Public health reform
A Scotland where everybody thrives

Public Health Reform Programme Specialist public health workforce Commission

Residential Workshop Record of Discussions 10th/11th December 2018

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Specialist Public Health Workforce Arrangement Commission Residential Workshop - Record of Discussions 10th/11th December 2018

Background:

The Specialist Public Health Workforce Commission's remit is to consider how the specialist public health workforce should be best organised in Scotland to most effectively meet the needs of national, regional and local partners, and to deliver the most effective and efficient public health function for Scotland going forward (the full terms of reference for the commission can be accessed here). The commission has also developed a question and answer document which can be accessed here.

Introduction

The Specialist Workforce Commission consists of an Expert Advisory Group who are working alongside a Core Working Group. The Expert Advisory Group came together for two days in order to develop options for the future of the specialist public health workforce. The group worked together during the two days to firstly consider the opportunities and challenges offered by public health reform and then to develop five options that had been suggested by the core working group.

This report is a record of those discussions, it has been compiled using the outputs from the residential and has not been subject to further editing or analysis by the core group – its purpose is to provide a record of the two days for those taking this work forward.

Day 1

Attendees were welcomed to the two day residential workshop and the purpose, proposed outputs and agenda for the day were outlined:

Workshop Purpose:

- Get to know one another and feel part of a 'team' working on this task, putting aside vested interests
- Hear about and have time to ask questions about/discuss the (changing) PH landscape in Scotland and elsewhere and what it might mean for delivering an effective, efficient, resilient SPHW function
- Develop an outline set of options (for further work up) for an effective, efficient and resilient SPHW function
- Agree criteria for options appraisal
- Carry out a high level options appraisal with strengths and weaknesses (for further work up after the residential)

Workshop outputs:

- Answers to key questions about the (changing) PH landscape and what it might mean for a future SPHW function
- An initial set of options for an effective, efficient and resilient SPHW function within the current landscape
- An initial appraisal of each option with strengths and weaknesses
- Prioritisation of the options

Public Health Reform in Scotland:

After a short outline presentation, attendees were asked to work as groups to discuss a number of questions around Public Health Reform in Scotland. Attendees provided their responses from their table discussions and then discussed as a whole group.

Q. How will Public Health Reform benefit Scotland?

Whole System / Collaboration	• Open up whole system conversation as led by Scottish Government • Develop holistic systems view – recognise all that public health does • Breaking out of silo mentality • More collaborative • Promotes whole system at a pace of breadth that needs our health of financial challenges
Inequalities	• Able to have wider vision both strategic level and household level • Improved health and reduction of inequalities
Workforce fit for future	• Better understanding of workforce arrangements of getting appropriate framework including registration, competencies, professional associated specialism's, training and development and consistency where appropriate
Efficiency and Effectiveness	• Less duplication • Reduce burden on health – foundation around growth • Opportunity for synergy • Bringing together/ enabling common view of what PH is/does

	• Opportunity to move from rhetoric. Develop common language people understand • Improving digital connectivity and information sharing • More joined up working (fewer organisational barriers / culture change?) • More productive • Co-ordinate / align the efforts, focus and resources better • View that "reorganising" vs. actually changing what we do and how we do things • Use all capacities • Next stage in evolution of public health in Scotland • Public health reform as part of public service reform • Improve efficiencies (remove duplication within and between agencies and groups)
Focus and Priorities	• Shared focus on one set of priorities • Better impact due to collective priorities • Strategic action towards goals • Having updated public health priorities • Common sense of purpose • Clarity of purpose for non public health voluntary service • More focus on place / communities • Better working with communities and individuals improving public health • Engaging all of us to contribute • Strengthening connections to citizens and local communities • Provide focus on public health across system • Manage/map our collective capacity against priorities • Local government / Scottish Government involvement
Profile	• Less obscure and easier to know who to go to • Better understanding of what public health is • Higher profile of public health nationally • Improved profile and understanding of public health • Clarifying and strengthening national public health voice
Sustainability	• National advocacy, local influence • Achieve a coherent national approach and then local approaches that are coherent with national approach • A sustainable inclusive economy • Effective and sustainable public health Scotland service • Programme approach will ensure ongoing evaluation and assessment of success • More sustainable public services+
Other	• More connection to individuals / community / strategic • Put people at the core of reform

Q. How positive are we feeling about the progress towards Public Health Reform?

- **What are the main challenges?**
- **What is going well so far?**

Challenges	• Shifting balance of care – making progress is a challenge • Levers for shifting resources from reactive to preventative systems • Variation and supervision of public health trainees • Resourcing and funding

