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Public Health Reform Programme Specialist Public Health Workforce Commission

Workshop Record of Discussions 7th February 2019

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Specialist Public Health Workforce Arrangement Commission Workshop - Record of Discussions 7th February 2019

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 a full day workshop in order to review the worked up options and complete high level assessment of each option for the future of the specialist public health workforce.

The group worked together building on the outputs from the December residential workshop with the added 6th Hybrid option. The outline of the day was as follows.

- Build on the outputs from the December Residential workshop
- Develop a shared understanding about Public Health functions and context of the group's work
- Recap on the options developed for an effective, efficient and resilient SPHW function and any assumptions
- Recap the criteria and process for options appraisal
- Carry out a high level, initial appraisal of the 6 options against agreed criteria
- Develop a shared understanding of leadership required for each option.

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

The group recapped the Options so far;

- Option 1 - Move staff in public health departments to local authorities
- Option 2 - Move staff to health and social care partnerships (IJBs)
- Option 3 - Staff remain in NHS Boards (+ PHS)
- Option 4 - All staff from Public Health Departments move to PHS and deployed from there
- Option 5 - Regional public health hubs
- Option 6 - Hybrid model with national, regional and local elements

The group recapped the Shared Assumptions

- The status quo has not been successful in delivering the level of improvements that we want to see for the health and wellbeing of the population of Scotland, therefore some form of change is inevitable
- There is a need to strengthen partnership working across the public and third sectors in order to achieve these improvements, therefore this needs to be a priority within any option developed

- The need for increased public health leadership at local and national level has been stated clearly by the Scottish Government and therefore all options need to consider how this can be strengthened
- Organisational change is disruptive, which can be both a positive and negative experience for those involved. Therefore significant organisational change will only take place where there are clear gains to public health in Scotland.

Exercise 1

Purpose:

- Consider the whole systems leadership requirements for each option

Q. What does good PH leadership look like in this option?

Option 1 (Move staff in public health departments to local authorities)	• Opportunity to build trusted relationships • Opportunity for strong local leadership across Social/Economic/Environmental determinants of Public Health (Population Health) • More direct influence on Community Planning/ Partnerships • Specialist Public Health Workforce can influence change… Managing Complex Systems is challenging • Strengthen DPH/Specialist Workforce role and influence in Local Gov/Community Planning • Local Government can also influence how local Public Health team can be more aligned • Ability to create/influence Local Government as a Public Health Body – clarify role in Public Health • Financials for Health Improvement within Local Government
Option 2 (Move staff to health and social care partnerships (IJBs))	• National Direction and Leadership of IJB through Commissioning - pulling together resources holistically • Working in Partnership already. Develop facilitated leadership • Use Public Health skills to influence decisions – potential to make more effective sustainable decisions on Public Policy • Offers opportunities of 'one door' into public health at HSCP and CPPs • Joint structure fits the ambition of the reform agenda • Having leadership of Chief Officer is critical • Leadership opportunity to influence SMT of HSCP • Shifting of resources commissioning. Move to upstream – early intervention • Need public health information to drive change in IJB • Based on Core Principles of integration • Avoid duplication > Risk in IJB model: Need one system
Option 3 (Staff remain in NHS Boards (+ PHS))	• Working better doesn't necessary require structural change • Working as a network e.g. SPHW and NoSPHN • Tried + tested model with good relationships across. Many disciplines/workforces. Could be further developed through Governance Structure • Identifying and supporting Community Planning with dedicated resource • Health protection leadership needs to cover wider population than in IJB/Council Areas – Need to avoid dilution of effective function • Dedicated Resource • Multi-disciplinary • Empowering wider workforce • Good partnership working

	• Trusted, independent voice • Strong advocates for population health • Avoids fragmentation of PH Leadership • Shared values and goals • Wherever we are we have to collaborate – Less disruption of current function – more time spent on partnership
Option 4 (All staff from Public Health Departments move to PHS and deployed from there)	• How nationally organized functions/orgs interact with others who are organized differently e.g. lessons from PS, SFRS in Community Planning • Ability to make voice of smaller/ less populous areas heard • Would need to have clear feedback mechanisms throughout the system • Two way communication + feedback. National <> Regional <> Local • Inclusivity – Barriers, duplication of effort • All leaderships to work in tandem – point in same direction • Leadership to minimize the divide between National, Local and regional • Leadership approach to be distributive and as an agreed approach across the system to see success • Dispersed leadership – one person can speak for multiple – but need clear accountability • Balance: Accountability vs. freedom to make things happen • Strategy > Centralized Task/Delivery > Local Specify who responsible/accountable – strategically responsible/task responsible • Know who is accountable at national/ regional/ local levels e.g. screening/health protection • How do you lead across the system when the workforce is deployed from one place • Collective action/partnership at national level while delivering effectively locally • Balance – Top down / bottom up (Top down need high level for influence) • Leadership needs to be able to deliver something more effective through PHS than current PH Leadership – weakness identified in PH review
Option 5 (Regional public health hubs)	• Knowing local and lead with degree of objectivity • Encourages cross team working. Increase resilience • Mobilise & Spread capacity • Developing staff – critical mass allows to do this • Reasonable critical mass – enhances ability to lead • Facilitate sharing good practice • Closer to people to keep motivated on journey and continue to win hearts & minds • Boundary Spanning • Read the runes & future proof • Supports & encourages teams to handle change across whole system • Encourages team to embrace emerging practice • Shared understanding of issues/SLAs/MOUs • Degree of distance & understanding key players & drivers • Inspire and draw on local people and assets • Inspire people and lead with credibility
Option 6 (Hybrid model with national, regional and	• Needs vertical and horizontal leadership • 'Performance' manage across the patch • What is the PH offer to our partners • Be clear what the offer is to Boards, IJBs, CPPs and Local Authorities • Need a separate requirement/acknowledgement that a PH representative should be on a CPP/HSCP Boards.

