

Public Health Reform Programme Specialist Public Health Workforce Arrangements Commission

Deliverable 4



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1. Background

Public health is a multidisciplinary specialty in the UK, currently overseen by four Regulators: the General Medical Council (GMC), General Dental Council (GDC) UK Public Health Register (UKPHR) and the Royal Environmental Health Institute Scotland REHIS.

The current workforce was described in the responses to the 2015 Public Health review as being highly skilled, professional, knowledgeable, committed and enthusiastic (Griesbach & Waterton, 2015). Other qualities included objectivity, the ability to offer an independent view and voice, advocacy for the public health function, flexibility, adaptability, and responsiveness. (Griesbach & Waterton, 2015). The CfWI report - mapping the core public health resource in Scotland (Centre for Workforce Intelligence, 2015) - shows a relatively small (compared to NHS staffing), but nevertheless significant, core and specialist public health workforce in Scotland. However, the public health workforce is dispersed, risks further dilution, and lacks a clear programme and structure for development. In addition some aspects of our public health endeavour are currently experiencing significant challenges with resilience and capacity.

The environmental health workforce is employed within local authorities and constitutes a small but highly skilled group of staff who have very specific statutory responsibilities in relation to public health. They are facing significant challenges in relation to both capacity and in relation to succession planning given their current age profile.

With this in mind, work is now required to consider how our specialist public health workforce should be best organised in Scotland to most effectively meet the needs of national, regional and local partners and customers, and to deliver the most effective and efficient public health function for Scotland going forward.

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.

Building on the learning from the earlier public health workforce 'think pieces' work, the Public Health Reform Programme Board would now like the following objectives to be achieved by this commission (the full Commission Brief can be accessed [here](#)):

1. Establishment of a short life working group – 'Specialist Expert Advisory Group' (SEAG)

2. This SEAG to:

- Define which staff should be included within the definition of 'specialist public health workforce'
- Identify the range of possible options for organisation of the specialist public health workforce including their employment and deployment;
- Review the legal situation as it relates to requirements placed on the specialist public health workforce and how that might impact on potential alternative models;
- Review models of specialist public health workforce arrangements implemented and operating elsewhere, including other parts of the UK, and consider the learning from these
- Consider any other relevant material
- Link with the other Public Health Reform commissions that have specialist workforce implications and ensure specialist workforce aspects within these commissions are taken into consideration;
- Take into account views from the range of relevant stakeholders.
- Assess the options against which would deliver the most effective, efficient and resilient specialist public health function;

- Consider the specific role of the Director of Public Health and how that that can be most effectively delivered;
- Provide a report to the Public Health Reform Programme Board with options/ proposals for how the specialist public health workforce in Scotland should be organised.
- Identify any other aspects of specialist public health workforce that should be considered within public health reform programme in order to support improvements in health, health protection, and reductions in health inequalities.
- Provide recommendations on the organisation of the environmental health workforce for both the Public Health Reform Programme and COSLA's consideration.
- Champion the principle of strengthening of public health

The purpose of this paper is to provide a view on how the specialist public health workforce should best be deployed in Scotland in order to achieve the greatest gains for the populations' health. It also identifies any associated factors that the PHR Programme should take into consideration for its ongoing reform work.

2. Approach taken by the commission

2.1 Specialist Expert Advisory Group

In order to meet the first objective of the commission a Specialist Expert Advisory Group (SEAG) was established, which was brought together from nominations which were sought from a range of organisations across the wider system. It was also emphasised when seeking nominations, the importance of adequate representation in the overall group from those in remote and rural areas.

A Core Planning Group was also formed from a subset of SEAG members in order to focus on the planning of activities required to address the requirements of the commission. It was agreed that due to the short timescales available, the best use of the SEAG members' time would be to hold a series of residential and full day workshops between December 2018 and February 2019.

Full Terms of Reference for the SEAG can be found [here](#).

2.2 Options Development

The SEAG for the Specialist Workforce Commission came together initially for two days in December 2018 with the purpose of:

- Getting 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) Public Health 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

Discussions began around agreeing a definition of the 'specialist public health workforce' – "Who do we mean?". It was agreed for the purpose of this commission 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 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?

It was agreed that the purpose of the workshop was to begin to define what each of the options could look like and to tease out and understand the unanswered questions with each, and how these options could be potentially further developed.

The SEAG members were divided into sub groups who worked together on one of the options; group members chose which group they joined and therefore which option they developed. The options were developed by answering a series of questions:

- 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?
- 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
 - Others?
- 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?

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

At the end of the initial residential workshop the SEAG had produced outline descriptions of five options, some of which were further developed than others. The outputs from this workshop are contained in [Appendix A](#).

The draft options from the residential workshop were then sent to the small groups of volunteers with a request from the Commission Leads to further develop the options, filling in gaps and considering any questions that may have been outstanding from the residential. Volunteers were asked to also consider the following shared assumptions which had been developed by the Core Planning Group, in order to answer some of the unknowns that had been discussed at the workshop:

- 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.

One of the outcomes from the day was a suggestion to develop a sixth option which would be a hybrid model based upon the perceived strengths of the other five models. A small group of volunteers were therefore invited to develop a potential Hybrid options using the strengths and weaknesses of the options developed to date.

2.3 Scoring of the options

Following further development of these options, an agreed set of options (five original options, plus a new potential hybrid option) was shared with SEAG members ahead of the next workshop held in February 2019. The purpose of this workshop was to:

- 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.

Attendees were asked to review the options again and to evaluate and describe 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?

A scoring exercise was then completed in order to assess each of the options against the agreed criteria. Further details of this exercise and the results can be found in [Section 3](#).

The detailed outputs from the workshop can be found in [Appendix A](#).

2.4 Leadership

In addition to the scoring of the options, the SEAG were tasked with considering the whole system leadership requirements for each of the options. A summary of the outcome of this discussion can be found on Page 3 of [Appendix A](#).