	• How we recruit positive leaders • Lack of citizens engagement in process • Public health reform work is taking up a lot of public health resource • Public health specialist workforce articulating with wider public health community • Rumour mill / uncertainty • How do we communicate with meaning and intent • Language needs to resonate with others • Competing priorities – how do we shift public health up the agenda • Different appetite for change across organisations and people. Culture change work needs to be part of programme • Concern that there is a hidden agenda • Small number of people resistant to change • Accept that health is politics and work with it rather than resist • Engaging with staff including senior staff who do not want change • Reliant on positive relationships for positive collaboration / positive working • Political differences can change the focus • Conflation of individual performance and systems issues (leading to sensitivities around criticism) • Joining up might do "right things" but if now working together lower impact • How do we manage perceptions to support others to think differently • Uncertainties about the future of public health reform which makes planning difficult • Website • Changing perception that it's just NHS, includes health as a whole • Reconcile tensions within specific public health workforce • Public health has been involved in reviews and reforms for four years • Constant review causing confusion • Public health concern about reform in England • Focus on public health needing to change without others • Professional boundaries • Decision making detached from process • Accountability still lies with individual organisations – no lever to promote (learn lessons from Health and Social Care Intelligence where has and hasn't worked) • Staff morale within specialist public health workforce • Competing agendas from all participants • Time/head space to think about bigger picture/longer term • Concerns that commission outputs aren't adequately reflecting discussions • Ensure good practice and experience already available isn't lost in public health reform – focus on relationships and partnerships • Complexity of the task – many different aspects of where does it start and end • Lack of sophisticated appropriate targets –e.g. SIMD not relevant for rural areas Ensure new arrangements based on evidence (not just who you

	know/your relationships) of clear, measurable success outcomes
Going Well	• Involvement in commissions from different partners • Bringing everyone together who has a part to play • Local government and others "owning" public health • Involvement of people who won't be employed by PHS • Relationships well established and generally good – usually know the people to speak to • Integration of health and social care – a lot of progress made • Local government involved in conversation • Themes locally link with wider priorities • Getting the right people round the table • Level of engagement/ inclusive • Looking and recognising progress and what to do next • Keeping momentum • Sound strategies and plans in place. Case studies could be developed about existing implementation • Opportunity to engage and discuss with groups not usually engaged • Non-PH perception changing • People are turning up • Early years work • Focusing on the long term future • We can learn lessons from NHS England and discuss different options • Reduce inequalities – renewed focus and commitment

A brief presentation was provided to the attendees "Setting the scene" which covered the challenges that Public Health Reform was aiming to address, the vision for the Public Health Reform, how Public Health Reform environment was changing, how the Public Health Reform programme was bringing all of these elements together and also how the Whole System was being enabled to work together.

Specialist Public Health Workforce – who do we mean?

The afternoon session began with a discussion around the definition of "Specialist Public Health Workforce" for the purpose of this commission. It was agreed with the group that the following staff groups should be included in this definition:

- Staff in public health departments
- Environmental health staff in local authorities
- Staff in health promotion departments
- Staff in Public Health Scotland
- Public Health Intelligence staff

However the additional following groups also needed to be considered as potential "key collaborators":

- Academic public health staff in universities
- Screening programme staff
- GCPH
- Public health registrars
- Health Improvement Scotland evidence team
- Public health nurses
- Scottish Government public health team

Attendees were then asked to consider a number of questions about how they could improve effectiveness, efficiency and resilience and what they needed to do differently to achieve this. Attendees were asked to discuss these with their table groups again and then feedback to a wider group discussion together.

Q - What needs to change to improve out effectiveness, efficiency and resilience?

- Making public health roles more attractive – including environmental health
- Ongoing development of staff – better access needed for shadowing, mentoring, secondments
- Sharing of education
- Forward planning and pathway for future of staff and standards
- Better use and coordination of staff
- Better identification of local needs and how best to meet those
- Balance between local reactive and national strategy/programmes (locally deployed)
- Better process for converting local needs into national support and action
- Need to have the evidence available that is needed to inform action
- More evidence informed and engaged with citizens and communities
- Make better use of different types of evidence
- More statutory requirements around resourcing
- Local authorities need to see themselves as having more of a public health role
- Embedding public health into community planning partnerships
- Organisational buy-in to public health agenda
- Improved support for learning from across localities
- Bring together good ideas/ways of doing things
- Less unwanted variation
- Less unintended duplication
- Get balance between duplication of effort / over reliance on one individual
- Using local and national capacity to do once for Scotland
- Less effort on multiple profiles and more on analysis and interpretation
- Reduced duplication between national and local agencies
- Flexibility across geographical boundaries – what models are working well/ why?
- Consistency nationally but recognition of variation to meet local needs and priorities
- Requires greater collaboration internally and externally
- More engagement between academic and general public health and engaging public
- Stronger respectful relationships between academia, public health, practitioners and communities
- Less jargon – make language easier to understand

Q - What does the specialist public health workforce need to do differently to achieve these changes?

