Protecting Health Commission

Deliverable 4: Documentation outlining customer requirements

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Table of Contents

1. Purpose

Health Protection is one of the key domains of public health. The aim of the Protecting Health Commission is to undertake work to describe and produce options for delivering a strong, effective, forward looking Health Protection domain at national level within the new public health body; and in turn, describe how this will support and enable activities at the regional and local level across the wider Scottish public health system.

In this paper, "health protection" relates to the domain as defined in deliverable 2:

"To protect the Scottish public[1] from being exposed to hazards which damage their health and to limit any impact on health when such exposures cannot be avoided."[2]

… whereas the term "protecting health" may include additional functions that are not traditionally included under the health protection umbrella such as accident prevention.

The purpose of this paper is to answer to deliverable 4 of the commission: to provide 'Documentation outlining customer requirements.'

As advised in the product description, provided by the Public Health Reform Team, this paper will outline what stakeholders[3] have voiced are essential, works well, doesn't work well and future requirements if identified.

2. Product & Content

This document describes the outcomes from the stakeholder engagement events held by the protecting health commission (PHC) in August and September 2018. As outlined in the commission's deliverable 3 report, the commission has worked with stakeholders and customers to better understand and plan what is needed in order to improve the Health Protection function working towards better health gains for people and communities (objective 2 of the commissioning brief). The insights from these engagement events will inform recommendations for functional arrangements for Health Protection now and in terms of future options for the new body, including proposed benefits and related benchmarks (objective 3 of the commissioning brief). The commissioning brief is available here.

3. Approach taken

This commission is being delivered by a Project Board (PB) supported by a Strategic Advisory Group (SAG) whose membership comprises many representatives (stakeholders) of the wider protecting health community.

The health protection function at a national level in Scotland is predicated on the existing and robust function provided by Health Protection Scotland. The task of the Commission was to explore the wider agenda of protecting health, the place of protecting health in a new Public Health Scotland organization, ways in which the new organization could support the wider system, and options for improvements that could be recommended in the detailed design of the new public health system with protecting health as the focus.

There is an acknowledged difference between the span of interests under a protecting health banner and the more defined area of health protection that form the focus of health protection as it currently works and the health protection service across local authorities and NHS Boards. Reconciliation of this difference in scope will be a matter for discussion in the preparation of Deliverable 5, and with other Commissions.

The PB and SAG worked collaboratively to prepare a "challenge paper" (annex 1) that identified four

1 Includes those living in, working in and visiting Scotland

2 Definition taken from the 2014 Health Protection Stocktake

3 Customers and stakeholders used interchangeably

improvement themes: leadership, resilience, relationships and connectedness. These themes were used to stimulate wider engagement on current and future state for the protecting health function in Scotland with the aim of developing practical measures for delivering a strong, effective, forward looking Health Protection domain at national level. A two day workshop for the PB and SAG held on 21st & 22nd August 2018 was used to explore the gap between current and ideal future states (detailed outputs provided in annex 2).

One output from this initial round of stakeholder consultation was the development of a draft vision statement for the Protecting Health function within Public Health Scotland. This is given below;

> "Through strong leadership, foster synergies in relationships to deliver a resilient, connected, innovative Health Protection function within Public Health Scotland."

The initial proposals developed by the PB and SAG and the draft vision were presented to a wider stakeholder group at a stakeholder engagement event on the 18th September 2018. The event was structured around workshops focusing on each of the four improvement themes. The outputs from these workshops are included in annex 3.

This is a qualitative report based on stakeholder feedback and not a systematic analysis of formal research into stakeholder views. Illustrative examples were drawn out of the verbatim outputs by the PHC project team to develop a coherent description of the views expressed within those themes. This is not a formal thematic analysis and the quotes are not always representative of a consensus view.

The resulting text, as shown below in sections 4-7, was presented to the PB for discussion and amendment, and reflects contributions from groups since their October meeting.

4. Leadership - what should the future leadership of the health protection function look like?

At the August stakeholder event, a number of statements were agreed that aimed to capture the approach to be taken to deliver a successful protecting health function:

- PHScotland will be an organisation that performs well
- Protecting Health leadership will be embedded, effective and collective
- Leadership is key to enabling a flexible and coordinated protecting health function within the public health system

A series of recommendations in support of these statements were made at the August workshop. They were reframed as questions for discussion with stakeholders at the September workshop. The questions and the comments made by stakeholders are shown in Annex 3 Table 1 below.

4.1 Summary of stakeholder feedback in relation to leadership challenge

The summary is categorised as requested in the PHR team guidance for deliverable 4. Illustrative quotes from stakeholders are included in italics.

A description of services required by the customer and the value it provides

Although there was agreement from all stakeholders that strong, effective and forward looking leadership is required, there was no collective stakeholder view of how that should be delivered in practice.

There was support for the concept of collaborative leadership but different views on how this could be delivered.

Some stakeholders suggested that a "hero" clinical leader is needed to provide a:

> *"strong clear voice for HP"*

and that the reform is an opportunity to

> *"embed stronger clinical leadership of the HP function"*

and that leadership

> *"needs to be informed by clinical expertise"*

as there is a

> *"need for a health protection leadership role which has professional credibility, real authority , parity with other PHS elements"*
>
> there was also a view that *"leadership should embrace clinical expertise; 'clinical' leadership does not need to be above others"*.

Other stakeholders argued that this was an opportunity for

> *"distribution of leadership in the system"*

and to

> *"improve multi disciplinary leadership of HP challenges"* and to *"include leaders across the partners involved in delivery and support them to be most effective"*.

It was anticipated that

> *"the combined knowledge skills of the 3 bodies coming together should enhance leadership structure"*

and that this is the time to move to *"decisive evidence-based leadership".*

Whichever approach was preferred, all agreed that the reform programme was a

> *"real chance for stepping up the team and strengthening leadership*".

These comments were made in the consultation phase of this commission but apply to the entire future organisation and system.

From the broader public health perspective, leadership for Public Health, and protecting health within it, is not only about leadership of a function but also about leading for protecting and improving the population's health. Therefore beyond leadership of the domain of health protection is system leadership – resilience, external relationships - academic & topic / expert leadership, corporate and management leadership, and distributed leadership to enhance - reach, understanding, capability and capacity.

Is the service essential and does it work well?

Our stakeholders believe there is a clear need for strong leadership with

> *"a clear HP mandate"*.

They recognise this as a

> *"window of opportunity"* to "*take strong direction*" that *"builds from a currently strong platform"*

but also the time to think beyond the establishment of PHScotland, that this is an

> *"opportunity to make most effective use of capability and capacity in Scotland"* and take a *"system wide approach – an integrated approach"*.

It was noted that *"leadership made in SHPN organisations is already collective, with a shared agenda and consensus based – it needs to be promoted and resourced better"*.

Discussions around the success of the current model focused on resilience and are explored further in section 5.

In relation to the current and future leadership approaches, areas of concern included

> "*leadership must listen to local opinion and not solely focus on national priority*"
>
> "*specialists use their power to protect systems and structure rather than population and health*".

It was agreed that this was a chance to bring

> *"clarity of roles and responsibilities where currently unclear or confusing"*.

5. Resilience - what does a resilient protecting health function look like?

At the workshops held in August it was agreed that, in order to be successful, the protecting health function required an enabled, embedded, dedicated and resilient workforce.

For the purpose of this document, resilience encompasses capacity issues.
Again, a series of recommendations were made at the August workshop in support of this statement. They were reframed as questions with the intention that they would be discussed with stakeholders at the September workshop. However, the first part of the workshop, i.e. what did the stakeholders see as positives, concerns or opportunities about the four themes engendered participation and discussion such that the sessions focused on this.
Subsequent discussion underlined the need to differentiate between resilience achievements, risks and arrangements at national and regional/local levels respectively. This section will reflect that twin-track approach, although the interdependence of the whole system still needs attention. This commission will work with the leadership for workforce development commission to embed good practice and ensure sustained career, training and educational support for the protecting health function.
The responses to the questions in Annex 3 Table 2 are taken from those comments.

5.1 Summary of stakeholder feedback in relation to resilience arrangements

The summary is categorised as requested in the PHR team guidance for deliverable 4.

A description of services required by the customer and the value they provide

There was broad acceptance that Health Protection Scotland had proven resilient in delivering sustained response to significant challenges over the period since its creation. When asked what was needed to provide a resilient HP service across Scotland, the perspective of some of the NHS Boards Health Protection representatives present was that

> *"we have this already - changing it risks breaking it."*

Conversely, others reported that

> *"some experts nationally are single handed"*

and others said, with regional / local arrangements in mind

> *"we need to see resilience as a Scotland wide problem. Staffing problem in one geographical area is an issue for Scotland and not just a problem for that area"*.