2.5 Peer Review

In addition to the engagement activity, a peer review group was also established with the following members:

- **Dr Garth Reid**, *Interim Head, Evidence for Action team, Lead Author (Chair)*
- **Katie Dee**, *Deputy Director of Public Health and Health Policy, NHS Lothian*
- **Dr. S Vittal Katikireddi**, *Senior Clinical Research Fellow & Honorary Consultant in Public Health, MRC/CSO Social & Public Health Sciences Unit, University of Glasgow*
- **Lynne McNiven**, *Interim Director of Public Health, NHS Ayrshire & Arran*
- **Paul Najsarek**, *Chief Executive, Ealing Council/ Deputy Policy Spokesperson on Community Wellbeing, SOLACE*

The peer review group were asked to review the materials produced from the workshops, and provide feedback on the following questions:

1. Do the conclusions reached to date seem logical from the discussions held and the papers reviewed?
2. Can you identify any unreasonable assumptions/propositions contained in any of the options/work to date?
3. Are there any other options for the organisation of the public health workforce which have not been considered?
4. Is there any work from elsewhere that the Core Group should consider as part of its final deliberations?
5. Are there any other things the Scottish Public Health system should be thinking about when implementing the options?

The output of Peer Review can be found in [Appendix C](#).

2.6 Legal Review

The Core group of the commission also identified the need for some legal advice. A legal review of the legislative workforce implications of each of the options was therefore requested and provided by Robert Girvan, Public Health Scotland Legislation Team Leader, Scottish Government – the output of the review can be found in [Appendix D](#).

2.7 Stakeholder Engagement

Following the completion of the SEAG workshops, the options identified and developed have since been shared with a wide range of stakeholders in order to receive feedback on behalf of professional bodies and staff. To facilitate this process a series of engagement slides were provided by the Core Planning Group which can be found in [Appendix B](#), along with an overview of

feedback received from constituent groups. Stakeholders were asked to consider the following questions for feedback:

- Is there anything you think the process so far has not considered/ captured?
- What would need to be considered further to explore the other options?
- Other questions and feedback?

3. Findings

The results of the appraisal of the options are provided in this section. A detailed description of each option can be found in [Appendix E](#).

3.1 Results from an appraisal of the options

The final exercise that SEAG members were asked to complete at the February workshop was to individually score each of the options using the following agreed 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) to 4 (most likely to achieve).

The results once combined were:

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

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

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

Option 4	Total
All staff from Public Health Departments move to PHS and deployed from there	
Efficiency	70
Effective	65
Dynamic Leadership	65

Resilient	76
Ease of establishing this model	64
Overall	340

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

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

The last exercise of the day involved each attendee placing a 'dot' on their preferred overall option; the results of this exercise were as follows:

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

A more detailed analysis of the scores was prepared by Gerry McCartney following the workshop and is provided in [Appendix A](#).

3.2 Options Conclusions

It is evident from the appraisal of the options that there are advantages and disadvantages from each of the options as they were described and scored. There were three options that scored more highly than others during the appraisal of options conducted by the SEAG, but even within these there remain significant weaknesses and barriers to be overcome and there is no guarantee that any of the options could deliver the improvements in outcomes that we would like to see in Scotland.

In addition to engaging the specialist public health workforce and wider system through the work of the SEAG, the reform team undertook targeted engagement with community planning partnerships. This focussed on the role and contribution of the specialist public health workforce - supported by Public Health Scotland – as enablers of a whole system approach (WSA) to improve health and wellbeing. There was a significant appetite for change from across the system with a number of consistent themes identified; these include:

- Knowledge and Skills – The value of the Public Health Workforce in local partnerships isn't always being realised and there is a need for a more consistent 'offer' to local partnerships that utilises the expertise available.
- Relationships –The importance of local knowledge and connections are vitally important to supporting a WSA. Currently, the workforce isn't always visible or seen as adding value to collaboration.
- Engagement – Linked to knowledge and skills, the workforce needs to be more effective at collaboration and engaging in local partnerships to maximise influence.
- Wider workforce – A WSA approach need to utilise not only specialist skills but also those within the wider workforce, innovative approaches to co-location and collaboration that strengthen partnership and relationships are critically important. This needs to be supported by Public Health Scotland.
- Leadership – The specialist public health workforce needs to be visible and provide local leadership. This needs to be adaptive and flexible to local needs.

The contribution of Public Health Scotland and the Specialist Public Health Workforce to driving and enabling a whole system approach to improve health and wellbeing will be critically important.

3.3 Leadership and the role of the Director of Public Health

From the exercise undertaken by the SEAG and the evidence gleaned from elsewhere, it is clear that a whole systems approach to public health needs to have strong leadership built on established professional relationships across the system. The SEAG identified the need for an approach which is about strategic influence and delivery but also empowerment of the public health workforce and the communities they work with. Public health leadership should focus on prevention, allocation of resources and supporting and leading community planning partnerships in addition to assuring the management and governance of public health programmes.

The SEAG also felt that the leadership required was collaborative, distributive and is able to challenge and support change across the system where needed. This is consistent with the whole system approach that sets out our ambition for a leadership approach that is able to build and sustain collaborative relationships; be committed to drive change over a longer period; empower leadership at all levels; be flexible; champion, test and learn from new ways of working across organisational boundaries. The role of the Director of Public Health was recognised as significant in this work but they cannot operate alone and therefore there is a need to create public health leadership within the wider workforce and across the system.

A recurring theme from Community Planning Partnerships was the desire to see a strengthened commitment from NHS Boards and the Specialist Public Health Workforce to community planning partnerships. This is consistent with findings from the Public Health Review 2015 in strengthening support for community planning and health and social care partnerships, this includes ensuring visible public health leadership contribution in each partnership consistent with the competencies described above.

3.4 Peer Review

Following the work completed by the SEAG, a Peer Review Group was established and provided the following conclusions and associated recommendations:

Do the conclusions reached to date seem logical from the discussions held and the papers reviewed?

Overall, the conclusions seem to be logical, based on the summary documents of the discussions held and papers reviewed. However, we have identified three issues which we feel need to be reflected on further:

- National leadership around Health Care Public Health and Education

- Academic Leadership
- Influence at a national and local level

Can you identify any unreasonable assumptions/propositions contained in any of the options/work to date?