- National coordination of workplans for SPHW
- Topic based support to enable effective local engagement in CPPs etc.
- Ensure national leads are building partnerships
- Good practice sharing across all areas not just single organisational area
- Equal voices for different groups
- Annual events to bring together stakeholders to identify research priorities
- Recognise contributions of others to achieve common goals
- Core competencies “tool kits” for shared information and understanding
- Put a registration in place for staff as appropriate – look at costs

- Strategic direction for environmental health
- National training for environmental health
- Public health lead at each local authority
- Chief public health officer appointed (same level as CMO)
- Understanding what the offer is from ISD data analysts
- Should we look at a specialism
- Design optimum model for distribution of public health workforce
- Adding in skills for collaboration with organisations across boundaries
- Looking at other ways to make the most of generic skills as well as specialist
- Training review – is it fit for purpose in new framework
- Framework for public health CPD, emerging skills

Development of Options:

Attendees were then asked to consider a number of potential options for how the SPHW could organise themselves to deliver the greatest improvements in Public Health.

Initial options for discussion provided were:

- Move staff in public health departments to local authorities alongside EHOs, housing etc.
- Move staff to health and social care partnerships
- Staff remain in NHS Boards
- All staff from Public Health Departments move to PHS and deployed from there
- Regional public health hubs
- Any others?

A group discussion followed whereby it was agreed that there was a level of ambiguity around each of the options, but that the purpose of the exercise was to tease this out and understand the unanswered questions with each, and how these could be potentially further developed.

Attendees were asked to join a group to discuss one of each of the options, by describing the following:

- What will the specialist workforce do?
- Where will they be located? (organisationally)
- Who will join them and who will they work with?
- How do we ensure specialist skills are retained and developed?

Following discussions, each option group were asked to feedback to the wider group for discussion.

Day 2

Day 2 began with a recap of the activities and progress made from Day 1. It was agreed that there were still some areas that required further discussion within each of the initial proposed models. In order to develop these further attendees were asked to join the group for the Option that they were interested in developing further, by answering the following questions:

- Consider where this model delivers the greatest impact?
- Consider what's in and what's out of the model:

    - Health protection
    - Screening
    - Health care public health
    - Public health intelligence
    - Health improvement
- Are the above areas in the model yes/no?
    - If not, where?
    - Local, regional or National?
- Where does this model deliver the greatest impact on population health?

Assessing the options:

Following these discussions attendees were asked to consider how each of the potential options might be assessed, and what criteria might be used for this. A number of potential assessment criteria were proposed, along with a discussion around the lessons learned from similar exercises previously completed within Shared Services. A final set of criteria were agreed by the group as follows:

- Efficient
    - Best use of resource
- Effective
    - Maximum impact on population health
- Resilient
    - Capacity to maintain delivery
- Dynamic Public Health leadership/presence across the public and third sector system
    - To mobilise and deliver

Finally attendees were then asked to review each of the proposed options, bearing in mind the previously agreed assessment criteria, for their Strengths and Weaknesses. Groups rotated around each of the Options adding their thoughts and comments, so that finally each option had been reviewed for Strengths and Weaknesses by each of the attendees.

The outputs of the models developed throughout the two days are contained within Appendix 1.

Next steps:

A final recap of the two days was provided along with a number of Next Steps to be taken forward:

- Volunteers to further develop each of the options were identified
- Options will be worked up in more detail by volunteers, and reviewed again by the Core Planning Group
- A communication will be provided by the Core Planning Group summarising the two days, which can be shared with attendees' constituent groups.
- Further timelines will be developed by the Core Planning Group and will be shared with attendees.

Feedback:

Before leaving, attendees were then asked to feedback on the workshop in the following areas:

- What went well?
- What could have been better?
- What do you still need to know?