local elements)	Rather than PH encapsulated within the Health representation • As a community level a national body identity may not be welcome but may create barriers • Importance of local team • Potential of 'leadership teams' for PH (not all on the head of DPH). Teams have role in engaging + leading collaboration with key local partnerships/bodies. Or Establishing a local PH Board – membership from local stakeholders. To agree local priorities and planning for PHS. • PH has a mandated seat at NHS, IJB, CPP • Hybrid model without contract change • Currently not equitable in the support given to each CPP plus local authority. Mandate for Public Health to be involved but flexible – keep it to a local representative. • Majority and Minority around a shared work plan • Need equal distribution of resource to CPPs across Scotland > dedicated team which is co-harmonious geographically can help facilitate collaborative working

Exercise 2

The group were asked to consider the 6 options against the following criteria and to provide comments prior to scoring against the options:

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

Option 1 *Move staff in public health departments to local authorities*	
Efficient	• Is there evidence this is efficient? • Duplication causing lack of efficiency • Spread of staff would reduce • Separate functions – increased potential for fragmentation • Not efficient due spread of PH • HI staff – if right level of staff in CPPs – governance would need to be right • Would fragment S/Workforce not effective. LA areas have different population sizes and not practical always to service • Investment • Assumption that HPT staff only do HPT

	• Staff work across areas
Effective	• Potential lack of independent voice • Reduced capacity as resources split • Effective on local population health • Effective connections with local • Effective chief Public Health Officer would allow Ind voice • More effective at addressing upstream determinants (potentially) • Specialist workforce split across too many individual organisations
Dynamic Leadership	• PH leadership is diluted between number of structures • Still need working across LA, NHS and other sectors • Divisions in preventative agenda potentially • Risk that local need overtakes (further risk to the Local/National Link) • Collaborative leadership doesn't exist • Positive influence on policies • Connecting into local CPPs
Resilient	• Access to Data/Analytical skills • Splitting resource reduces resilience • Finance could be cut • Fragmentation of public health specialist function risks ineffective and poorer quality of practice • Split workforce • Budget cuts and stretched resources make resilience LOW • 32 LA / 14 PH Teams • Specialist workforce development/training at risk • Model of delivery in Local Government potential for reform (Changing landscape). • Resilience of Health Protection function is compromised in this model • Location of health protection staff into local Authorities would dilute resilience and increase duplication
Ease of establishing this model	• Where would the DPH sit? • Practically very difficult • LAs don't have the same focus over health • To spread across 32 would reduce capacity • Funding (Ring fenced)

Option 2 *Move staff to health and social care partnerships (IJBs)*	
Efficient	• Less disruptive • For adults services can't do everything within an IJB – Not good. More efficient to work with IJB • Not efficient 31 HSCP 14 PH teams • Splitting resource causing lack in efficiency

	• PH, HP and screening problematic • Social Care • How different would this be? Many already part of/in partnership • Duplication
Effective	• IJB have different delegation regarding children's service not good • Already exists – Short term efficiency only • Assumption this option would improve relationship across partners • Bring Pop perspective • Drive change required in integration. PH as a positive force
Dynamic Leadership	• IJBs not changing and embracing Public Health and what is there to do • Confusion over lines or accountability and Governance • Location of PH leadership
Resilient	• 3rd sector relates to LA – vast majority of 3rd sector relate to LA as they are all community based
Ease of establishing this model	• Maintained Governance in LAs – retained budget • Different reporting structures • No physical change on HI • Funding issues • Ownership – Don't see the themselves as PH