Overall the assumptions in the documentation we reviewed were reasonable. However, we have identified four key issues where assumptions have been made that could be reflected on:

- Decrease in life expectancy being due to public health
- Disruption
- Local level action will reduce inequalities
- Popular options for structuring workforce arrangements are effective
- Flexibility

Are there any other options for the organisation of the public health workforce which have not been considered?

- Options need to be clearly specified to be properly evaluated
- Relationship with government
- Strengthening existing arrangements

Is there any work from elsewhere that the Core Group should consider as part of its final deliberations?

There are a four additional pieces of evidence we think would be useful to consider:

- McKee M, Hurst L, Aldridge RW, Raine R, Mindell JS, Wolfe I, et al. Public health in England: an option for the way forward? *The Lancet*. 2011; 378 (9790):536 - 9.
- Katikireddi SV, Smith KE, Stuckler D, McKee M. Devolution of power, revolution in public health? *J Public Health (Oxf)*. 2017; 39 (2):241-7.
- [Academy of Medical Sciences. Improving the health of the public by 2040. Optimising the research environment for a healthier, fairer future. London: The Academy of Medical Sciences London; 2016.](#)
- [Rechel B, Maresso A, Sagan A, Hernández-Quevedo C, Richardson E, Jakubowski E, et al. The role of public health organizations in addressing public health problems in Europe: The case of obesity, alcohol and antimicrobial resistance: European Observatory on Health Systems and Policies; 2018.](#)

Are there any other things the Scottish Public Health system should be thinking about when implementing the options?

- Creating a system which can cope with future challenges
- Relationships are key
- Achieving balance
- Accountability, governance and relationships
- Creating a workforce which is fit for purpose

A full detailed response from the peer review group can be found in [Appendix C](#).

3.5 Legislative Review

A legislative review of the options developed from the work of the SEAG was also undertaken of the legislation which outlines the statutory duties and powers in relation to public health functions:

- Local authority legislation
- NHS legislation
- UK Level legislations

Within this context, each of the options were reviewed to analyse the legislative implications and staff transfer arrangements which would be required to implement each. In conclusion Option 3 represented the simplest option to implement from a legislative perspective.

Each of the other options would result in level of disruption, potential legislative changes required and potential staff transfer arrangements to be implemented.

A full detailed Legislative Overview response can be found in [Appendix D](#).

3.6 Stakeholder Engagement feedback

Once engagement responses around the Options were received a further analysis of key themes and conclusions was completed by a Senior Improvement Officer, NHS Health Scotland.

From this high-level analysis it was clear that there is wide recognition of the need for change and there is support for that.

However, the findings suggest there are still many questions to be answered because there is a lack of detail within the proposed options, including associated costs for each. Staff need more information to understand what each model would look like and what it would cost, which would assist to make a more informed decision. Drawing on lessons learned, best practice would help with this.

There was some concern that proposed options may have been biased to some extent towards professional interests of those involved, hence the need for increased staff and staff side involvement to ensure their voices have been heard and listened to.

Clarity on the process, how decisions will be made, timescales and next steps are required by stakeholders so they can see how the options will be developed further.

The most popular options were 3 and 4 – and option 6, subject to more detail being provided. The least supported option was undoubtedly option 1, followed by options 2 and 5, which also had little support in comparison.

A full analysis of the engagement responses can be found in [Appendix B](#).

4. Discussion and Conclusions – Interim

This commission has attempted to be as transparent and inclusive as possible, working with the specialist public health workforce and those in the wider system who work with them in order to improve population health and address health inequalities. The Specialist Expert Advisory Group provided a breadth of knowledge and expertise that was considered alongside some of the evidence available to the commission. The introduction of a peer review process provided an additional layer of analysis and perspective for the core group to draw upon.

It is evident that changes in the role of the core and specialist public health workforce are required, and opportunities are apparent both in the willingness of the workforce to embrace change and the desire of Community Planning Partners to support a strengthened role of the core and specialist public health workforce across local partnerships to deliver better health and wellbeing outcomes for local populations.

While some structural solutions were more popular than others, underlying the vast majority of the feedback were factors which are not fundamentally about how we structure our core and specialist public health workforce, rather they reflected aspects of effectively working together, having commonly agreed goals and having governance and accountability which supports effective delivery.

Initial conclusions from the work are therefore that achieving significant change in these areas should be the focus for taking the work forward, rather than pursuing structural changes, and ways to achieve this should be explored, agreed and progressed.

The Core group for the commission has identified possible actions and timescales for taking these forward which will be shared with the Public Health Reform Oversight Board in April. Following that meeting the discussion and conclusions section of this report will be refined.

Appendix A: Workshop Outputs

Workshop 1: 10 & 11th December 2018 (Residential workshop)
Doubletree by Hilton, Queensferry Crossing, Edinburgh

[SPHWA December Residential Workshop – Record of Discussion](#)

[SPHWA December Residential Workshop – Development of Options](#)

[SPHWA December Residential Workshop – Stakeholder Briefing](#)

Workshop 2: 7th February 2019
Quaker Meeting House, 7 Victoria Terrace, Edinburgh

[SPHWA February Workshop – Record of Discussions](#)

[SPHWA February Workshop – Options Appraisal Summary](#)

[SPHWA December Residential Workshop – Stakeholder Briefing](#)

[SPHWA Q and A – February 2019](#)

Appendix B: Options Engagement, Responses and Analysis

Following the completion of the SEAG workshops, a standard engagement pack was developed in order to allow members to engage with their constituent groups and staff for further feedback on the options and process used to develop them. Once engagement responses were received a further analysis of key themes and conclusions was completed by Lisa Young, Senior Improvement Officer, NHS Health Scotland.

Engagement Pack:



Presentation Slides
for Engagement Mast

Options Engagement Responses:



SPHWA Options
Engagement Responses

Options Engagement Responses Analysis:



Analysis of the
Options Engagement.