What worked well?
• Really productive discussion with a diverse group – not just same old, same old • The fact we were here for two days together helped the discussion/ outputs progress quicker • Multi disciplinary nature • Process gave good visibility of the range of views from the professionals • Clarity of the chairing and ability to make pragmatic decision making • Integration and Engagement • Place of work and collaborative approach • Opportunity to be candid • Collaborative thinking • The interaction with other professionals • Involvement of non-NHS and non-PH colleagues in discussions • Good to flush out the options as it dealt with the elephant in the room – well done! • Intensity • Well organised and led • Honest discussions • Opportunity to discuss • Good level of discussion around the various issues • Group interaction • Two days intensive approach • Engagement with different people/ backgrounds • Challenged by other perspectives • Recognition for the options for change • Well run – everyone had the opportunity to speak • Dedicated time to think • Excellent two days. Glad there was flexibility to change from what was planned in response to the way the day went

What could have been better?
• Some people spoke multiple times in a row • Table facilitators • Unsure if all delegates were aware of the totality of PH functions. Assumptions > behind options • At times it felt like criticism was being directed at groups which was not in the spirit of the event • Representation of the groups could have been developed more • It is a necessary process so don't have any major issues with the two days • Linearity/Silos of the models

- Probably need everyone to have a greater understanding of Public Health Services in total
- Clarity is still outstanding on the key success factors (measure success/failure)
- Delegated facilitator in each group to keep the discussion on tack/ on topic
- Focus on function before form
- More clarity on objectives/criteria
- Was the representation equitable?
- Clearer picture of where we want to be
- Ambitious – Blue sky thinking
- More emphasis on the big picture 'why' to set the ambition
- It was all fine
- Should have spent more time tying down SPHWA to be for the future that PHS has to respond to/ impact on
- Keeping people succinct
- Understanding of rules
- Some colleagues are not yet ready for change, or aren't insightful about the problems
- I think it was difficult for some people to visualise a messy change + live with it while discussing options
- I'm not sure that I have any observations about the organisation or the two days that might have improved the experience.

What I still need to know

- What will happen (Skills + workforce) to lead and collaborate with the whole system
- Uncertainties about Commission inter-dependencies
- Who ultimately decides?
- The results of the other commission groups
- Scale of change acceptable to 'profession'
- Where environmental health fits
- Milestones/ Decisions
- Clarity about health protection organisation in Scotland would make it easier to think about how PH workforce could function
- Will any of this have some resource attached?
- The review of Environmental Health Service
- Wish we could have talked about future workforce – who we want to attract into public health public health including values & behaviors
- Why some service are Public Health
- Assurance that the core 'specialist workforce' are seen as equal
- Process for negotiation with accountable bodies and staff side workforce
- Our constraints
- What do the workforce think? What do they bring?
- How do we get the right "bits" from each model and how can they fit together in the best way (Rather than taking five discrete options)
- Teasing out risks and unintended consequences
- This is ultimately about moving staff around. Little on implication for individuals and system
- What is the preferred option to see the impact assessment (intended and potential or actual unintended)
- To what extent is the selection of the preferred model best delivered by a vote – and whose vote?
- Would be good to do some forensic analysis of the options. Possibly a business case approach.

Appendix 1 – Development of Options

1) **Move staff in public health departments to local authorities alongside EHOs, housing etc.**

Volunteers	Drew Hall – Environmental Health
What will the specialist workforce do?	• Provide leadership and give direction • Develop and challenge local authority • Influence the local focus • Encourage collaboration and engagement • Provide advocacy for improving health wellbeing • Democratic Accountability • Opportunity for influence • Independent view • Influence council involvement • Community planning workforce as opposed to local authority. • Consider a clear 'employed in LA' model, not just deployed as different e.g. Priorities, management etc.
Where will they be located? (organisationally)	• Council property • Local discretion in terms of what service • Agile working • May link to some council services (Housing/Planning etc) • Elements of public health intelligence in localities • Assumptions – co-located but not LA management?
Who will join them and who will they work with?	**Who will join them:-** • Equalities Officers • Environment staff • Licensing Officers • Community Planning • Education **Who will they work with:-** • NHS Services • Police • Fire • Scottish Enterprise • 3rd Sector • Community councils (engage and liaise with public bodies). Assumptions – not just work with LA but wider CPP
How do we ensure specialist skills are retained and developed?	• Statutory appointment • Registration & Accreditation • Annual appraisals and CPD
What's in the model? - Health protection - Screening - Health Care PH - PH Intelligence - Health Improvement	• Public Health intelligence • Some functions better delivered in localities • Health improvement • Health care public health – some elements in/some out
If not in the model, where would PH functions sit?	• Some NHS functions don't fit well with local authorities – we should take some with us, and look at a hybrid model for the others.

