public health policy. These issues were seen to be the shared responsibility of SCIEH, REHIS and the academic community.

### *The Future of the Profession*

The following question was explored in the various parts of the consultation processes:

“What type of profession would you as an environmental health professional wish to see in ten years time?”

The most surprising outcome from this aspect of the consultation was how, when asked to look beyond their immediate fears and concerns, the attitude of respondents immediately became overwhelmingly positive. The vision was of a leading profession comfortable and effective in multidisciplinary settings with a holistic viewpoint on health issues. The future profession would have a strong input to policy and strategic decisions, be respected and valued for its work to a greater extent than is apparent today. There was a drive to be seen as a profession which had earned the right to be consulted on health issues and whose views would be actively sought by government. On a more practical theme many raised the issue of resource, hoping to see a much better resourced profession. There was enthusiasm for widening the profession's role, but an equally strong resolve, to retain core functions with which the profession has historically been associated. A modern presentation of the traditional role was favoured.

There was some divergence of opinion as to the home for environmental health but there was a general feeling that the local authority remained the best solution. This was qualified by a statement of the absolute necessity of raising the professions status within the employing organisations.

As a conclusion to the Consultation Day in Stirling, with internal respondents which was billed as an opportunity for the profession to have its say, workshop participants were asked to distil the key immediate actions for the profession. These were:

- Increase communication both within the profession and with their external stakeholders
- Campaign for adequate funding for the environmental health function
- Be more prepared to seek assistance from specialist consultants in the field of environmental health
- Make more appropriate use of the rich data sources which reside in environmental health departments e.g. in the service of the ongoing Environmental Health Surveillance project
- Improve the skill base of the profession by examining all aspects of the current training programme and identifying gaps in the curriculum

- Prioritise health improvement activities
- Actively promote the profession
- Urgently address the issue of low membership and low rates of participation of REHIS
- Lobby government on topical issues such as passive smoking
- Try and change the apathetic culture of environmental health

## **Discussion**

In some senses the consultation exercise was all it might have been predicted to be and we have summarised the outcome largely without comment. Both the Internal and External Respondent Groups believed that there were real problems confronting the profession and although the external group were generally well disposed to the profession they did see it as locked into a narrow statutory role. Only one external respondent actually used the words “old fashioned” but there is no doubt the term captures many of the sentiments expressed. In short, there is a view of a worthy effective, and on occasions even vital, workforce but one that is not engaging with the modern agenda in the way that it might. Training and education are regarded as emphasising the traditional role and not providing the skills and insights necessary to operate effectively in the multidisciplinary partnerships.

Encouragingly though, most external commentators exhibited a seemingly genuine desire to see environmental health back in a position of prominence and a willingness to facilitate this where possible. There was a view however that the profession’s future is largely in its own hands and if it is to have a position of influence at the centre of the health improvement effort it will require to act. A profession of the size of environmental health could be hugely effective in the service of health improvement if optimally deployed.

On balance, the issues and the priorities amongst the External Respondent Group closely matched those of the profession although the environmental health professionals were perhaps inevitably more willing to attach blame. Blame was apportioned for the professions lack of profile, its lack of influence on policy, its

diminished status in local government, its poor recruitment in recent years and also the perceived mismatch between education and training and the role the profession should play. Few of the supporting structures in the profession escaped criticism. REHIS was perhaps predictably in the firing line on many occasions, but set against this was a willingness to admit to apathy amongst the membership in supporting its institutions.

## **Conclusions**

The consultation exercise was extremely rewarding and challenging and we believe that reading the above account will give a good flavour of the key findings. However we wish to highlight the following matters:

### A Multifaceted Project

Certainly for the Internal Respondent Group, it was simply not practicable or possible for participants to disentangle matters relating to the Health Improvement Challenge with its attendant implications, threats and opportunities from their very real concerns surrounding the future of their profession. This implies a need to address both issues as a matter of urgency.

### A Vision and a Plan

The idea that environmental health ought to have a strategic vision and to work towards it in a co-ordinated and systematic way was generally accepted as being the only way forward.