Appendix C: Peer Review

SPHWA Peer Review Group Response:



SPHWA Peer Review
Group Response

Appendix D: Workforce Legislative Overview

SPHWA Options – Legislative Overview:



PHR Specialist
Workforce Legal Impl

Appendix E: Detailed Options

- **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

Option 1 - Move staff in public health departments to local authorities

Volunteers	Drew Hall, Audrey Sutton, Liz Manson and Eibhlin McHugh
What will the specialist workforce do?	<ul style="list-style-type: none"> • Provide leadership and give direction to local PH activity, with a focus on asset-based and early intervention and preventative approaches, particularly in relation to communities, early years, physical and mental wellbeing, preventative approaches to addictions and equalities and economic activity. • Develop and grow a culture of ownership of PH, its determinants and its impacts across the wider public, community and private sectors. • Support the socio-economic duty to tackle inequalities through the Local Outcomes Improvement Plans (LOIPs), Equality Outcomes and particularly around minority Protected Characteristics and people experiencing poverty. • Develop and support a PH culture and approach across Community Planning Partnerships (CPP) (including with the statutory and Guidance organisations of Councils, NHS, Police Scotland, Scottish Enterprise, Scottish Fire and Rescue Service and Third Sector Interfaces) through the co-ordination role of the local authorities. • Support the role of Locality Partnerships and communities in improving the understanding and importance of PH at all levels, including participation in health improvement, health protection and screening activity. • Develop and support a culture where the PH contribution of a wide range of related Council services, including environmental health, housing, planning, leisure & sport, education, licensing, community learning & development, community resilience & safety and health and social care is understood and recognised, through the development and embedding of generic and specialist skills and knowledge. • Influence the local focus and drive innovation through the use of PH data intelligence. • Provide advocacy for improving health wellbeing. • Encourage engagement, collaboration and innovation

	<p>across services, partners and with communities.</p> <ul style="list-style-type: none"> • Provide clarity, advice and direction for democratically Elected Members and with CPP Boards (Appointed/Non-Exec and Board members) through the co-ordination role of the local authorities.
<p>Where will they be located? (organisationally)</p>	<p>The SPHW should be organised in a way that makes best use of the resources and expertise in the system.</p> <ul style="list-style-type: none"> • The SPHW should be embedded at as local a level as possible to be effective, according to the approaches of current community planning and health and social care partnerships (e.g. tailored to agreed 'locality' boundaries). • The organisational specifics should be determined by each local authority consistent with its unique organisational structure, taking into account the opportunities presented by co-location with the service groups highlighted above (e.g. environmental health, housing, planning, leisure & sport, education, licensing, community learning & development, community resilience & safety and health and social care). • Consideration should be given to the following organisational matters: <ul style="list-style-type: none"> - LA Schemes of Administration will require to include purpose, role and oversight of PH function in LA responsibilities. - The relationship of PH to HSCP and IJBs will require to be considered in each LA in relation to terms of reference of IJBs. - Council plans and LOIPs and Locality Plans should specifically reflect PH priorities and contributions. - Partnership agreements/SLAs may require to be developed between LAs and NHS Boards within the context of LOIPs and delivery plans, to continue a whole systems approach to and development of the PH function. - The role of environmental health services should be strengthened to increase its influence across all local government functions and enable it to take on a leadership role in relation to local government's contribution to health protection and the wider environment. This will require the current challenges around the resilience of the workforce to be addressed. - Guidance may be required to identify the role of PH in LAs to prevent too much assimilation into any specific service and that miss the opportunity to maximise the opportunity presented to ensure a whole systems approach. - Consideration will be required as to how national resources will complement local arrangements and this will feed into the proposed design of services at LA and regional level.

<p>Who will join them and who will they work with?</p>	<p>Who will join them:</p> <ul style="list-style-type: none"> - PH intelligence staff <p>Who will they work with:</p> <p>Local authority services</p> <p>CE(S)A 2015 CP Statutory and Guidance partners</p> <ul style="list-style-type: none"> • NHS Services • Police Scotland • Scottish Fire and Rescue Service • Scottish Enterprise • Third Sector Interfaces <p>CE(S)A 2015 ‘Schedule 1’ CP partners including</p> <ul style="list-style-type: none"> • Health and Social Care Partnerships • SEPA • SportScotland • Colleges • <i>Public Health Scotland</i> <ul style="list-style-type: none"> • Locality Planning Partnerships • Primary care • IJBs/HSCPs • Care providers <ul style="list-style-type: none"> • COSLA • Community Planning Network • Communities of geography and interest, within Locality Planning Partnerships and HSCP Fora • Community councils <ul style="list-style-type: none"> • Community organisations in addition to those within the formal local governance arrangements described above, to maximise asset-based understanding and approaches to early intervention and prevention and to maximise the value of social capital and community empowerment within the new model.
<p>How do we ensure specialist skills are retained and developed?</p>	<ul style="list-style-type: none"> • We are ambitious to create a new context and culture for PH, developing a shared understanding of how a variety of partners can contribute to improvement and innovation. Generic and specialist skills and knowledge will be developed across partnerships, with the development of relationships and trust being key. • Continued development of leadership, at all levels, including collaborative leadership opportunities. • Registration & accreditation • Annual appraisals; and ongoing support and supervision sessions • CPD • A national lead role should be established for environmental health officers similar to Chief Social Work Advisor role. This post based in PHS would maintain an overview of EH statutory responsibilities, the support requirements of the profession and address the current resilience and