- Local - Regional - National - Other/Hybrid?	• Screening not fit for this model. • Immunisation/vaccination not fit for this model. • The 'Dental service aspect of Dental Public Health wouldn't fit in LA. • Health protection
Where does this model deliver the greatest impact on population health?	• Brings local knowledge together to provide health and social care partnership. • Address health issues before becoming patients of NHS • LA has more influence to persuade people to attend screening etc.
Strengths?	• Social detriments more aligned • Analytics could be pooled resources • Collaboration – Healthcare elements of public health has DVFIA(?)/working • Greater emphasis on prevention • Use of local intelligence with direct links to communities • Potential opportunity to address wider issues of life expectancy • Empowerment of communities and people is high on the agenda • Additional resource & capacity to focus on social determines • Visible local Public Health Leadership in system (effective) • Separation of PH from Health (NHS) care • Opportunity to get into dialogue re Public Health priorities of local issues • Most effective impact on population health • Visible local democratic accountability • Closeness to communities (community councils, customer groups, TS orgs) • Inspire, influence & mobilise greater range of services around tackling inequalities • Power & influence at right levels • Rural/remote addressed • Alignment with related professions (social work, environmental health, planning, CLD, education, transport) • Local political support • Potential to raise profile Public Health • Could raise profile of PH & opportunity to develop • Independent voice? • Access to National Intelligence • This model reflects the focus on working with CPPs, which is also a focus for PHS. • Increased democratic accountability
Weaknesses?	• Leaving some PH staff behind in Boards would potentially leave gaps in resilience • NHS funding follow into LA? • Impact on Population Health? • Impact on Whole System? • Independent voice? • Loss of current specialist function may be more challenging, e.g. start to dilute • Inefficient use of the small resource. • Fragmentation affecting efficiency & resilience

	• Weakening P.H. leadership & visibility (although not locally) • Loss of alignment of related professions (acute health, Dentistry, professionally aligned to health) • Difficulties in co-ordinating PH activity • Duplication • NHS links more default • Distance from patient groups? • If resources not protected, the English PH experience might be replicated • Proven difficult fit for specialist PH services. • Financial model (Health not necessary protected). • NHS may lose interest • Loss of critical mass • Potential dilution of Public Health profession/direction. • Timeous decisions & challenging in democratic process. • Most difficult for staff transfer • 14 PH depts. into 32 LA - How? • Not attractive for health profession • Vulnerable within LA • Frustrating previous experiences of working with LA's in the past • If health protection delivered in LA – how would this affect links to real-time clinical NHS data?

2) Move staff to health and social care partnerships (IJBs)

Volunteers	Ella Simpson
What will the specialist workforce do?	• Needs assessment (whole system) • Priorities & agenda • Systematic approach • Influence and negotiation • Collaboration/partnerships • Research, evidence, evaluation • Change agents • Child services need to be integrated • Be un-popular, but necessary • PHP close to local agenda and be influenced by it • Strong governance routes
Where will they be located? (organisationally)	• In localities/with teams • Importance of relationships/virtual teams • Multi-agency teams with professional accessibility • Data – rules will need definition to follow caldicott • Sharing data – we need openness with public re their data • Turn it into local on interrogation – measure impact • Opportunity to improve & integrate data • Brings together H&SC tool to keep moving • Health improvement to integrate more • Data analysis at national level – capacity/experts/value benefit • Planning & Designing screening • Activity screening out – focus on population • Boots on ground have local data access to expertise needed • Turning data into intelligence • Joint directors of social care? • Strong governance routes will be required • Matrix management with a multi-agency approach • Joint directors H&SCP? – DPH able to manage cross boundaries? • We need to map decision making structures we want to influence
Who will join them and who will they work with?	• Will join the partnership • Practitioners join teams • PE+1(?) • Strategic commissioning & Planning team • Social workers, GPs, Nurses, community, BLP (allied with practitioners), 3rd Sector • Environmental health, part of matrix, better links • Work with CPP – Fire, police etc • Structure up to BOBRA(?) would remain out • Data analysis/analysts – access by other groups who don't currently see/work with them • Working better needs to be more than tick box exercise • Pushing to fight protection-ism that currently exists • Children's services
How do we ensure specialist skills are retained and developed?	• PH career framework • Professional lines of accountability • Help in recruitment & substantiality • PH Registration