From a pragmatic local/national perspective, there was support for

> *"clear command and control for big incidents"*

and it was noted that to allow cross-organisational, cross-territorial or cross–sector working

> *"information governance must be effective and proportionate"*.

Is the service essential and does it work well?

Despite the different opinions about how it should be delivered, the need for a resilient local/regional service is recognised by all, supported by the protecting health function of PHS.

Views on how resilient the system is currently were varied, and may have depended on whether or not the perspective was of HPS as a national function, or of capability and capacity across Scotland as a whole, encompassing regional/local arrangements and as a whole system. The commission was seen by one stakeholder as an

"opportunity to call out the elephant in the room about future structures eg regional /national/ local"

and

"PHScotland critical mass to staff 24/7 service especially out of hours".

There was a view that this would not be possible without taking a wider perspective, acknowledging the interdependence of the system at times when it is stress tested i.e. beyond PHScotland, and so some saw the commission as

"too PHS focussed - needs to include key partners. No point PHS resilient if others aren't"

and a challenge to use all resources available:

"PHScotland delegated authority to utilise specialist HP workforce - why not whole PH workforce?"

6. Connectedness & Innovation

A series of recommendations were made at the August workshop to tease out what a "digitally literate and enabled protecting health function" might look like. These statements were used as the basis for discussion with stakeholders at the September workshop. The statements and the comments made by stakeholders are shown in Annex 3 Table 3.

6.1 Summary of stakeholder feedback in relation to connectedness and innovation

The summary is categorised as requested in the PHR team guidance for deliverable 4.

A description of services required by the customer and the value it provides

Stakeholders felt that a good place to start on IT connectedness could be between HPS and NHS Boards, for example, HPZone. This would require a national overview, real-time data and capacity to analyse data. There was a feeling that "*HP zone works relatively well across Scotland (relative to previous systems employed)*" and that "*officially seeing how this can be safely embedded into a single system*" would be a good start. The key was seen as being able to bring together different datasets from different areas, e.g. environmental exposures and non-communicable diseases.

A variety of constructive suggestions were made including connections with community empowerment and engagement with "citizen science". Stakeholders asked PHScotland to

> "*develop the capacity to support citizen science to increase data understanding*"

and to

> "*engage local communities in understanding health through social wellbeing in their area through access to mapping data for their area*".

Though there was a concern that a

> "*focus on internal digital connections detracts from need to make info externally available for free*".

A challenge was the perception that Health Protection data are not seen as a priority at the front-line with too many competing issues for staff making it difficult to collect data in front-line settings.

There was a suggestion that the aspiration of a "single system" should be logical rather than physical, i.e., it shouldn't be one piece of software, but rather a system of programmes which are compatible with one another;

> "a *focus on trying to get one system is high risk - need connection return systems*".

There was a request that we

> *"don't miss the opportunity to improve external as well as internal connectivity".*

Requests for improvement included marrying up the "incidents world", e.g. Food Standards, HPTs, environmental health, SEPA to maximise surveillance potential. PHScotland should enable layering information e.g. ScotPHO profiles, health protection information, flooding risk areas – what is needed is a

> *"big data overlay of health and environmental information - assessing impacts on public health*".

Geographical mapping was also seen to have the potential to be very useful, as was the need to move to providing analysis and interpretation of data suitable for a broader range of user needs.

Is the service essential and does it work well?

The efficient and effective collection and analysis and presentation of data is clearly an essential element of a service. The creation of PHScotland was seen as a major opportunity to improve surveillance and health protection. Data security, confidentiality, resilience and high security were all highlighted as essential to ensure continuing public trust of connected data systems. The need for improved connectivity between the different applications used was also highlighted, eg HPZone, ICNet

etc.

Whilst linking with local datasets may have already begun with Local Intelligence Support Teams (LIST), connecting “with outside” was flagged as an issue; how do those outside an organisation know where to go for information/data? Perhaps improvement work will also need to look at improving linkages with data systems in collaboration with external organisations, e.g. DWQR, Scottish Water, SEPA etc.

7. Relationships

A series of recommendations were made at the August workshop to explore who the protecting health function of PHScotland should develop strong working relationships with and how the organisation could make these relationships as constructive as possible for all involved. These statements were used as the basis for discussion with stakeholders at the September workshop. The statements and the comments made by stakeholders are shown in Annex 3 Table 4.

7.1 Summary of stakeholder feedback on relationships

The summary is categorised as requested in the PHR team guidance for deliverable 4.

A description of services required by the customer and the value they provide

As noted above, the workshop was structured around statements generated at an earlier event that had been circulated to delegates in advance of this workshop. The first challenge was around language, with the initial reaction from stakeholders being that they found the language used in the statements difficult to understand and sometimes to be meaningless.

Stakeholders responded to the first statement by saying

> "*not sure what this means*"
>
> "*no idea what this means, words sound lofty but what's an HP domain*?"
>
> "*Don't understand this statement*"
>
> "'*promoted partnership' is a jargon*".

Our stakeholders told us that

> "*if HP wants to build relationships, the language needs to be more accessible*"
>
> But also that we a have a mechanism to do this via SHPN:
>
> *"If we don't support the Scottish Health Protection Network we will lose influence and the respect of our partners.*

PHScotland needs to develop the right relationships at strategic, tactical (community, co-production) and operational levels, this will allow it to improve communication and collaboration between partners and communities and to take its position as a key partner in relation to planned and unplanned events.

This is an opportunity to work with other organisations to agree on issues, priorities, roles and proactively use relationships to realise added value.

We need to think

> "*how PHS will maintain relationships in a sustainable and structured way*".

What is needed was described as an

> "*absolutely clear partnership arrangement with soft boundaries to facilitate effective working relationships*".

Some saw this as an

> "*opportunity for individuals and communities to be at the centre to positively influence their own health."*

Stakeholders told us that presently

> "*often HP is quite directive - it would be interesting to explore this further*"
>
> "*community empowerment and making use of community assets and social capital = good".*

Stakeholders were supportive of the "one health" approach, though there was some discussion about what it means, seeing this is an

"*opportunity for establishing ourselves as world leaders in one health*" and

"*one health is key and connects to PHS priorities*".

There was a view that

"SHPN already encompasses one health".

Is the service essential and does it work well?

All agreed that it is

"*really important that PHS has good relationship with everyone who can influence HP outcomes*" and that

"*relationships / links are fundamental - good to see this highlighted*".

There are many existing good relationships which must be maintained and developed (e.g. Partnership on Health and Safety in Scotland, PHASS) but PHScotland should recognise where new effort is required as

"*tradition sits elsewhere*".

It was also noted that the required shift from "data" to "intelligence" will require behaviour change.

Areas of concern included the scope of change required:

"*Scotland cannot do this - it is not a Government and does not control fiscal or housing policy*"[4] and also

"*we need to decide if the health protection teams in NHS Boards are part of the integrated health protection services within PHS".*

To improve on current outcomes it was suggested that PHScotland should

"*target energy and resource at most at risk communities to make inroads to health equalities*".

Concern was expressed that there is

"*complacency about how good and extensive existing relationships are- there is room for improvement*"

and that PHScotland needs to

"*engage beyond the existing stakeholders, look beyond narrow boundaries and relationships*".

[4] In fact, Scottish Government does control public housing policy and through planning policy has a level of control over private housing development. This shows the complex landscape we are trying to negotiate.

8. Conclusions

The commission has undertaken a series of successful engagement events that have generated a diverse range of views, perhaps reflecting their experience of core health protection functions.

In making sense of the feedback received, we have worked from the following position:

- The "core" of the current health protection function works well on a business as usual, steady state, basis.
- Given the above, the PHC will advocate for Health Protection Scotland to move to PHS largely in its current form, that the Scottish Health Protection Network be the core for collaborative professional activity, but will advocate for forms of leadership that reflect stakeholder views.
- The themes of leadership, resilience, connectedness and innovation, and relationships remain key to chart the future course for a stronger, more effective and forward-looking public health service in this domain.
- The commission will take seriously the views expressed by external stakeholders and these will drive suggested improvements.
- Future arrangements will engage and involve the full range of stakeholders in its function and governance.