	<p>sustainability workforce challenges in partnership with local government and PHS.</p> <ul style="list-style-type: none"> • More specifically for environmental health services the following actions are required: A national trainee scheme that would support all EH graduates into employment. A review current qualification pathway to develop a post graduate course for EH in Scotland. • Support from PHS in its role in providing Leadership for the Public Health workforce
<p>What's in the model?</p> <ul style="list-style-type: none"> - Health protection - Screening - Health Care PH - PH Intelligence - Health Improvement 	<ul style="list-style-type: none"> • The golden thread of responsibility and activity with the new national PHS organisation will be crucial in refining any new model. Currently, the following is proposed: <ul style="list-style-type: none"> - Public Health Intelligence - Health Improvement - Environmental Health - Health Care Public Health - Health Protection: some aspects including work with partners and communities to create relationship contexts and awareness of opportunities for better understanding and uptake and support for the delivery of localised approaches to health protection, immunisation/vaccination, dental services and screening etc. - Staff based in this model could continue to provide direct support to resilience of health protection functions.
<p>If not in the model, where would PH functions sit?</p> <ul style="list-style-type: none"> - Local - Regional - National - Other/Hybrid? 	<ul style="list-style-type: none"> - As above, the development of this theme would need to be informed by the agreement in relation to the role of PHS. For the purposes of developing the current model. The following is proposed: - Health Protection: A resilient model requires to be developed at regional level (with NHS Regional Boards), This model would provide opportunities for robust local partnerships to provide local support for promotion and delivery of health protection services. - For environmental health a national leadership role should be established within PHS that will provide a national overview of the profession and its statutory functions ensure close collaboration across health protection at a local and national level and in collaboration address the current workforce resilience challenges. - National (with PHS) - Screening
<p>Where does this model deliver the greatest impact on population health?</p>	<p>The new local arrangements will enable a decisive shift in how PH is regarded and delivered, embracing asset-based approaches in a strategic manner, and focusing on population health with rather than for communities and partners.</p> <p>Greater co-location with partners will foster and embed a whole system approach to public health in a way that creates a context for more ambitious and effective collaboration and innovation.</p> <p>The model will enhance the impact of public health</p>

	<p>interventions to tackle the socio-economic and environmental determinants of health and make best use of the resources, skills and expertise available across the whole system.</p> <p>It will enable greater local co-ordination of related services and access to communities and individuals.</p> <p>A wider group of decision-makers will understand, promote and share responsibility for PH approaches.</p> <p>There will be better access to and use of evidence and data intelligence across partners to create capacity for innovative approaches to tackling complex problems.</p> <p>By creating a strong public sector partnership locally this model will maximise the reach and capacity of Public Health Scotland to support local delivery and realise its ambitions as a national body. It will also provide PHS with real time intelligence on local challenges and opportunities to increase its effectiveness as a national leadership body.</p>
<p>Strengths?</p>	<p>Ability to deliver decisive change: as above</p> <p>Profile and influence of PH approach:</p> <ul style="list-style-type: none"> • Power and influence at right levels • Greater emphasis on prevention • Visible local Public Health leadership in local authorities and CPPs • Separation of PH from Health (NHS) clinical care to provide an opportunity to rebalance to stronger focus on health improvement in Primary Health Care through closer and more localised work with IJBs and local communities. • Environmental health will increase its influence across local government and the national leadership role will strengthen connections and influence between the national and local functions level as well as supporting the resolution of workforce resilience challenges. • Closer involvement with national groupings - COSLA and CP Network - and a wider range of professional associations to drive improvement and impact. <p>Closeness to communities (geographic and interest)</p> <ul style="list-style-type: none"> • Visible and democratic local accountability • Access to local intelligence with direct links to communities • Empowerment of communities and recognition of the value of social capital and capacity building • Links to Community Councils, community organisations, customer groups and Third Sector organisations • Direct links to CP thematic forums e.g. business and the economy, equality and diversity, tackling poverty, CLD and the CLD Strategic Plans • Direct links to CP Locality Planning Partnerships and Locality Forums. <p>Best use of scarce resources:</p> <ul style="list-style-type: none"> • Resources for PH Intelligence and Health Improvement

	<p>aligned and collocated with other related services and partners</p> <ul style="list-style-type: none"> • Greater collaboration across related services and partners • Additional resource and capacity to focus on social determinants <p>Consistency with the PH Priorities and ‘whole system’ approach:</p> <ul style="list-style-type: none"> • Co-location with related professionals (including e.g. social workers, environmental health officers, planners, CLD officers, teachers) • The model will inspire, influence and mobilise greater range of services around tackling inequalities increasing capacity to understand complexity of challenges and opportunities to develop innovative approaches embedded in a culture of learning. • Direct involvement in the development and implementation of the LOIPs. <p>Practicalities</p> <ul style="list-style-type: none"> • A wide range of existing relationships • Local authorities have a range of accommodation available • Experience of health and social care integration will inform local transfer arrangements.
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Weaknesses?	<table border="1"> <thead> <tr> <th>Risks</th> <th>Support and management</th> </tr> </thead> <tbody> <tr> <td> <ul style="list-style-type: none"> - PH funding will be vulnerable - Loss of specialist functions </td> <td> <p>New shared governance arrangements should be explored for shared resources that ensure commitment to protection of resources.</p> </td> </tr> <tr> <td> <ul style="list-style-type: none"> - Weakened P.H. leadership and visibility - Co-ordination of PH activity - Resilience if functions are split - Loss of alignment of related professions (acute health, Dentistry, professionally aligned to health) - Loss of critical mass - Loss of independent voice </td> <td> <p>Robust leadership will be required – Chief Officer for PH identified at LA level to coordinate activity with regional and national work; safeguard professional independence and provide advocacy and support for PH workforce.</p> </td> </tr> <tr> <td> <ul style="list-style-type: none"> - Potential dilution of Public Health profession/direction </td> <td> <p>New arrangements will require a deliberative process across stakeholders to develop a shared understanding of how and where specialist public health skills are best deployed across partnership to achieve greatest impact. This process</p> </td> </tr> </tbody> </table>		Risks	Support and management	<ul style="list-style-type: none"> - PH funding will be vulnerable - Loss of specialist functions 	<p>New shared governance arrangements should be explored for shared resources that ensure commitment to protection of resources.</p>	<ul style="list-style-type: none"> - Weakened P.H. leadership and visibility - Co-ordination of PH activity - Resilience if functions are split - Loss of alignment of related professions (acute health, Dentistry, professionally aligned to health) - Loss of critical mass - Loss of independent voice 	<p>Robust leadership will be required – Chief Officer for PH identified at LA level to coordinate activity with regional and national work; safeguard professional independence and provide advocacy and support for PH workforce.</p>	<ul style="list-style-type: none"> - Potential dilution of Public Health profession/direction 	<p>New arrangements will require a deliberative process across stakeholders to develop a shared understanding of how and where specialist public health skills are best deployed across partnership to achieve greatest impact. This process</p>
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		<p>will affirm and strengthen the professional contribution of the specialist public health workforce.</p> <p>Role of PHS, allied with LA Chief Officer and Regional PH leads, would be to ensure professional integrity and excellence.</p>
	<ul style="list-style-type: none"> - Links to real-time clinical NHS data may be lost - 	Assessment of data sharing protocols and systems
	<ul style="list-style-type: none"> - Timeous decisions and challenge within a democratic process 	Local authority scheme of administration will take into account the matters which are urgent and time-critical and which may be delegated to officers.
	<ul style="list-style-type: none"> - Distance from patient groups: NHS may lose interest 	Organisational arrangements will require to address partnership working; and the added value of building knowledge and capacity in communities in a preventative setting will increase aspiration and reduce the need for “treatment” based approaches.
	<ul style="list-style-type: none"> - Staff transfer - 14 PH depts. into 32 LA - Not attractive for some of the health professionals - Some negative previous experiences of working with LA’s in the past that would need to be overcome 	<p>The opportunity to develop and embrace new ways of working, in a whole systems approach, is at the heart of PH transformation.</p> <p>Practical arrangements would be designed to maximise impact on our communities and this in turn will motivate and inspire professions to work together and grow mutual respect and complementary skills.</p> <p>Leadership, of the CPP and beyond, is critical to success and new ways of working will be developed.</p> <p>A CPP approach which enables a range of professionals and communities to align behind a common theme is recommended e.g. the North Ayrshire Active Communities</p>