Option 3 *Staff remain in NHS Boards (+ PHS)*	
Efficient	• Effective/efficient networks work well • Improve link with PHS improve efficiency • This model has reached its limit in what it can do, but be mindful to capture the best of what is happening – continuation • Quality approach in place • Best use of experience of resources • Least disruption – status quo, easier to bring people on board
Effective	• It is not clear how the obligation would be mandated • Reaching a common understanding of an approach • Networks have been tried and not worked (Non PH) • Good for rural PH • Over reliance on the effectiveness of networks • Not different enough • Working well/risk to disrupt • Existing strengths and weaknesses still there • Not much change so partners will ask 'what is the reform' not really Reform • Geography – size of screening, health protection, intelligence etc. But need to co-ordinate/manage PHS and Local specialist staff
Dynamic Leadership	• Not transformational in presentation

	• Collaborative working/good buy in
Resilient	• On call
Ease of establishing this model	• Health Protection is an after thought • Integration Legislation • SPHN is about how they work and can still remain in any option

Option 4 *All staff from Public Health Departments move to PHS and deployed from there*	
Efficient	• Ability/System support to work across all areas of PH • Minimise fragmentation • Risks not bringing people board • Local accountability lost • May provide opportunity to re-distribute resource longer term • Potential for Once for Scotland
Effective	• Strong Risk of centralization • Career development opportunities resilient • Shared vision and focus • Loss of local identity is all deployed nationally • Loss of local connections/ local focus • Would make training much easier and facilitate learning opportunities • More ability to deploy • Easy for public to relate to and identify with • Can be deployed according to need • Easier for academics to relate to; and to support innovation and research • Gov, Acc and relation at local level impacted
Dynamic Leadership	• National messages stronger comments • May need local identity as well as PHS • Stronger public perception of PH • Clear on identity • Potential for POS. influence up • Strong public health message to Public
Resilient	• Same disruption, but still NHS contract • Local preferences working with local chance to make difference • Tall order for coordinating so many staff across so many levels
Ease of establishing this model	• Disruptive • Issue of data transfer • PH agenda seen as PHS • Risk that workforce skills not used and bodies use others to do PH work

Option 5 *Regional public health hubs*	
Efficient	• Balance between Geography/population • Depending on delivery, could be duplication • Coordinated workforce critical mass
Effective	• Reduce duplication • Regional dimension is important across all options • Ability to relate to regional planning/development • Support for rural and smaller • Relationship to stakeholders • Critical mass – service specific • Joint Rota's on, on call work • Doesn't align to other structures (unlikely to be effective or efficient) • Other structures still allow for regional working when appropriate
Dynamic Leadership	• Ability to influence at a more strategic level • Opportunity to adopt and influence rest of system to work this way
Resilient	• Positive resilient • Could be more effective for much of PH system
Ease of establishing this model	• Rest of system doesn't work this way • Allows you to work both ways • E.g. NosPHN coordinates • Smaller Boards but voiced by larger • Concern of negative impact on opportunity to influence smaller structures • Do things region without structure extra layer of complexity

Option 6 *Hybrid model with national, regional and local elements*	
Efficient	• This is more like Norwegian model/.approach – only works if supported, service is governed and delivered at community level • Use resources capable for on-call • More adaptable flexibility • Re-distributed potential • Similar benefits to option 4, however less disruptive and more reassuring to CEOs
Effective	• Difficult to articulate as diffuse • Welsh model for how workforce deployed • Good history of joint contracting working for academic PH • Allow more formality around networks • Doesn't seem to add anything • Needs to remain rooted in local

Dynamic Leadership	• CPHO as part of SMT – Provide Local Leadership
Resilient	• Wider reach, Development for staff • Critical mass • Less upheaval • National work more planned • Less disruptive and more palatable
Ease of establishing this model	• CPHO in local looking after PH services • CPHO locally employed – to gain buy in • CPHO would strengthen local leadership

Exercise 3

Scoring the Options

The group were asked to individually score each option against the following criteria:

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

1 (least likely to achieve) – 4 (most likely to achieve)

The results once combined;

Option 1 Move staff in public health departments to local authorities	**Total**
Efficiency	27
Effective	37
Dynamic Leadership	38
Resilient	26
Ease of establishing this model	43
Overall	*171*

Option 2 Move staff to health and social care partnerships (IJBs)	**Total**
Efficiency	33
Effective	38
Dynamic Leadership	40
Resilient	29
Ease of establishing this model	36
Overall	176

Option 3 Staff remain in NHS Boards (+ PHS)	**Total**
Efficiency	59
Effective	60
Dynamic Leadership	57
Resilient	65
Ease of establishing this model	69
Overall	310

Option 4 All staff from Public Health Departments move to PHS and deployed from there	**Total**
Efficiency	70
Effective	65
Dynamic Leadership	65
Resilient	76
Ease of establishing this model	64
Overall	340

Option 5 Regional public health hubs	**Total**
Efficiency	48
Effective	47
Dynamic Leadership	50
Resilient	57
Ease of establishing this model	50
Overall	252

Option 6 Hybrid model with national, regional and local elements	**Total**
Efficiency	75
Effective	69
Dynamic Leadership	70
Resilient	74
Ease of establishing this model	63
Overall	351

A more detailed analysis of the scores was prepared following the workshop and is provided in a separate paper.