### A Forum to Promote the Profession and Provide Strategic Direction

Irrespective of whether the criticisms of existing structures are justified or not, a common observation by external commentators and the almost universal view of the profession was that some new group or indeed an existing player, perhaps REHIS or the SOCOEH, requires to take responsibility addressing the challenges facing the profession, particularly in relation to raising its profile. There is perceived to be a lack of leadership in the profession.

### Develop and Communicate an Identity

This was again an underlying theme. The profession was perceived to be fragmented and hence vulnerable. There should be strong unifying identity, which ought to be readily communicable to others and ought to capture as succinctly as possible the profession's contribution to public health.

### Make the Workforce fit for Purpose

The key issue here was that training and education were believed to be totally out of kilter with the agenda the profession should now be pursuing. The feeling from both groups was that the situation had been allowed to drift and that the matter now requires close attention.

In addition to attention directed towards the undergraduate curriculum, there was a perceived need to devise flexible and accessible strategies for upgrading the profession's skills and knowledge for the modern era. Options discussed included Masters programmes (which would of necessity require to be flexible, accessible programmes, available on a module-only basis) through to less formal but co-ordinated training delivered through seminars and road shows.

A closely related theme was the need for materials to support the profession's advances into new and unfamiliar areas.

### Conflicts

Many internal and a few external commentators see that there is a lack of co-ordination and a failure to unite around a common purpose. As reported above, a few commentators mentioned what they perceived as a lack of co-ordination between the SCOEH and REHIS. We are unable to offer comment save to observe that this view was strongly but not widely held.

A more disturbing issue emerging from the consultation exercise was the extent of disillusionment many in the profession had concerning REHIS. The respondents may, of course, not be representative and their criticisms may not be fair. Most centred on perceived inaction and failure to respond to threats and opportunities. We do consider the profession places an unrealistic burden of expectation on an organisation of finite resource. This expectation cannot be fulfilled irrespective of the professionalism and dedication of staff. The situation is however dispiriting for all parties and needs to be confronted.

#### Local Authorities or Elsewhere?

There was an acceptance that Environmental Health could remain within the local Authority domain. There was a divergence of opinion as to whether this was seen as the best avenue for the profession but the local contact with the population was seen as being generally advantageous.

#### Communicate

This was perhaps the key theme emerging, the fact that the profession needs to make itself heard in the corridors of power, in the institutions in which it operates, with the media and with the public at large. The issue is certainly about being visible, presenting a professional personality and a professional view where possible. More thoughtful respondents, internal and external, were convinced it was also about listening to understand the views of others outside the profession and, through this, to develop the right sort of relationships on all levels.

## **APPENDIX 2**

### **Developing the Public Health Workforce in Scotland**

#### **Context**

Recent policy documents in Scotland have stated clearly the need to address the many factors that impact on health status and perpetuate inequalities in health <sup>(1,2 & 5)</sup>. If a change is to be made there is a pressing need for a skilled multidisciplinary workforce, which can deliver the health improvement agenda. The public health workforce is deployed at three levels:

#### National

Those members of the public health workforce working at national level would include those in the Scottish Executive Health Department or in agencies like SCIEH, NHS Health Scotland and the Food Standards Agency.

#### Regional

The most obvious regional locations for the public health workforce are NHS Boards and local authorities.

#### Community/Neighbourhood Level

At this level, the most obvious employers are the Local Health Community Councils (LHCCs). However, other organisations may potentially employ public health workers.

#### **Levels of Public Health Practice**

Based on work originating in England but regarded as appropriate to Scotland also, the workforce is seen as falling into three groups although there is acceptance that there is some overlap between these.

### Public Health Specialists

This group work mainly at strategic level or show a senior level of scientific expertise. They would exhibit adequate competency in all of the key public health competencies (see “Standards and Competencies” below). The group currently comprises mainly Consultants in Public Health medicine (CPHMs) although individuals from other disciplines, e.g. nursing., health promotion or environmental health who can demonstrate accredited competency are likely to form an increasing percentage of the Specialist cohort. Public protection is assured by the requirement for aspiring Specialists to seek inclusion on the Voluntary Register of Public Health Specialists administered by the Royal Institute of public Health.