	• Matrix management • Shared CPD
What's in the model? - Health protection - Screening - Health Care PH - PH Intelligence - Health Improvement	• Health promotion/improvement • Screening?
If not in the model, where would PH functions sit? - Local - Regional - National - Other/Hybrid?	• Health Protection out but still need collaboration • Health care Public Health out • Some areas don't fit into H&SCP • Unsure where environmental health would sit • Variance/complexity means no single option would capture all – we need to consider elements of each.
Where does this model deliver the greatest impact on population health?	
Strengths?	• Opens PH to a new range of stakeholders • NHS & LG ownership • Third sector already closely engaged • Locality Planning • Existing partnership with governance • Integrated approach • Strength is from on the ground • Potential for stronger role for HPS & Public Health • More influence design & delivery HCP • Local led • Possible to draw down national resource • Community empowerment is already part of their agenda • Meet local need (flexible) • Potential for synergy • Visible local democratic accountability • Opportunity to build a HiAP approach into H&SCP
Weaknesses?	• Could you be un-popular if you are core to the team? • Existing partnership to governance • Duplication (e.g. Screening) • Degree to which others focus on inequalities & HiAP • Still need for wider collaboration • Where does Health protection live? • Loss of influence on Health work force - Nurses, DRs, AHPs, dentists etc. • Seen as Health Care issue • Not looking at the whole population – adult focused • No presence across public sector system • Existing partnerships unusable • Resource fragmented • Financial resources are restricted (would PH be sacrificed) • No legal entity - viability questionable? Need potential to change legal framework? • 14 Public Health departments into 31 H&SCP, how?

	• Difficult to resource • Different drivers • PH priorities could be lost to service demand • Doesn't have as high a status in community planning/whole system as NHS or local Auth • Accountability is with HB & LA • We've got this just now – hard for special standards consultant 'jack of all trades' • Does it meet criteria in terms of size, scale & scope? Not efficient or effective • Fragmentation • Different models in different areas currently (i.e. Highland) • Hard to measure success • Different models H&SCP could be confusing for SPHW • Unable to get data at more granular level currently • Splitting PH functions could be a false economy – separating health improvement could be disempowering • More resources required to address wider PH issues

3) Staff remain in NHS Boards (+ PHS)

Volunteers	Liz Smart, Jennifer Darnborough & Jenny Wares
What will the specialist workforce do?	• Meet the organisation's own priorities • Make yourself 'useful' but may not always be 'public health' • Boards have responsibility for the health of their populations
Where will they be located? (organisationally)	• Staff located within NHS Boards • Working better across Boards to improve resilience e.g. On-call rotas (regional), sharing workloads that are best done once across Boards • Obligate networks • Boards could provide single organisation with remit/ responsibility for all (health/environment etc).
Who will join them and who will they work with?	• Strengthen relationships with councils and communities • More cross border working required • How to maximise staff with IJBs with a relatively small core workforce • Obligate networks bring knowledge from local and national together • Should consider working closer with IJBs
How do we ensure specialist skills are retained and developed?	• Up skill current workforce e.g. clearer pathways for all of the workforce • Arrangements for being contracted in to PHS to provide opportunities to do national work • National training and career paths should be available for all • Important not to fragment departments • Explore obligate networks further to allow workforce opportunity to work at National level and develop skills
What's in the model? - Health protection - Screening - Health Care PH - PH Intelligence - Health Improvement	• All PH staff in Boards • Health protection – this is currently working well in Boards • Screening (currently under review) • Health Improvement • Health/Social care/Services/Public Health
If not in the model, where would PH functions sit? - Local - Regional - National - Other/Hybrid?	• Currently there are legislative barriers to bringing in Environmental health to work in Boards.
Where does this model deliver the greatest impact on population health?	• Strong relationships • No fragmentation • Learn from good practice • Reprioritising of resource for health improvement • Obligate networks could be used to deliver regional and national work, developing guidance and implementing new ways of working – obligate networks should be formalised in job descriptions
Strengths?	• Benefit of NHS label • Connections with NHS influencers • Less Disruptive