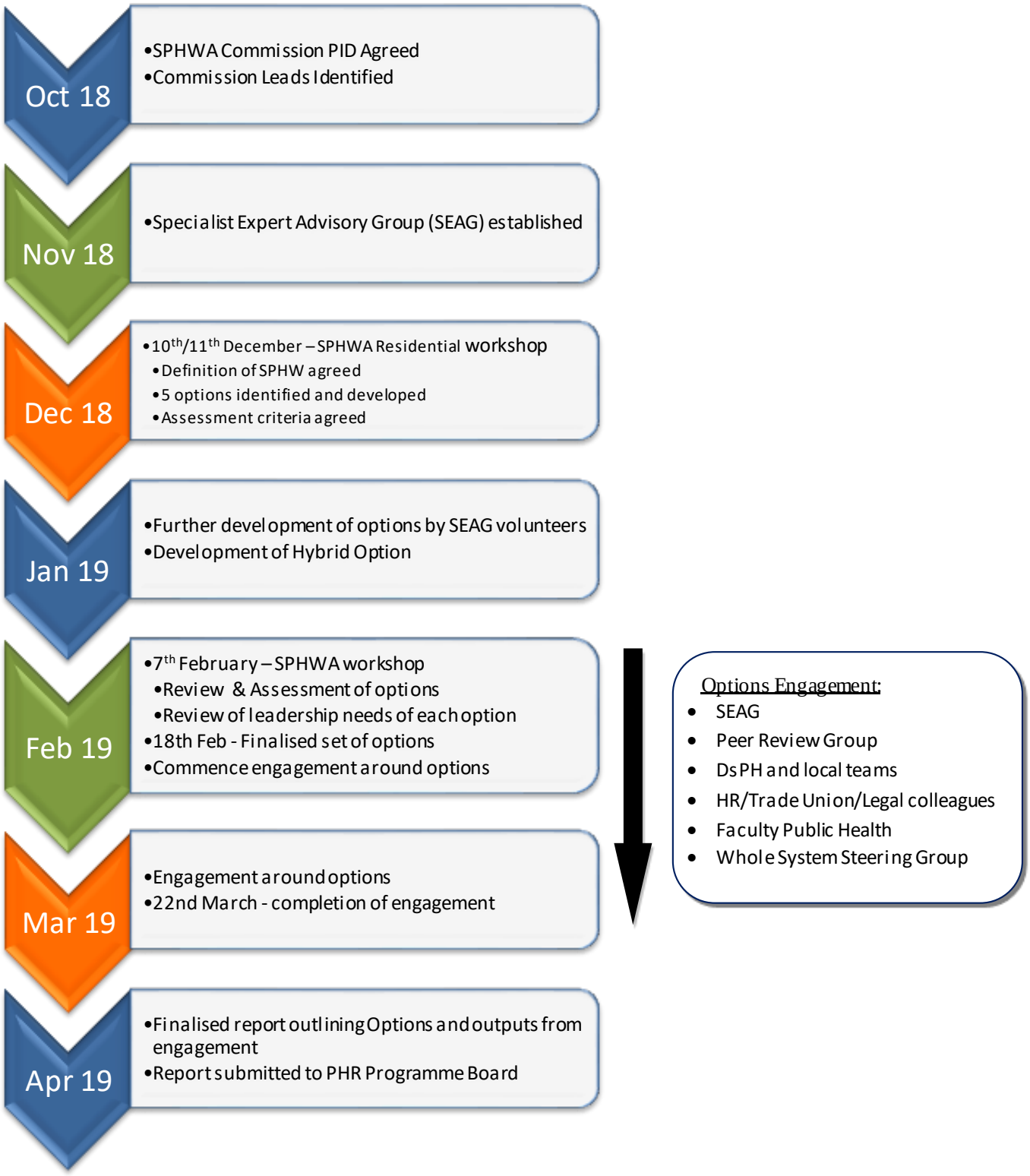
Exercise 4

Dot Voting

The group were then given one dot and were asked to place the dot on their preferred option. This was also an individual task.

Option 1 Move staff in public health departments to local authorities	**0**
Option 2 Move staff to health and social care partnerships (IJBs)	**2**
Option 3 Staff remain in NHS Boards (+ PHS)	**5**
Option 4 All staff from Public Health Departments move to PHS and deployed from there	**2**
Option 5 Regional public health hubs	**4**
Option 6 Hybrid model with national, regional and local elements	**12**

SPHWA Timeline



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