8.1 Vision statement

The feedback received from stakeholders supports further qualification of the proposed vision statement to be specific about the type of leadership proposed and the outcomes it can achieve.

> **"To deliver a forward-looking resilient, connected, innovative protecting health function within Public Health Scotland and across the whole system through collaborative, clinical professional[5], collective leadership, foster synergies in relationships.**

8.2 Leadership

Our stakeholders supported our call for clinical professional and managerial systems leadership, but asked us to be thoughtful about how that was delivered and expressed their support for a more collaborative and devolved style of leadership. Stakeholders stated that enhanced leadership should not translate into greater command and control from the centre.

A range of views was expressed about the need for subject expertise in leadership roles, with a view expressed that leadership should embrace clinical professional expertise but that this shouldn't be seen to be above other expertise.

The view of the commission is there is a need for a new interpretation of the challenge of leadership of the protecting health function. The new enlarged public health-focused organization has potential for health protection to have wider reach, influence and impact. It will depend on collaborative/systems leadership of the domain of health protection within PHScotland and externally across the system, sustained expertise, profile and corporate influence. At the same time, there will be the opportunity for the health protection domain to be influenced and to be interdependent on other domains and supporting functions. PHScotland must organise to deliver credibility and capability on which its effectiveness in tackling health protection threats will rest. That quality of its service will mean leadership within and around protecting health that influences the system, is adaptable, empowers, supports and nurtures PHScotland's entire staff, and beyond to all stakeholders.

8.3 Resilience

Resilience can be considered as provided by HPS at national level and by NHS Boards at local level. HPS

[5] clinical in this context is understood to include those with health protection experience from a variety of specialist backgrounds.

and NHS Boards have a track record in delivering sustained responses to significant challenges. Some stakeholders sought firm assurances that resilience capability across topics would be sufficient in a large, sustained incident. For example, the issue of EHOs not being available out of hours, and sustained responses in support of local NHS Boards' Public Health departments of varying sizes were raised as weaknesses in the overall system on more than one occasion by stakeholders.

However, resilience should also be considered at regional and local level. The current role of HPS may be clear; however the future role of the protecting health function of PHScotland in providing or supporting regional and local resilience is less clear to all stakeholders. The role of a diversity of health protection professionals, including scientists, nurses and infection prevention and control professionals, should be considered in future resilience planning.

The engagement sessions supported the view that HPS had been demonstrably resilient. There is the ongoing need for assurance that resilience in individual areas of expertise at national level is managed. However, though the national view may be that everything is in good shape; on consideration of regional and local perspectives, concerns remain for some stakeholders about the extent and coverage of resilience arrangements across Scotland, for example, capacity issues.

Further discussion needs Government-level involvement as the role of supporting the wider system assigned in future to PHScotland from Government is part of the picture. Another piece of the jigsaw is the resilience capacity of the stakeholders who support the health protection function, for example, those working in microbiology/ICD, infectious disease, infection prevention and control, environmental health, laboratories and their availability to input to the management of incidents at weekends or out of hours.

At neither stakeholder event was there a clarion call for Health Protection within the NHS Boards to be subsumed within PHS, though the question was not specifically asked. Some stakeholders expressed a view that delivery of local health protection should remain at local NHS Board level, whilst Directors of Public Health acknowledged that other options were worth consideration and reflected wider considerations across all local NHS Board public health functions. PHScotland needs a clear remit to support the wider protecting health system, acknowledging and alongside the respective roles of local and Scottish Governments.

When considering the health protection service in Scotland from the perspective of the wider system, i.e. national, interdependent with local and regional levels and organisations, there have been a number of initiatives in the past to address issues relating to resilience, capacity, quality and effectiveness. These culminated in the establishment of the Scottish Health Protection Network (SHPN) in 2015. A further working group under the NHS Scotland Shared Services initiative reported in 2018, which recommended a range of models to address out of hours on-call resilience requirements, for local determination. The view of the commission, however, is that it will remain challenging to meet normal service standards and pressures unless supported through more formalised resilience arrangements eg MOUs.

The PHR team have commissioned a short life working group to co-ordinate work to identify and assess options for the specialist public health workforce arrangements across Scotland. The Project Team will seek to set out common purpose and interests that it has in this area.

Addressing this will take the commission beyond the bounds of PHScotland as an organisation and may require funding and resource. Previous consultative processes, including the Health Protection Stocktake and more recent Shared Services Programme should act as useful guides to explore the limitations of delivery and flexibility. Work currently underway to address resilience issues should continue and link with the work of this and other commissions, ensuring continued vigilance across all systems to maximise resilience.

8.4 Connectedness & Innovation

The sessions covering the theme of connectedness provided different perspectives on the future of the protecting health function – those in the core health protection workforce discussed how dispersed information and expertise could be shared with the national body. Customers outwith this

workforce focussed more on innovation for an outward looking protecting health function, including how information and expertise held centrally by various bodies can be shared across the population and how PHS can actively engage with and empower communities across the country.

Feedback from stakeholders told us that PHScotland must be both forward looking and outward looking. The coming together of the different public health bodies offers an opportunity for a joined-up approach to making public health data and intelligence available to the public and other partners and stakeholders.

Openness and transparency with information were seen as key. Those working to protect health should be active in engaging with both institutional customers and the general public, encompassing community empowerment through access to data and intelligence, including understandable interpretation. Harnessing data to integrate diverse datasets on health, social and environmental issues could allow communities to use information meaningfully to affect local and national decision-making according to their own priorities.

The potential of social media was also recognised both for active engagement with the public and for information gathering such as syndromic surveillance and understanding public attitudes towards health protection issues such as vaccination. This was seen in the context of a protecting health function which will see connecting with the general public as part of its core business.

The view of the commission is that the Health Protection function needs data and intelligence that supports and empowers people and communities, as well as the needs of organisations and Scottish Government. The creation of PHS is an opportunity to seize momentum and be innovative in relation to big data, m-health and social media. PHS should have a collaborating centre for software management, information collection, data analysis, research and communication. Such a centre will provide expertise to all the domains of public health for data, m-health and social media on cross-cutting issues.

PHS has the potential to be the mechanism for working across domains and addressing cross-cutting issues such as stalling trends in life-expectancy, transforming population prevention programmes. Health Protection leaders need to be future thinkers and have a longer term perspective than simply the immediate incident response.. This commission shares a focus on innovation with others, and will share this perspective across other work streams. PHS should create a centre for horizon scanning, innovation and strategy development for the benefit all domains of public health.

8.5 Relationships

In general there is agreement that

> *"there is an appetite to build on existing good local connections - Health Boards, third sector, councils, to share knowledge, access to the public to reduce risk and encourage self protection".*

However, there is a contrast in views: within the health protection community there is some skepticism of the benefits to be gained from significant developments in this area as existing relationships are felt to be proportionate to delivery of the protecting health function, and representations from outwith the health protection community that improved external engagement and relationship-building would prepare the protecting health function better for greater influence and understanding. This would take place through leadership and wider profile, stronger resilience through responsiveness at times of relative quiescence, and connectedness underpinning greater understanding of the purpose and vital role of health protection to public health.

There is also an appetite across Commissions, domains and public health stakeholders to take seriously the challenge of sustained relationship-building in enhancing the effectiveness and impact of public health services overall.

Building on existing relationships, the protecting health function is keen to become better connected with those working in the other domains of public health, with the wider public health workforce and with the public.

Issues such as inequalities, cultural considerations, community empowerment concern all domains of

public health and PHS should be placed to address these in a coordinated way. Physical and organisational co-location will aid collaboration and co-ordination, but PHS should be ambitious about how it will establish and nurture connections that will succeed in practice. The new protecting health function in PHS should be forward looking and ready to consider how the health protection function can contribute to the national public health priorities (eg making our waterways, air, roads, and green space safe for active travel, childhood play, or making our food chain safe and healthy).

Those stakeholders from within the health system referenced SHPN as a good model for developing and building multi-professional and multi-agency relationships. The SHPN has a strong emphasis on relationships typified by the co-chairing leadership model which has involved NHS Boards and other stakeholders as co-leads for such work; there is strong support for this to continue into the reformed system. Stakeholders from outwith the health system recognised SHPN as a good place to start but did see it as an area for improvement rather than the answer. Some stakeholders told us that the traditional health protection approach to relationships is somewhat directive – that a small community of professionals interacts on their own terms. There was a view that the health protection function was currently more focused on transactions than relationships and that the health protection function should move to a more mature model of relationships with a stronger outward focus, able to deal with offers of outside support, perspective and challenge.