*N.B. In England, work is already underway to provide support, training and a recognised career route for non- medically qualified professionals at the early part of their career. Similar developments are likely to be forthcoming in Scotland although matters are not as far advanced. In Scotland the priority was seen to be for expansion and development of the public health workforce at community and neighbourhood level and at the public practitioner level.*

### Public Health Practitioners

This group spend a major part or all their time carrying out public health functions. Among those likely to be included are:

- The holders of posts in the LHCCs
- Most of the health promotion specialists
- Some employees in the forthcoming Health Protection Organisation for Scotland
- A mixture of professionals currently working for, e.g. SCIEH, NHS Health Scotland and local NHS Boards with job titles such as epidemiologist, research manager, information scientist etc.
- Some health visitors, environmental health professionals or GPs with a community emphasis in their day-to-day work.
- Many new types of posts such as Health Improvement Officers in local authorities.

### The Wider Workforce

This group consist of professional and non-professionals in a variety of sectors that have a role in health improvement or reducing inequalities in health. These may include:

- Some Local Authority personnel such as planners and building control
- Personnel involved in the voluntary sectors
- Teachers and other educational staff

### **Standards and Competencies**

With such a wide spectrum of public health staff the need for a definition of standards and competencies required for the practice of public health was identified as a priority action. This work has been informed by a number of national and UK wide developments including work carried out by Healthwork UK on National Standards for Specialist Practice in Public Health (2001)<sup>(18)</sup> and a Public Health Skills Audit completed by Meyrick et al (2001)<sup>(19)</sup> for the Health Development Agency. Listed below are the ten areas of specialist public health practice developed by Healthwork UK (2001), which with expressed in considerably greater detail form the basis of accreditation as a Specialist in Public Health (see the “Voluntary Register for Public Health Specialists” below):

1. surveillance and assessment of the populations health and well being
2. promoting and protecting the populations health and well being
3. developing quality and risk management within an evaluative culture
4. collaborative working for health and well being
5. developing health programmes and services and reducing inequalities
6. policy and strategy development and implementation to improve health and well being
7. working with and for communities to improve health and well being
8. strategic leadership for health and well being
9. research and development to improve health and well being
10. ethically managing self, people and resources to improve health and well being.

These National Standards were adopted and modified by the Public Health Institute for Scotland (now NHS Health Scotland) for the development of the LHCC Public Health Practitioner Posts and have been utilised in a modified form for the development of competency portfolios. The required standards demanded within the 10 key areas will vary according to the level at which the staff member operates. It should be noted that the Health Development Agency has engaged in a number of projects to explore different aspects of public health capacity. Of particular relevance is the work done in conjunction with the Chartered Institute of Environmental Health looking at capacity and capability issues around public health activity<sup>(20)</sup>.

### **The Voluntary Register of Specialists in Public Health**

The Voluntary Register of Specialists in Public Health was established by a body known as the Tripartite Steering Group which comprises the Multidisciplinary Public Health Forum (MDPHF), the Faculty of Public Health Medicine (FPHM) and the Royal Institute of Public Health (RIPH). The latter organisation holds and administers the Register. Registration is intended to assure the public and employers that individuals aspiring to or operating in Specialist posts are appropriately qualified and competent.

The Voluntary Register will operate within the developing regulatory context for multidisciplinary public health and will be explicit in its commitment to professional values. The register is initially for those public health specialists who have no other regulatory body. It is not for those who are sometimes called public health practitioners, who do not work at a strategic or senior management level.

Development work is currently underway which may ultimately result in an extension of the Voluntary Register to encompass a group who are termed “defined specialist”. Very simply these might be individuals operating at senior level within a particular area of public health. This may have long term implications for environmental health professionals or health protection specialists but many issues still require to be resolved.

Registration may be accomplished by two routes:

*The Normal Route* is by joining a national training scheme and to pass Part 1 and Part 2 of the Faculty of Public Health Medicine membership examinations. Successful completion the RITA (Record of In-Service Training and Assessment) process.

*The Portfolio Route* is a transitional arrangement and will be open until May 2006. It will run in parallel with the normal route. Competence will be demonstrated by the submission of a portfolio using the assessment framework as a guide to content. Applicants will be expected to present evidence that they meet competency levels in all ten key areas of public health specialist practice.

Full current details on the Voluntary Register can be accessed on [www.publichealthregister.org.uk](http://www.publichealthregister.org.uk)

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