		Strategic Partnership, which enables themes where PH is a key partner to be explored, developed and acted upon out with traditional service areas. D&G has a similar approach.
Assumptions?	<ol style="list-style-type: none"> 1. The success of this model will require a shared understanding of the contribution of the specialist public health workforce and the conditions required to enable collaboration and partnership working to flourish across the public sector at a local level. All partners will need to commit to their contribution to developing and maintaining these conditions. 2. Local Governance Reform will provide a new context to strengthen this model through shared local governance arrangements. This opportunity should be explored further. 3. A PH function and team will be based in each LA (not regional teams) 4. Relevant staff will be based in LA. 5. Staff could be employed by LAs or alternative governance arrangements for workforce and related resources could be developed. . 6. Services not suitable for LA management will need to be managed by regionally or nationally as appropriate (screening, immunisation etc) – we need to more clearly identify what these services are. 7. Statutory PH Chief Officer posts will be identified in each LA. 8. PH Chief Officers will have key locus in CPP SMTs and Boards. 9. LA Schemes of Administration will require to include purpose, role and oversight of PH function in LA responsibilities, and areas of delegation to officers. 10. Governance relationships with HSCP and IJBs will require to be stated in each LA in Terms of Reference of IJBs. 11. Council plans and LOIPs and Locality Plans should specifically reflect PH priorities and contributions. 12. There will be sufficient funding to allow capacity for PH services to be split between LAs and regional Health Boards. 13. Governance and line management arrangements will require to be created for those services identified as being best delivered within NHS Boards. 14. Partnership agreements/SLAs will require to be developed between LAs and NHS Boards within the context of LOIPs and delivery plans, to continue a whole systems development of the PH function. 15. Funding for PH function in LAs should be considered for ring fencing to afford protection for desired outcomes. 16. Consideration of how national resources will complement local arrangements will feed into the proposed design of services at LA and regional level. 	

Initial analysis of Option 1 against assessment criteria:

Efficient – best use of resource	<ul style="list-style-type: none"> • 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
Effective – Maximum impact on population health	<ul style="list-style-type: none"> • 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 – presence across the public and third sector to mobilise and deliver	<ul style="list-style-type: none"> • 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 – capacity to maintain delivery	<ul style="list-style-type: none"> • 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 model?	<ul style="list-style-type: none"> • 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)

Volunteers	Ella Simpson, Patricia Cassidy, Christina Naismith, Hazel Young (Eibhlin McHugh)
What will the specialist workforce do?	<ul style="list-style-type: none"> • Provide a population health perspective to support the strategic needs assessment and strategic plan for health and care services. • Provide a population health perspective to support health and care services commissioning and service redesign. • Strengthen Primary Care Services' contribution to improving health and prevention. • Support the H&SC Partnership to develop and implement its work to address health inequalities. • Work with Council and Community Planning Partnership and other local partnerships to strengthen their approach to collaboration and tackling inequalities • Build on the work that List are doing to extend capacity to provide support to wider Council and Community Planning partnerships. • Identify areas of challenge and “wicked issues” and create space for innovative thinking and collaboration to identify options/solutions • Support activities to strengthen community participation in decision making. • Work with partners to strengthen capacity to work collaboratively and develop a whole system approach to implementing the public health priorities • Work with Council officers and individual community planning partners to adopt health and wellbeing in all policies. • Work with partners to identify areas for research/evaluation to ensure that research is grounded in local challenges and support the transfer of learning into practice. • Bring challenge to local systems, be un-popular, but necessary • PHP close to local agenda and be influenced by it • Strong governance arrangements • The role of environmental health services needs to be strengthened to increase its influence across all local government functions and enable it to take on a leadership role in relation to local government's contribution to health protection and the wider environment. This will require the current challenges around the resilience of the workforce to be addressed.
Where will they be located? (organisationally)	<ul style="list-style-type: none"> • Within Health and Social Care Partnership
Who will join them and who will they work with?	<ul style="list-style-type: none"> • Will co-locate within the H&SC Partnership • Identify and establish working relationships with a range of partners to establish virtual teams to support delivery of public health priorities. • IJB Board • Elected members • Strategic commissioning & Planning team • A range of professional groups Social workers, GPs, Nurses,