The view of the commission is that, at important times, customers of the Health Protection service are not necessarily asking the questions that current arrangements are set up to answer. PHScotland will need to develop responsive, cohesive relationships that are open to challenge and can respond promptly to the questions that stakeholders pose, across domains.

The protecting health function should consider how to engage with communities across Scotland and to respond to the population's needs as expressed by the population themselves.

Greater connections with partners in various sectors can only improve the protecting health function, increasing resilience and making the function more responsive to and familiar with the needs of the population. It is difficult to see how developments in relationship-building can be anything other than positive.

Having gathered views from all stakeholders, the commission will now take stakeholder questions and concerns into account in addressing deliverable 5 of the PHC.

Annex 1 Protecting Health challenge paper

Introduction and Purpose

Following the first meeting of the Strategic Advisory Group on June 27th, there was consensus that the improvement themes of the Protecting Health Commission would be as follows:

- Resilience
- Relationships - between the national Health Protection organization, future Public Health Scotland, and stakeholders
- Leadership issues
- Connectedness - making the most of digital and new technologies in communicating and enhancing the data and intelligence function in this domain.
- Specific attention to Environmental Public Health.

These themes bear further exploration and definition in order to develop practical measures that are likely to yield the best results for delivering a strong, effective, forward looking Health Protection domain at national level within the new public health body as required to deliver the Protecting Health Commission.

The SAG is scheduled for two-day meeting in August. These discussions will yield options for the top priority issues drawn from themes above, with specific proposals for engagement at meetings through the autumn.

This paper prepares the ground to identify key elements of specific measures for improvement. It should yield a small number of candidate propositions for development during the two day meeting. After further preparation, these propositions would be the subject of wider consultation with a view to offering a preferred option as part of the Commission's work.

There are two further points to bear in mind:

- Separate out what is important to focus on the 'detailed design of the new public health body' along with its effects on the wider system, and matters that should be for the new organization to address when it forms.
- Separate and assign (with agreement) issues that are better addressed by other Commissions.

Resilience

Resilience is:

The capacity to recover quickly from difficulties; toughness.

(Oxford Dictionaries)

In the context of Protecting Health, the qualities of toughness encompasses endurance; the 'event, stressor' or 'difficulties' may exert themselves over a considerable time. Although incident or emergency management might be the prime issue, there are other resilience-type issues to list and consider.

Resilience issues over the shorter–term include events or threats that compromise the capacity of the heath protection system of the country; they encompass staff and wider resource issues, and cross disciplines and organizations. This is important, given the regular seasonal surges that include influenza-like illness with health and care pressures, and sustained high terrorist threat levels. For such occurrences, there is a requirement for specialist expertise within Scotland and across its organizations; resources not normally provided in Scotland; inter-dependency of UK health protection systems and international bio-security. In the latter category, resilience is involved in the country's response to an internationally important incident, as a) lead or b) participant country. Examples of a) would be a CBRN incident or a legionella outbreak in central Edinburgh; and b) would be Ebola outbreak centred on West Africa.

Resilience at normal and rising demands over the longer term - Assured quality 24/7 advice, durable in 10 years' time. The difficulties might include recruitment, retention of highly qualified staff, inter-dependence with vital services and professional groups, and resources. Threats to resilience may involve the on-call system, or any of the fields of health protection, be it a disease grouping (e.g.BBV), anatomical or clinical system (respiratory, gastro-intestinal), discipline (e.g. veterinary), threat group or setting (antimicrobial resistance, environmental, toxicological etc.) – in this area of risk management, the SHPN has a role.

There will be common features to some but not all of these resilience scenarios.

Variables will be:

The event: Scale of incident, alternative provision of services, and/or speed with which it develops,

The people: Replacement or augmentation of staff expertise and resource within the organisation, the health protection community, the public health community (all domains), and skill sets or blends.

The context: Political and international interest and need for certain control measures and assurances.

Partnerships and wider considerations: Partnerships between public service sectors and third sector involvement - For example, involvement with the legal process, collection of evidence where there is the potential for criminal investigation, and possibility of civil litigation

Questions relevant to Resilience in the first challenge paper included:

In terms of functional effectiveness -

If there is a major incident, are there agreed and robust scaling up, mutual aid procedures within NHS Board departments, connecting well with front-line community based health and care services, across NHS Boards?

Are relationships and accountabilities between Health Protection teams, including Environmental Health departments, and HPS (and FSS, SEPA, PHE where appropriate, other agencies) strong and effective?

Is there the skilled multi-disciplinary capacity, with protocols and standards, efficient and safe methods of work at each level to assure good governance for resilience?

Do those who are on-call feel that, everywhere in Scotland, there is an effective and sustainable on-call system that will endure for the professional workforce or public expectation in 10-20 years' time?

In terms of organizational design options –

Are there interfaces where health protection can be stronger as part of the integrated organisation than alone – candidates may include drugs and addictions /BBV, knowledge into action with evidence, communications, academic ties and joint purpose? Is there good alignment of career development with service needs, such as government advice, joint appointments with other organisations outside the health sector, local specialists with national-level interests and expertise?

In terms of staff and specific skills matters -

Within the new organisation [PHS], if a subject expert is incapacitated, are there prompt and competent resilience arrangements?

Is there succession planning for key skills, topic areas and leadership positions?

What does a future health protection function do to attract and retain training specialists and practitioners of all disciplines?

Which disciplines are least resilient in the short-term (for incidents); in the longer term?

Which of these resilience matters presents the highest risks in the shorter and longer term? Which risks are most likely to occur, or have occurred and incomplete responses are in place?

Which of these questions should be shared with or assigned to other Commissions; addressed now or held over for the new leadership of Public health Scotland to address?

Relationships - between the national Health Protection organization and stakeholders

In terms of the Commission, this is particularly relevant when considering the effects of the national public health organization on the wider system, but it is not confined to that dimension. In terms of resilience risk and mitigation, it is relevant to consider the obligations of one part of the health protection skilled resource and its obligation in mutual aid to another part, in event of a skills or resource shortage.

What are customer / stakeholder views in this area?

Questions relevant to Relationships in the first challenge paper included:

In terms of design of the new agency-

If the function is to be strong nationally, locally, what elements are better located regionally? What elements should be co-located (SAG contribution about Public and Environmental health resources)?

Where is the Health Protection function best placed to ensure a flexible, safe, responsive, effective and efficient service across all settings? Which position best encompasses all aspects of Health Protection including primary, community and secondary care ICP

If NHS Boards of the future focus predominantly on acute health services, where is Health Protection best placed to be effective? Equally (contribution from the SAG) where there is a need for strong and effective links to support community-infection control, are relationships sufficiently good this area – what is the best configuration?

Should current accountability lines change?

Can we or should we use a composite service model from other UK Health Protection systems such as in England Wales or NI as *Public Health Scotland* moves toward an arrangement that is jointly accountable

to local NHS Boards, Local and Scottish Government, and local public health chooses a destiny that is different, or mirrored in local circumstances?

In terms of accountability, resolution and responsiveness -

Are internal relationships and accountabilities between health protection teams and their Directors strong and effective? Is this true at national agency level, national-local level; local-local level relationships within regions?

If there is cross-Board or Scotland-wide challenge or criticism of the Health Protection service, is there a way of addressing that?

If there is inconsistent advice or differences in approach to operational management, is there a way of reconciling these conflicts promptly, and respecting the adjudication?

Is there a way of addressing local criticism effectively?

In terms of relationships between parts of the public health community -

Is there good connection between health protection and other domains of service at every level?

Within this section are a small number of important issues and questions that need to be addressed and assigned clearly within this or another Commission, specifically the Commission on Specialist work. Until the Commission on Specialists is established, this Commission will retain ownership of these matters.

Leadership

Leadership issues emerge in several areas, and are particularly relevant to the detailed design of the new Public Health Scotland, its relationships with the wider system and with leadership embedded elsewhere – so there is overlap. One dimension is the issue of fairness and multi-disciplinary working to ensure the best use of many and different skills within the available resource.

What types of leadership are essential, and desirable?

Questions relevant to Leadership in the first challenge paper (and subsequent SAG discussion) included:

What is the vision of health protection that its leaders in five to ten years wish to achieve?

Is leadership in emergencies well prepared, distributed, sufficient in capacity, and recognized?

Are internal relationships and accountabilities between health protection teams and their Directors strong and effective? Is this true at national agency level, national-local level; local-local level relationships within regions?