	• We have made headway with this arrangement • Less disruption & easier to maintain access for health protection to key NHS services • PH Expertise • Partnership working • There are clinical services in health improvement • Better change of influencing NHS spend • Influence on workforce (nurses, Doctors, AHPs etc) • One of the main CP partners in each of the 32 CPPs • Visible local accountability (public appointments) • Evolution not revolution • Provide local workforce with capacity/budget to be involved in national work • Ease of clinical data flows
Weaknesses?	• Great variation across Boards • Challenge to build momentum for transformation • Compromised/ Dominated by demands of (acute) health system • Fragile (resilience) • Poor community/ public engagement • Not enough focus on social determinants of health • Does not enable wider ownership of health across Public/Third sectors • PH suffers in financial choices against acute care • Environmental health not linked as well as it could be – fragmented • Not enough change • Most PH expertise outside PHS • Not dynamic public health leadership • No disruption • Reduced public health leadership and presence opportunity in whole system – less visible • Whole system more challenged to connect with Public health priorities as setup more confusing • Barrier of NHS label • Some NHS Boards don't feel local (where cover multiple local authority areas). • How to we provide local engagement on national policy? • More resource needed • How does this address wider/whole system approach? • Need to improve working with CPPs from current • Need clearer obligation with data to population health and not just service focused

4) All staff from Public Health Departments move to PHS and deployed from there

Volunteers	Paul Dowie, Liz Smart, Jenny Wares, Paul Southworth & Lorna Boyne
What will the specialist workforce do?	• National advocacy – local influence • Manage/Map our collective capacity against National & Local priorities • Relationships • Achieve a coherent national approach and then local approaches that are coherent with national approach • Clear direction for others to understand • Clear identify • Feeding up and down between National, Regional & Local • Ability to identify what's missing currently by bringing together • Stronger governance & accountability – leads to health improvements (reduced fragmentation)
Where will they be located? (organisationally)	• Democratic accountability of PHS? Need to be able to influence upwards. • Regional 3 or 14? (West, South-end, NHS Boards)? • Local – Council, H&SCP • Employed Nationally – local accountability • Versatility to move across boundaries • Less fragmented workforce – combined resources & evidence • Most effective leaders – local levers, feed powerful national voice • Evolution vs. revolution/Implementation (Iterative organisation) • Connection into local systems? • DPH joint appointment • Relationships will be key • Locations – still to be decided (Regions, all localities, arranged by priority/outcomes) • Structural employment issues still to be investigated
Who will join them and who will they work with?	• Education, FSS, CPPs, Social work, SEPA etc, Scottish Government, Academics, Communities, Spatial Planning • Integrate local resources/knowledge to PHS so it can be utilised directly – efficiency & effectiveness • Environmental Health – Risks to community re governance/locally elected member? Democratic accountability • Local authority colleagues (i.e. education, planning etc.)
How do we ensure specialist skills are retained and developed?	• Clear career pathways throughout the SPHW • Build on UKPHR & FPH work
What's in the model? - Health protection - Screening - Health Care PH - PH Intelligence - Health Improvement	• All SPHW • Bring local PH teams into PHS • Move all functions to PHS • Health Protection – Remove duplication, greater resilience, free up resources • HCPH – Part of PHS. Work with CPPs/wider system • Improving Health – must work with wider system
If not in the model,	• Where does PH leadership at more local level go e.g. DPH

where would PH functions sit? - Local - Regional - National - Other/Hybrid?	roles? •
Where does this model deliver the greatest impact on population health?	• National approach, work 'up the way' with local joint authority • Less duplication, more efficiency with immediate access to data
Strengths?	• Population don't care about structures, so providing a strong single brand/organisation would improve understanding of PH and how to interact with services • Workforce planning prospectively would help re-distribute resources but no detriment guarantee to existing staff – i.e. not expected to moved from a board with lots of HP staff to one with less • Consistent with other CP partners where national but local delivery & presence and access to national resource • Increase versatility • Flexible adaptability • Improved co-ordination • Creative disruption • Resilience/deployment of resource • Meet diversity • Easy professional governance • Standards may be easier to maintain in teams & effectiveness • Management of PH training easy • Coherence through nations – regional – local • Opportunities to strengthen career options for workforce • Reduced fragmentation • Work across all domains of public health • Might offer development opportunities • PH voice & identity louder • PH as strategic influencer • Sound credible voice • Flexible system to change according to need/priorities • Reduce duplication? • Local expertise becomes a resource • Stronger if regional hubs option is added into this and stronger local government links • Move equity into one workforce • PHS driving community planning • Understands local needs • Dynamism ability of local – regional – national expertise • Will be a partner in CPP (in the comm. Empowerment legislation) on same basis as H+SCP/IJBs • New and different culture & ethos (whole system focus) • External agencies would likely find it easier to deal with a single national body
Weaknesses?	• Risks linked to Health Boards (Risk of distancing from HB?). • Environmental clear statutory work – currently duty of LA. • Potential for resource concerned on urban areas (negative impact on rural areas but possible max impact on Scotland)

	• Roles of DM? • Potential loss of independence • Lack of democratic accountability? • Governance & accountability • NHS Boards & councils etc. stop doing prevention • Underestimate need for change in non – PHS partners e.g. Councils. Burn on SPHW) • Visible/local • National override local • Underestimate resistance with HS to change • Might encourage command control • Challenge to meet/partner expectations • Potential to become an 'Ivory Tower' • Accountability: who, SG or COSLA or to Health board, must be clear • Central belt led perception • Organisation and centralisation • Ensuring integration of PH at local level • Over reliance on being corporate • Seen as separate from related local services (SW, Adult care, Education, Planning, transport, third sector) • Don't want to be seen as purely advisory • How does this address rural needs?