	<p>community, BLP (allied with practitioners), 3rd Sector</p> <ul style="list-style-type: none"> • Environmental health, • Local businesses/employers. • Work with CPP partners– Fire, police etc • Community Justice partners and other local partnerships. • Data analysis/analysts – access by other groups who don't currently see/work with them • Council officers across a range of services • Voluntary sector • Community groups
How do we ensure specialist skills are retained and developed?	<ul style="list-style-type: none"> • PH career framework • Professional leadership and clinical governance arrangements for NHS employees in place • New context within which impact of public health professional practice can be strengthened. • Lines of accountability within H&SC Partnership • PH Registration • Matrix management • Shared CPD to strengthen the role of the wider workforce in public health
What's in the model? - Health protection - Screening - Health Care PH - PH Intelligence - Health Improvement	<ul style="list-style-type: none"> • Health promotion/improvement • Health Care/Public Health • Environmental Health • Support to ensure reach/impact of screening across local population • Practitioners provide direct support to delivery of health protection • Support to strengthen partners contribution to health protection
If not in the model, where would PH functions sit? - Local - Regional - National - Other/Hybrid?	<ul style="list-style-type: none"> • Health Protection out but still need collaboration • Variance/complexity means no single option would capture all – we need to consider elements of each. • For environmental health a national leadership role should be established within PHS that will provide a national overview of the profession and its statutory functions ensure close collaboration across health protection at a local and national level and in collaboration address the current workforce resilience challenges. • Screening regional or national with local support for implementation maintaining a whole population focus.
Where does this model deliver the greatest impact on population health?	<ul style="list-style-type: none"> • Health Improvement..... a strong collaborative approach across local community planning systems to deliver the public health priorities and shift to a preventative approach. • Health care public health....develop practice in population needs assessment and strategic planning to ensure health and care services including acute services are responsive to local population needs.
Strengths?	<ul style="list-style-type: none"> • Minimises disruption for staff. Many health promotion staff have already made this transition and are located and managed within health and social care partnerships. • Provides NHS employees with assurance of continuing employment within NHS environment including staff governance standards and also provides new opportunities to work in closer with local stakeholders and communities. Extends their influence across a range of decision making

	<p>forums</p> <ul style="list-style-type: none"> • Opens PH to a new range of stakeholders • NHS & LG ownership • Strong partnership already established with third sector and local community networks. • Many health and social care partnerships have taken on an active leadership role in community planning and are using their whole population focus to make an important contribution to community planning partners contribution to health inequalities, the development of local and more collaborative ways of working. • Locality Planning is already well established • Potential opportunity to enable shared budgeting arrangements. • IJB can provide governance, democratic accountability and leadership arrangements as well as support integration of Specialist Public Health workforce with wider public health • Provides a space for Public Health professionals with separate governance arrangements that will enable them to challenge local systems. • Pre-existing arrangements to align employees employed by LA and NHS within services. • Professional leadership arrangements already in place. • Build on good practice in engaging with communities and co-producing local solutions • Access to NHS and Council data systems. • Build on work of LIST teams to extend the approach to data and intelligence to drive innovation across other partners. • Experience in driving Integration within and across sectors and developing culture to support new ways of working. • Proximity to key decision makers and forums with local government. • Strength is connectivity to local communities and local decision making forums. • Potential to develop a stronger role for HPS & Health Care Public Health within local partnerships • More influence design & delivery HCP • Environmental health will increase its influence across local government and the national leadership role will strengthen connections and influence between the national and local functions level as well as supporting the resolution of workforce resilience challenges. • Locally led ability to tailor solutions to local needs. • Possible to draw down national resource • Community empowerment is already part of their agenda
<p>Weaknesses?</p>	<ul style="list-style-type: none"> • Could you be un-popular/challenge if you are core to the team? • Duplication (e.g. Screening) • Need to ensure all H&SC Partnerships have a strong focus on inequalities & HiAP • Risk that public health's is seen as a health service and its contribution to other services that impact on the economic determinants of health e.g. economic planning and spatial planning are not recognised. • Difficult to maintain a whole population focus because of IJBs

	<p>preoccupation with clinical care although evidence that many IJBs have developed strong focus on whole population needs. (Patients rather than the whole population – adult focused)</p> <ul style="list-style-type: none"> • Some H&SC Partnerships don't have as high a status in community planning/whole system as NHS or local authority. • Risk of fragmentation of public health. • Different models in different areas currently (i.e. Highland) • More resources required to address wider PH issues?
Assumptions?	<ul style="list-style-type: none"> • Where there are current difficulties in partnership arrangements these difficulties and their underlying causes are addressed as a priority before this model is adopted. • Consideration is given to changes that are required to scheme of delegation for IJBs to review both NHS and council services/resources e.g. homelessness, children's services that should be delegated to IJBs to ensure the success of this integration. • Consideration is given to reviewing the Council's Scheme of Delegation to provide a clearly defined role for public health professional advice in key decision forums. • All staff retain existing T&Cs and consideration can be given to employment by NHS Boards or PHS.

Initial analysis of Option 2 against assessment criteria:

Efficient – best use of resource	<ul style="list-style-type: none"> • 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
Effective – Maximum impact on population health	<ul style="list-style-type: none"> • 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 – presence across the public and third sector to mobilise and deliver	<ul style="list-style-type: none"> • 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 – capacity to maintain delivery	<ul style="list-style-type: none"> • 3rd sector relates to LA – vast majority of 3rd sector relate to LA as they are all community based
Ease of establishing model?	<ul style="list-style-type: none"> • 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)

Note from volunteers:

Although this option has been described as the status quo, we feel that the option described below is materially different whilst retaining many of the existing key strengths and adding value through greater collaboration across networks and with Public Health Scotland. This option illustrates how the 'NHS and obligate network' will contribute to some of the recommendations of Scotland's public health review. It is acknowledged that the public health reform is not about any one organisation and the benefits will be achieved through greater collaboration and working more effectively together. A number of examples of good practice are provided to demonstrate how obligate networks might work such as the Scottish Health Protection Network (SHPN).