What is the best arrangement for identifiable and recognized leaders of the Health Protection function to be most effective, within Public Health Scotland and across the public health community in Scotland?

Is there good connection between health protection and other domains of service at every level?

The series of questions on discrepancy and dispute resolution are also relevant.

In terms of organizational leadership and fairness -

Is the on-call system fair for all who work in it, and does it offer a consistently high-quality service to the public and people who depend on it for their work, everywhere and at all times?

Whilst there are matters to tackle now, there are also questions and issues for the new leaders of Public Health Scotland to address. Other Commissions, focussed on organizational development and leadership of the wider public health workforce will also wish to be aware of the matters arising.

Connectedness

The theme of connectedness, whilst acknowledging overlap with other headings, is in the context of making the most of digital and new technologies in communicating and enhancing the data and intelligence function in this domain. Related themes from elsewhere which we will note but not include for further consideration at this time, are relationship with other technological developments in the information sphere, such as whole genome sequencing and laboratory matters.

This is a relevant 'detailed design' matter but it may belong more appropriately in another Commission such as Organizational Development.

Questions relevant to Connectedness in the first challenge paper and with subsequent consultation, include:

We need a service that can undertake effective disease surveillance, monitor, anticipate, stay connected internationally and locally, and maintain expertise in the face of change.

Can Health Protection harness Digital developments to connect better within itself, with the public, in monitoring and surveillance of cohorts or specific diseases and risk behaviours, in resilience planning?

How best do we organize across Public Health Scotland to exploit the potential of data science?

Is Health Protection aligned to and best organized to innovate as part of Public Health Scotland; and as part of a wider professional, clinical and laboratory science community?

Other Commissions, focussed on intelligence and data, and leadership of the wider public health workforce will also wish to be aware of the matters arising.

Environmental Public Health

There were calls for specific attention to Environmental Public Health relating to climate change, sustainability and inequalities. There were further contributions relating to strengthening relationships at local level.

These aspects would perhaps be remitted to SHPN at a stage where the detailed design turns to topic priorities.

Conclusion

This paper is a development of the Challenge paper to the first meeting of SAG that elicited acknowledgement of many strengths of work in Scotland that is effective in Protecting Health, and areas where there is consensus on priority for improvement. From these headings, points and questions need to develop a facilitated discussion that results in a small number of propositions, offering practical steps for improvement to our effectiveness in Protecting Health.

AKF 11.07.18

Annex 2 Outputs from workshops held on 21st & 22nd August 2018

Area with scope for improvement:	**Leadership**
What might happen if we don't improve leadership?	**What will happen if leadership does improve?**
Inconsistent and un-collective leadership that causing short-termism, inadequate use of resource and a low profile Short-termism prevents sustaining, lasting, trusted relationships with stakeholders who are critical to achieving PH gains	Improvement in population health, delivery of agreed outcomes for HP priorities
Leaders will not be joined up at system level, reduction in synergy between teams/departments/organisations	We will have long term trusted partnerships with stakeholders
Fragmentation and part delivery of agreed outcomes	Shared vision, clear direction
Government departments remain non-cohesive in approach to priorities, funding and workforce. Things that fall between departments will continue to be confused e.g. Lyme disease	Effective and efficient services. Joined up resources, better approach to working together
More stressful work environment	Every part counts in delivery
No clear strategy to improve outcomes. Lack of shared priorities. No clear direction for staff. Culture would remain as is	Leadership at different levels
Not achieving our overall aim/vision	Capable, coherent, agile, confident and enthusiastic team willing and able to help
Fire fighting instead of shift in focus to preventative measures	Positive professional development
Lack of shared agenda causing potential conflict – pull in different directions, becoming side lined	Resilient workforce with plans for future leadership
Disempowerment to take decisions about priorities and resource deployment	Time to focus more on prevention
Resource implications, not using resources as effectively as we could	Mutual respect
Reduced reduction in HP related morbidity and mortality	Leadership will be more connected
Vulnerable to reduction in resources or miss chances to increase resources	
Lack of robust evidence base to inform improvement e.g. lack of research connections, forward/innovative thinking, appropriate measurement	
Continuing culture of not sharing between health and social care	
HP will not be at the top table, we will have low influence, declining resource and	

fail to make links	
Not open to new thinking	
What is the gap? Why haven't we fixed this?	
Lack of collective leadership and vision and a lack of ownership - nobody taking ownership of gaps	
HP is a small player in a big landscape	
Lack of resource. More resource needed so that HPTs do not spend so much of their time working reactively.	
Issues and themes vary in complexity: the more complex with more stakeholders are more difficult: shared responsibility	
Enduring uncertainty and perpetual change undermines confidence at all levels: there is a lack of trust because no one knows if it will change	
More resources needed for workforce education and development	
SHPN is an evolving network and is still developing positively. It needs time to mature and resources should be available to support it.	
The timescales over which these things are expected to occur are unrealistic. We need to be thinking over 5-10 years.	
Not all of the required leaders are around the right table to make links (animal, LAs, social care, etc.)	

Area with scope for improvement:	Resilience
What might happen if we are not more resilient?	**What will happen if we are more resilient?**
Some areas will remain under continual pressure which is a risk	More flexibility in deploying staff to address changing priorities for PHS / HP in future
Communities may be unsafe, risk increases	Continuity - improvement
Staff unsupported and unconnected to other parts of the service	Exchange of ideas across the system
Failure to deal with an HP threat, could lead to major / significant incident with serious implications for population health	Improved skill mix
Fire fighting gets in way of planned work	Consultants supported fully
Rigidity of staff deployment will impair the ability to adapt to changing demands / priorities.	Risks known and managed
Reduced range of staff experience of different topics - less job satisfaction; reduced opportunity for career development	We make better use of all the assets we have to hand/ better allocation of resources and sustain protection of health as resources reduce
Rota Gaps, variation in approaches because of "make do" delays in making decisions - impact on other priorities	Health protection threats are more likely to be dealt with effectively as a sustainable system is able to respond to threats more appropriately.
Health inequalities - gaps continue to widen and most vulnerable health populations do not enjoy equal health protection	Whole system - assets based, co-productive approach to resources and resilience enables inroads to health inequalities
Long term preparedness is compromised	
Burning out - mistakes - legal action - reputational damage	
What is the gap? Why haven't we fixed this?	
Inappropriate use of resources e.g. consultants writing minutes	
Different perceptions of problem	
Lack of resources/ resources gaps but better than in many parts of UK/ partly due to reduced resources in a system that is already struggling to cope with demands	
Ability or willingness to change.	
Inertia of current organisations /	

Area with scope for improvement:	Connectedness – digital
What might happen if we do not become better connected digitally?	**What will happen if we are better connected digitally?**
We risk duplication of effort and resource	Connection with other domains in the new PH Scotland we have more effective coverage of all topics and emerging threats
Poorer co-ordination, efficiency decreases	Connected local Health Protection systems will support resilience across all HP topics
Missed opportunities	There will be consistent delivery of services to address agreed HP/PH priorities across Scotland.
We may suffer from the effects of isolation	Connecting HP with the Digital H&C Strategy will ensure better intelligence systems sooner
Out of Hours response variable and sometimes inadequate responses	Less duplication - shared direction - better relationships - clearer roles; greater opportunity for more efficient use of scarce resources
Potential inequalities in HP service across Scotland	services are seamless and health improves; mutually supportive services
Services are disjointed and health is affected adversely	
We'll still be doing HP things 14/32 different ways with no consistency	
What is the gap? Why haven't we fixed this?	
Governance and Accountability: 1. Lack of shared vision and clarity of purpose. 2. No ability to direct funds to areas of greater need 3. Fragmented structures so some problems belong to others.	
Too busy fire fighting to work collectively and resilience and capacity already reduced	
Concerns about hierarchy and change in service priority	
Difficult to connect (people, plans, resources, priorities) when the parts are in multiple separate places	
Attempts to connect are seen as a power grab by national agencies and resisted	
Lack of focus on Support Services for Health Protection	
Need more influence and profile a) Digital b) LA resources and priorities	