5) Regional public health hubs

Volunteers	Jillian Evans, Carol Stewart, Irene Beautyman & Morag Muir
What will the specialist workforce do?	• Public health intelligence • Allows cross working with other organisations e.g. Community and strategic • Specialist focus on specific areas of Health Intelligence and Health Protection • Building and Developing local relationships • Ensure specialist skills available equally across all areas • Retain local public health leadership • Modern public health surveillance • Access to professionals skilled and able to manipulate and analyse data • Research and innovation • Bringing people population along as we integrate data • Not only model – include local and national • Localness and regional coordination = impact • Regional cords – regional economic agenda • Economic development • Inclusive growth
Where will they be located? (organisationally)	• Not single level • Over national, local and regional • Virtual/obligate network? • Needs further understanding of defined legislative regions • 3 centres of population health • Part of a tiered model – Hub & Spoke
Who will join them and who will they work with?	• New partners • Resource able to describe focus and specialist service • Public sector capacity • Local Authority • Health • Universities
How do we ensure specialist skills are retained and developed?	• Local boots on the ground to allow skills in all regions • Combining public sector skills locally
What's in the model? - Health protection - Screening - Health Care PH - PH Intelligence - Health Improvement	<u>Health Protection:</u> - Improve how we work currently/ efficiencies - Greater potential for resilience - Local ownership <u>Screening:</u> - Working across boards and focus on prevention - Some local board level delivery - Potential for greater resilience - Regional coordination <u>Health care public health:</u> - Mainly local - Move to regional services e.g. cancer <u>Public health intelligence:</u> - Local and mainly teams regional alliance + PHS <u>Health Improvement:</u> - Local Teams - Regional Coordination

If not in the model, where would PH functions sit? - Local - Regional - National - Other/Hybrid?	
Where does this model deliver the greatest impact on population health?	• 3 centres population health • Regional coordinators playing into regional economic agenda e.g. city deal • Economic development / inclusive growth
Strengths?	• Strong leadership contribution that is fed locally • Closer linkage with national and local • Improved resilience of health partnerships (on call) • Could improve capacity/resilience – screening • Will resolve recruitment challenges in North of Scotland • Impact on social determination of Health • Look at NORSPHN model as way of working • Link in to other work happening at regional level • Regional coordination can feed into city/region working and deals • Increased credibility • Maximise the potential strengths of local work • Duplication increases innovation • May be more efficient for on call etc. • Useful model for some aspects e.g. intelligence • SFRS distributed power approach • Rep at regional level for city deals etc • Innovation and new – no baggage • Keep public health together – less fragmented • Minimalist national • Proportionality – local/regional/national – what sits best where? • Engaging with wider partners • Provides opportunity to create something closer for health and local • Best use of local intelligence to a regional collection • Regional hubs alone not enough still needs national and local level • Able to move staff around easily and between levels • Builds of principles of Christie and builds capacity • Able to play into City Deals
Weaknesses?	• Non pre-existing statutory body • What are the regions? • May require additional resource – 'boots on the ground' required for delivery • Still need national and local functions – duplication? • Different regions • So much diversity in regions not enough commonality • Who is holding the reigns? • Non equally strong voices • Duplicate national quickly • Lacks local influence • Once for Scotland

	• Lacks clarity • Doesn't resolve duplication issue • Seems unnecessary layer • Few decision making levels at regional level • Unclear leadership • Screening – no savings / reduced effectiveness • Potential inconsistency with other public bodies sub national structure = confusion • Data could be integrated with LA's, however scale of ambition might be better located at local level – how do we get access to more local data? <u>Dependencies:</u> • People in health boards in regional hub – national links to regional • Could get rid of health boards and create regional hubs but need to be critical mass working with national and local – coordinated at regional • Regional and local data – not a statutory presence has a presence – could operate at national level • Could have regional teams in national • Bear in mind geographic differences within region e.g. rural/urban

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