Area with scope for improvement:	Connectedness – but really relationships
What might happen if we are not better connected?	**What will happen if we are better connected?**
We risk duplication of effort and resource	Strong HP and training / career pathways will give us a pipeline for future leadership
Divergent aims and direction – e.g. local versus national	There will be a connection to planetary health
Poorer coordination, efficiency decreases	PHS will be able to influence research to address gaps in the evidence base
Missed opportunities e.g. to direct / influence research to improve evidence-based PH decision making	Connection with other domains in the new PH Scotland we have more effective coverage of all topics and emerging threats
We may suffer from the effects of isolation	Clarity on roles and responsibilities for PHS and NHS Boards in HP
If we don't fix the place of non-Health Protecting specialists in OOH, we will have variable and sometimes inadequate responses	Connected local Health Protection systems will support resilience across all HP topics
Potential inequalities in HP service across Scotland	The population of Scotland will know what to expect from all partners delivering HP services
Services are disjointed and health is affected adversely	There will be consistent delivery of services to address agreed HP/PH priorities across Scotland.
We'll still be doing HP things 14/32 different ways with no consistency	Connecting HP with the Digital H&C Strategy will ensure better intelligence systems sooner
New body will not get the traction across all partners it desires, no buy-in at the outset.	Shared knowledge, goals, pooled resources - efforts leading to an improvement in the health and welfare of the Scottish population as well as environmental and animal health
	People will live longer, healthier happier lives
	Less duplication - shared direction - better relationships - clearer roles; greater opportunity for more efficient use of scarce resources
	Services are seamless and health improves; mutually supportive services

What is the gap? Why haven't we fixed this?
Governance and Accountability: 4. Lack of shared vision and clarity of purpose. Need a clear statement and buy-in for HP priorities

5. Lines are not clear, not clear who leads and who supports – too many people are "in charge", lack of clarity of roles, , complex governance structures 6. No ability to direct funds to areas of greater need 7. Fragmented structures so some problems belong to others.
Professional Barriers, defence of traditional roles, and silo working at all levels, difficulties in sectoral work from SG down, historically services not under one domain
Too busy fire fighting to work collectively and resilience and capacity already reduced
Concerns about hierarchy and change in service priority
Difficult to connect (people, plans, resources, priorities) when the parts are in multiple separate places
Attempts to connect are seen as a power grab by national agencies and resisted
Narrow definition of "Health Protection" i.e. not the day job. 2. Betrayal of the young and the "as yet not born" by the old. 3. Failure to see and/or accept the progressing degradation of planetary ecology, etc.
No clear understanding of LA (other stakeholder in PH)
Lack of knowledge and understanding of planet health
Lack of focus on Support Services for Health Protection
Too much focus on what is done well and not considered weak spots in services
Need more influence and profile a) Digital b) LA resources and priorities

Area with scope for improvement:	Relationships
What might happen if we don't improve our relationships with each other?	**What will happen if we relationships improve?**
If we don't fix our relationship with citizens they won't take responsibility for their own risks	Much to gain by increasing our joint working with academia
Gaps in provision and peoples' needs will not be met - poor health outcomes	Health Protection will • be more effective and efficient • better health outcomes • less wasted effort, better use of resources and skills, duplication between Health Protection services will be minimised • less frustrating for those involved
If poor relationship with individual components is not fixed, then overall standing of health provision will be diminished	Cost savings
duplication and wasted effort that could be better used, ineffective use of resources	Better national goals
no connection - common goals, purpose, lack of understanding, lack of engagement, miscommunications	Integration
conflict over responsibilities	Harness innovation from others
Protecting Health will be swamped and lose resources	we have a powerful voice for whole system /person change, other organisations will listen to us
Continue working in silos and not know what others are doing miscommunication to other, duplication	The sum of resources of individual components will have a greater impact
If we don't support the Scottish Health Protection Network we will lose influence and the respect of our partners.	good relationships/ Stronger working relationships
If we don't fix relationships in PHR, Protecting Health will not get the resources it needs	Organisational openness & transparency will benefit all
we have a less than complete view of what synergies are possible by encompassing the strengths of our new partners in PHS	Regional/national/local ownership - responsibility - accountability

What is the gap? Why haven't we fixed this?
Not recognised as an issue as previously separate bodies, so no ownership of issue, not hitherto recognised as important to build relationships.

SILO working
Lack of understanding of benefit of working relationship. Lack of appreciation of importance in comparison to other things that might need "fixing" more. Lack of defining need for relationship
Funders don't get that this is a priority. Priority not high enough yet when competing demands have higher priority for the day job.
needs very strong clinical leadership to argue for resource.
Limited examples (proof of concept) of how health protection can work with other domains in new PH organisation
HP hides its light under a bushel
HP is historically low priority - until it goes wrong.
Insufficient resources within finite reducing capacity. Lack of resource / people training. Time / Money / Resources. Poor control over available national HP resources, needs shared governance structure
Conflicting views from short term sequential strategy / policy re: relative role of research in health protection.
Comms between organisations
Focus on relationship management
Historical reasons / structures
Legislative requirements of each body limiting
Joint goals / outcomes have not been articulated.
Organisations delivering to different agenda / priorities. Different organisations with different governance, structures, sponsors, priorities, and legal responsibilities

Annex 3 Outputs from workshop held on 18th September 2018

	TABLE 1: Leadership questions posed by PB & SAG	Response from stakeholders
1.	**How do we define and agree HP organisational roles and responsibilities within and beyond PHScotland?** **- with SG** **- with local government** **- with NHS Boards?**	Why a government approach? Why HP not a PH priority? It's wider than SG - all levels of government. HP issues widely ignored, Still working off 2006 HP priorities. Let's have a conversation about funding. HP has a lot of "must do ..." functions. SG role is to enable what needs to be done. Do we mean "PH systems" not government? Is it a shared vision alone? Defining national + local system functions will also be required. Health Protection is an integral part of Public Health, therefore HP needs to be clear and visible internally and externally
2.	**What are the current leadership roles in relevant organisations?** - **professional** - **national and local** - **managerial & corporate** - **system** **Are they harmonious, acting together to create something that is greater than the sum of the parts? Are they well understood by all stakeholders?** **Do we need change the number and arrangement of manager-leaders across Scotland to consolidate accountability?**	Leadership will be by people with direct experience of delivering HP currently Needs to be informed by clinical expertise. PHS's role in clinical leadership working across boundaries HP leadership goes beyond traditional public health Needs to be authoritative with SG, locally and within HP Use empowering leadership models like SHPN Empowering relates to raw resources - having enough to empower. Playing the role of "higher power" locally (authoritative not authoritarian). In current leadership arrangements there is not sufficient clinical focus for direction-setting. Reflecting on the SHPN mechanism – shared vision – top down as well as bottom up – the mechanism for this is evolving, but it's good for what it is Vision needs to be detailed in terms of how (subsets - surveillance, etc). More operational.

3.	**Can we articulate the challenge we are facing?** **What are the top 5 health protection leadership and management (not professional) priorities?**	HP Priorities (Challenges and Responses) Non Communicable Diseases and Environmental Pollution Burden (CM) England 207 Report) Comprehensive - To include Health Protection needs assessment and management plan Taking account of Public Health priorities (vertical and horizontal threads) to maintain what we do on Health Protection (threats and opportunities) There are two leadership challenges: 1. How do we make sure e.g. Fire Service and Health Service can talk to each other? 2. Plus Health Protection leadership (quite a technical sphere) in the new body; knowledge / evidence-based Need to understand local constraints; not all equal geographically We have professional expertise (SHPN) – but do we have strength and depth? (we are a small country) Distributed' leadership is important – all involved at other levels in the leadership function
4.	**Should PHScotland have a Director of Health Protection and should they be a member of the senior leadership and management team?**	YES but: professional versus managerial lead? Is it professional or managerial? Health Protection = integral part of leadership management team of PHScotland – requires parity with other areas of PHScotland Supporting wider system (PHS) (Fire, police, etc) Equal Partnerships Fire, EH, etc on PHS Board Future proof - (inc fire like Germany)
5.	**How do we establish leadership that is professional, capable and inspirational?** **How do we create a culture that everyone is happy to**	Harness the distributed leadership across local and national bodies to ensure a collaborative approach to protecting health - avoid "top down" leadership with stakeholders Leadership vision is all about behaviours

	follow?	"Strong" leadership means "with conviction" or someone who is "identifiable and authoritative" Leadership is about an ethos and there needs to be a structure; form it first to then identify what we are going to do 'Leadership' is a hierarchical term (!) – "empowering" should be in there / "collective" Oak tree = strong but inflexible – whereas HP now needs to be fluid and able to move; to easily adapt and collaborate to achieve synergies A national approach to prioritising HP function & resources appropriately - adopting a flexible approach to local issues - connecting a broader HP workforce (APHA, NHS, LA, SEPA, FSS, DWQR, etc)
6.	**What needs to be in place to allow the Director of HP and their senior team to have sufficient, dedicated leadership opportunity?** **How do we ensure their freedom to act, and they have support from professional colleagues, in Health Protection, in other domains?**	Standards of practice required – enable people to get the same quality and experience – making sure that it's not delivered in an unsupportive way**.** Integrated and more efficient infrastructure multi-agency working, utilising local partnerships Use SHPN structure and relationships - good concept, just needs improving Should local HP teams sit in PHScotland? More focus on prevention, not just fire-fighting = working with partners and communities Empowering communities - better understanding for health protection / not health improvement
7.	**What does a strong HP brand look like?**	PHS will develop and sustain HP as a strong brand or element of its work Brand - does it matter? Need a trusted voice for PH HP - need to translate the priorities to be meaningful to work HP - visibility and well defined in PHS (purpose) Transition phase Awareness raising of new brand including HPS Public facing as well as professional facing (communication channels, websites) to keep people informed.
8.	**What kind of resources does the HP leadership team need to be able to empower the workforce to serve the public**	Specialist (where we focus now)

	optimally?	Generalist (making every contact count) Creating opportunities Resources: - Functions - Laboratory capacity - Leadership expertise - Finance Expertise and responsibility for the competent / confident workforce – those resources focused in a specialist workforce – need for expanding to the generalist workforce
9.	**How does PHScotland develop a resilient senior leadership team to cover topics, prolonged and sustained incidents, leave, shifts, succession?**	National approach to prioritising flexible approach to local connection with broader. More than resilience - take seriously. Listening and learning over a period of time.
10.	**What should PHScotland do to develop a strong, collaborative network of leaders, local, regional, national, SG?**	Local "Nous" is important - BUT how can we define the local leadership requirement to deliver effectively whilst supporting nationally - led innovation in practice & sustaining the public protection service in a consistent way? Equality of practice & outcomes not equivalence of service configurations.
11.	**Do you think a Government interdepartmental PH group/forum to promote and discuss Health in All Policies and One-Health, influencing priority setting and planning, is a way forward?**	
12.	**What are the metrics/ outcome measures that will help PHScotland deliver?**	Metrics need to fall out of: - Organisation objectives - HP priorities across Scotland Work with partner to ensure not duplicating and build on existing Distinction between: - Corporate operation - HP outcomes

		Metrics defined with partners as their input to define and monitor and buy-in. Who decides what the metrics are? Metrics should be defined as partnership working together based on Health Protection priorities Set across Scotland and ensure not duplicating – collaborative approach Metrics should increase profile upon which Health Protection can build – consistent messaging / especially when dealing with media and best route to get message across – new routes – e.g. celebrities – tailored for different audiences / populations Regular evaluation for continuous improvement There is a leadership role of holding to account for achieving things We should consider how to develop performance indicators for Public Health to link to performance framework for Scotland – accountable to local and national government
13.	**What processes will PHScotland need to establish in order to work more effectively with the wider network/system?**	Ditch PH language Strong evidence base - 1st stop for secure evidence Focus on locality with evidence above Pulling of more sources of community data = richer data Strengthen relationships with wider stakeholders (fire, police etc) PHS to display sense of prioritisation on work with national and local HPS will also look after human and work with others to improve animal health Must engage in a meaningful way with non HP agencies to achieve HP outcomes Must remember the community dealing with the issue Identify key relationships and if they are working - maintain excellence working.
14.	**What are the important communication channels?** **How do we make them work better?**	Joint Campaigns - Develop and deliver cooperatively Agree with Statement Explore and Utilise New Routes e.g. Use celebrities

		Essential to draft and distribute consistent messages (especially with media) Define collaboration and pathways for communications with media Explore and use all different forms of communication to reach different populations Evaluate regularly for ongoing improvement
15.	**What existing channels should be kept?** **Which are no longer useful and could be removed?**	

	TABLE 2: Resilience statements posed by PB & SAG	Response from stakeholders
1.	**How do we create a culture where the PHScotland workforce understand and committed to a common purpose and empowered to act and to challenge up the chain if needed ?**	Workforce behaviours and cultures are important: there is an opportunity to build a new culture drawing on all parts of the workforce Reinforce a common purpose through communication and collaboration with 'wider workforce' that is not 'traditionally' health protection PHS culture must recognise diversity in approach to improving outcomes Good workforce development will help create a culture where challenge is grounded from confident and competent staff, and is expected Recognise the service will experience regular peaks and troughs and understand how this affects the workforce – involved and empowered can sometimes be seen as in conflict with command and control Agree what is already working well – don't reinvent, build on good arrangements, networks and practices Recognise that there is a 'stronger together' opportunity, and that the new organisation should be greater than the sum of its parts There is an opportunity to review current activity and think about what is needed
2.	**Do we need to review governance, arrangement of staff, terms and conditions of the workforce to enhance flexibility, e.g. allowing staff to cover different areas?** **Who should undertake this review?** **What would its scope be?** **Should it relate to other Commissions?**	PHS can be an attractive place to work – good career pathways that encourage recruitment and retention which fosters commitment to the right thing We will have a well educated workforce equally able to deal with HP work wherever need arises: being a flexible and resilient service must not come at the cost of staff's mental well being There is an opportunity to listen to the workforce and engage positively In relation to other commissions, there is a need to work with the specialist workforce commission: a resilient and flexible workforce is as strong as its weakest link so it has to be about PHS and the wider workforce, in particular when considering a delegated authority to move resource. This may include consideration of other structural changes, such as regionalisation.
3.	**How do we develop local, national and UK career pathways in HP across all disciplines?**	Strengthen the understanding of public health, and health protection, across sectors through national engagement in workforce development Build on existing good practices, such as career frameworks: we should extend and enhance

		existing models Skills and knowledge transfer must go beyond PHS employers to wider system HP PHS should have a national leadership role in facilitating development of wider HP workforce especially local workforce– development cannot be in isolation from front line needs
4.	**Do we need to embed a leadership talent programme?** **What would it look like?**	There should be broad engagement of expertise in PHS to support workforce development Recognising the demographics and expertise of the current workforce, a leadership development programme is required: it should allow and encourage talent to emerge across the whole system and be linked to workforce development
5.	**How do we work with local authorities, third sector organisations to develop workforce core competencies?**	Agreed that third sector and non-traditional services would be better utilised - we need them in the room. Be clear who is part of this wider group so we can communicate effectively, and avoid the risk of over communicating Think about things that a) can be delivered by PHS b) can be delivered by suppliers or partner organisations or c) can be delivered in collaboration
6.	**How do we create a knowledge hub that allows all parts to access information appropriately and understand the whole system?**	Prevent the build up of silos or fiefdoms Build on existing models e.g. SHPN SOPs reduce need for local staff to work reactively to situations
7.	**What is our role in relation to creating an adaptable workforce for front line delivery?** **Should we identify other potential community workforces? Who are they? Do we have a role in preparing them, training them?**	Rationalise resource capacity across the whole system: we should think about what constitutes a minimum viable service See resilience as a Scotland wide problem: a staffing problem in one geographical area is a problem for all of Scotland, not just the area affected. PHS should build on good practice already in place, where resource is shared according to need across traditional boundaries: Resilience: PHS need critical mass of staff 24/7 service especially out of hours Ensure development opportunities are in place for front line delivery teams Consider the creation of regional field epidemiology to link with local teams Develop common practices, guidance SOPs that are adaptable to the locality

	TABLE 3: Connectedness & innovation statements posed by PB & SAG	Response from stakeholders
1.	**The infrastructure of PHScotland will be established to enable smart, agile working.**	There is no national view of HP zone Start with data flow within HP teams, national view for HP Zone - who owns this This is an opportunity for increased workflow / data exchange between existing systems (LA / Health ? cross border) Making it easier to feedback data from HP team to PHS - limit duplication Connect NSS within PHS will also be important How do we make sure these are joined up in terms of stakeholders / users not drawn by one organisation /local behind closed doors Need to understand who does what in terms of Health Scotland, HPS+IJB, where is the overlap & who takes the lead, how this affects the current structure, etc. Need to consider requirements for skilled workforce i.e. statistician, epidemiologist, comms team Link datasets to GIS No point in having data if it is not easily reachable for people to have time to do something with it Don't forget safety of data particularly personal data required for health protection
2.	**PHScotland must work with a single IT system.**	More important to ensure connected systems. Whether that is one system or signposting to systems to connect data In Scotland wealth of data that can be linked - CHI (list model) Risks associated with the use of commercial platform sole providers Positive vision of single joined up digital system from field investigations through data collation in central analysis Might a single system work against future innovations? Do we have expertise to create such system Difficult to assess risk of some access- role based access?

		single system might inhibit innovation - bureaucracy inhibits innovation - fear of using resources IT products must be easily adaptable not a stand-alone system Invest in data science and analytics to make best use of data and information can we ensure capacity to innovate with tech supporting emerging areas - injury / violence Need to develop systems in collaboration with other public bodies once for Scotland Improve access to interpretation and visualisation of data to ensure specific QS. Map health economics issue into system e.g. via Seweb There is lack of knowledge of data in different organisations which will merge in PHScot. It would be good to catalogue all the datasets in the HPS, ISD, NHSHS etc. See where connections/overlaps would make most sense and start there.
3.	**PHScotland will have in place a system to analyse and prioritise incidents.**	Already do this relatively well in terms of health protection - risk assessment based, etc Data systems need to speak to wider LA systems, third party sector Culture around speed of communications / time to consider impact in fast moving situations Issues with getting real data time for surveillance purposes **What is meant by "prioritise" incidents , what about hazards** **develop connectivity between systems to allow early detection of incidents e.g. context listing as in HP Zone** **identify non standard incidents - interpretation surveillance, etc** **Innovation to support new and emerging challenges e.g. AMR one health surveillance** **Improve multi agency work / interactions in responding to environmental incidents and accidents**
4.	**PHScotland will have refined data linkage capability to demonstrate why secondary use of data is important.**	Is there an opportunity to monetarise data Understanding what data are available- this is a challenge even at the national body level at the moment Need a way of recording what currently exists in terms of data in NSS +wide+ how this links together as a first step

		CHI Numbers very useful Need to be forward facing and to consider external organisations in and out - SEPA, FSS, LAs, etc. Connect mapping of health and environmental data to support better prioritising local engagement and delivery Geographical mapping of health data and health regularities e.g. health profile mapped with important aspects of HP work e.g. biodiversity, flooding, pollutions, etc.
5.	**PHScotland will embrace social media in day to day information gathering and outgoing targeted messaging.**	Use social media to gather intelligence - epidemic intelligence - early warning systems Also consider how to present info in visual formats - Mapping background & incidents routinely and publicly accessible link - social media, etc. Social media is tried and tested as a PUSH tech - more needed to base / ground surveillance systems Open access datasets for public stakeholder and communities Excellent opportunity to engage with communities through social media & empower citizen science Need care around empowerment of individuals, caution around the individual agenda, the interpretations will be key in community influence If we are able to embrace social media we need the infrastructure to allow us to do this e.g. access to face book and twitter on workplace PC

	TABLE 4: Relationship statements posed by PB & SAG	**Response from stakeholders**
1.	**PHScotland will improve and secure the quality and quantity of healthy life for the people of Scotland through a strong, effective, forward thinking HP domain.**	Could this be reworded to clarify what you mean here Better definition of terms needed to move forward - Protecting Health / Health Protection Direct influence on SG (policy) and other organisations on issues that influence protecting health Greater understanding of broader church of PH areas across all domains. Fair enough but HP can't do this on its own Vitally important to respond to current & future threats

		Important for Health Improvement
2.	**The remit of the HP function will include the wider aspects affecting human health – One Health – particularly the environment.**	Improving / sharing of internal resources to identify what works in areas of success. ONE HEALTH - 10/10 Be clear on definition of "One Health" (Planetary Health and Planetary Health Alliance) This will require education - messages - behaviour change (professions and public) and workforce development (capability and capacity building) what 2 domains? This seems like a broad statement, and why is environmental singled out, not poverty and homelessness ONE HEALTH , means a holistic, whole system inclusive approach that engages wider stakeholders Concern that HP function becomes diluted One health is key and connects to PHS priorities
3.	**PHScotland will refocus our service to support community empowerment and empower individuals to act positively for their own outcomes.**	Should this be engage/ work collaboratively with LAs, 3rd Sectors, private sector and academics Identify and address gaps in partnerships (a lot = good) but gaps e.g. housing CPPs - police, environment, third sector, etc- engagement there but could be stronger Build on models that work well, e.g. Dunbartonshire CPP Opportunities around BBV and TB + homeless and vulnerable populations etc., for more CPP partnership working Opportunities around clustering of off licences / gambling etc., i.e. for evidence to inform decision making Prisons and HP Make use of "LIST" team and inform local interventions Support communities through improved information and advice Integrity - where is the focus now and where does it need to be? Opportunity for use of innovative ways to engage communities in own health and well being

		This only recognises Health improvement aspect of HP is this HP? Empowerment many resource being diverted to low priority HP work
4.	**PHScotland will have promoted partnership arrangements – national and local.**	What does " promoted partnership arrangement " mean? Address grey areas - scope for more joined up relationships/responsibility) re: drugs, alcohol, (sexual health, TB e.g. HPS doesn't get involved) SHPN - how practical and effective? - how embedded in local authorities - not the most effective mechanism currently for local authorities - opportunity for more effective networks that are cross-sectoral or more expanded Missed opportunities and new opportunities for HP to engage: - community empowerment act - CPPs working at local level with people, third sector, etc., - locality plans (missed opportunities re HP currently) Opportunity for new simple procedure (with lead person) re: those people who fall through the gaps and are no-one's / everyone's responsibility / no-one takes responsibility Shared intelligence e.g. homeless people who are drug users (& 2 way sharing e.g. with additional charities) Recognition that, out with the new PHS organisation, then in order for health protection to work then stronger relationships required with CPHM and local government services Currently community planning structures exist and health protection needs to be part of this (just as health improvement is - delivered locally through HSCPs) This needs to be agreements between PHs and Health Protection Scotland with senior local government & CPPs - formalised - to ensure delivery. Increased understanding of environmental health role & formalising relationship. Similar with CPP CPP take forward Health Protection as well as Health Improvement. Promoting relationships leads to opportunities & new types of knowledge

		Opportunity for coproduction of HP with non NHS partners e.g. CPPS/ LAs Third sectors Should it be about individual perspective rather than structure led? Second to organisations e.g. academia, voluntary sector, to promote innovation and relationships Improved partnership and information sharing could raise profile of concentration issues like HCU & TB among partners.
5.	**PHScotland will have direct engagement with at risk communities.**	Just at "At Risk" or other? Shouldn't be direct engagement - already bodies who do this and do so well Need to define risk - HOW? Direct engagement with communities, third community sectors can help PHS with this How could HPS engagement with at risk communities complement rather than compete with local engagement? At risk communities- travellers, needle users, communities in area of deprivation, lots more (what else) Direct engagement with at risk communities best done locally Connecting with at risk communities as preventative HP effort There are opportunities for more joined up working on issues such as BBU, TB etc and drug alcohol deprivation etc

Annex 4 List of invited stakeholders

(not all able to attend)

Academic Public Health representatives
Animal and Plant Health Agency
British Geological Survey
British Medical Association
Commission representatives; PH workforce development, Corporate IT, Underpinning data and intelligence
Community Planning Managers
Consultants in Public Health (CPH) representatives
CoSLA Health and Social Care Committee
Directors of Public Health (DsPH) / Consultants in Public Health (CPH)
Drinking Water Quality Regulator
ECDC
Employee Directors
Faculty of Public Health (Scotland)
Food Standards Scotland
Health Protection Scotland staff
Health and Social Care Alliance
Health & Social Care Partnerships

Healthcare / Public health Scientist representatives
Health Protection Nursing representatives
Health and Safety Executive Scotland
Hepatitis Scotland
Improvement Service
Infection Control Nurses
Integration Joint Boards Chairs
Local government representatives
NHS Health Scotland
NHS National Services Scotland
NHS Scotland Chief Executives
Royal College of Nursing Scotland
Public Health England
Public Health trainees
Royal Environmental Health Institute for Scotland
Society of Chief Officers of Environmental Health in Scotland
ScotPHN
Scottish Agricultural College
Scottish Community Development Centre
Scottish Council for Voluntary Organisations (SCVO)

Scottish Directors of Public Health Group
Scottish Environmental Protection Agency
Scottish Government Agency Sponsors, Policy Leads, Comms team, Analytical Services, Primary Care Transformation Team
Scottish Health Protection Network
Scottish Water
Solace
Staffside representatives
UKPHR
Veterinary Medicine representative
Voluntary Action Scotland
Voluntary Health Scotland
Waverley Care