Volunteers	Jennifer Darnborough, Martin Higgins, Elisabeth Smart and Jenny Wares
What will the specialist workforce do?	<p>NHS Boards have responsibility for protecting and improving the health of their populations and work in partnership with colleagues within the wider public sector to support population health.</p> <p>Within NHS Boards, each Public Health Department (PHD) will have a clear business plan. This will reflect the national public health priorities for each area and the way in which local public health teams will work with key stakeholders such as hospital healthcare providers, Community Planning Partnerships (CPPs), voluntary and community organisations and Integrated Joint Boards (IJBs) and Health and Social Care Partnerships (H&SCPS) to improve and protect population health. There will be an obligation for the workforce to support the networks and these will require further work to ascertain the need, adequate governance and resourcing.</p> <p>There will be key principles informing the work of each public health team. PHDs will:</p> <ul style="list-style-type: none"> • work across all domains of public health: health care public health and screening, health protection, health improvement and supported through health intelligence • will address population based health need and address inequalities by developing and influencing policy in partnership with others • provide strong leadership for population based health • strengthen and influence strategic direction nationally with a focus on local influence and delivery by individuals based in NHS Boards in conjunction with partners • work effectively across NHS Boards to improve resilience and reduce duplication e.g. On-call rotas, sharing workloads that are best done once across Boards. <p>Furthermore, the creation of Public Health Scotland (PHS) in addition to the development of obligate networks will enable the achievement of a coherent national approach with aligned local approaches. It will also provide a clear identity and direction of</p>

	<p>travel for others/partners to understand.</p> <p>Workforce standards have been set for the workforce as defined in the FPH's Workforce Strategy and Standards Document 2018-2021.</p>
<p>Where will they be located? (organisationally)</p>	<ul style="list-style-type: none"> • At a local level, the public health specialist workforce will be predominantly located within NHS Boards but with remits across a number of areas such as Community Planning Partnerships, and Health and Social Care Partnerships. • The public health specialist workforce with a national remit will be based within Public Health Scotland.
<p>Who will join them and who will they work with?</p>	<p><u>Who will join them?</u></p> <ul style="list-style-type: none"> • This model aims to address how we can work better together and does not seek significant structural change to achieve this. As such, it would not be proposed that there would be significant staff movements. Input to the networks would be required from a range of partners and would be far wider than the specialist workforce. They would be multi-disciplinary networks representing many agencies and partnerships. • Although structural change is not proposed, this model seeks to achieve greater coordination, reduced duplication and thus make the most effective use of a limited resource through the use of networks. • Implementation of this approach would be through the use of an obligate network or more formally through, for example, the use of honorary contracts with Public Health Scotland (with local NHS Board contracts as the primary employer). • Honorary contracts are already extensively used and many of the existing SPHW already hold honorary contracts for the delivery of academic commitments. Similarly, the obligate approach has already demonstrated its effectiveness, for example, across the North of Scotland through the development of the North of Scotland Public Health Network (NoSPHN) and through the development of the Scottish Health Protection Network (SHPN). For illustrative purposes, the definition of the SHPN is detailed below: <p>“The SHPN has a structure, governance and operational management arrangements designed to enable national and local health protection organisations, across sectors and disciplines, to work together cooperatively to promote and support a cohesive ‘health protection service for Scotland’. As an obligate network, the SHPN is based on key principles of joint ownership, comprehensive engagement, consensus decision making and pragmatism. Decisions once made through member consensus are then implemented across Scotland allowing for pragmatic adaptation, clinical judgement and acknowledgement of the local and national context. The network thereby promotes a shared model of collective leadership for the health protection function, balancing local</p>

	<p>and national service needs and priorities.”</p> <p><u>Who will they work with?</u></p> <ul style="list-style-type: none"> • Networks, whether obligate or formal, bring skills, knowledge and leadership from local and national organisations together to work collaboratively towards shared priorities, for example, Community Planning Partners, Integrated Joint Boards, community councils, the third sector, Public Health Scotland, Food Standards Scotland, Scottish Water, Scottish Environment Protection Agency and academics. This will enable building on local community expertise and assets. • Any decision regarding who will join them and who they will work with has to reflect the area of public health practice in question and as such the wide range of potential partners has not been detailed here. • Increased NHS cross border working to meet need. • Closer working with IJBs and H&SCPs – maximise efforts of the current teams and build on local community expertise and local assets. • Environmental Health (EH): collaborative working is essential for this model but where EH will be located requires further consultation with this professional group.
<p>How do we ensure specialist skills are retained and developed?</p>	<ul style="list-style-type: none"> • National training and career paths should be available and attractive for all. This should include those from the specialist public health workforce and those with a public health remit reflecting the multi-disciplinary workforce and should build on existing work undertaken by the UK Public Health Register (UKPHR) and the Faculty of Public Health (FPH). • National leadership to support the development of the public health workforce. • Up skill current workforce e.g. clearer pathways for all the workforce. • Support for staff to obtain professional registrations. This provides public assurance and helps maintain standards. • Job descriptions should specify working towards or on a specialist register. • This approach does not fragment departments which in turn promotes the retention of specialist skills and supports effective practice (plus training) across the breadth of public health practice at a local and national level, There is value in maintaining a critical mass at local/Health Board level which can then be deployed more locally as required e.g. to localities to support community development work. • The use of this approach will provide further opportunity to work at national level and develop skills. • Partnerships with academic institutions to ensure courses/curricula reflect future public health priorities.
<p>What’s in the model? - Health protection</p>	<ul style="list-style-type: none"> • At a local level, all of the specialist public health workforce

<ul style="list-style-type: none"> - Screening - Health Care PH - PH Intelligence - Health Improvement 	<p>across the domains of public health practice would be within this model and sit within NHS Boards but would be working at different levels according to the needs of the specific network.</p> <ul style="list-style-type: none"> • Arrangements for being contracted into PHS (for example for an agreed number of sessions each week or on a short term basis according to need) will need to be incorporated within the job planning process and will provide opportunities to deliver national work. Depending upon the detail of contractual arrangements, this may require an additional resource or need to be pooled from existing budgets nationally. • Health Protection – this function is already working within an obligate network and is largely working well. • Screening - this function is currently under review but it is expected that the majority of specialists will remain in NHS Boards with a strengthened national co-ordination function. • Health Improvement – kept as a critical mass to avoid fragmentation and the inevitable duplication. • Health Care Public Health – there is an opportunity to extend public health support and influence for colleagues in particular in health and social care. • Public Health Intelligence – essential to support all domains of public health. • Alcohol and Drug Partnerships (if currently hosted by Boards). <p>Given not all of the specialist workforce are currently based within a territorial board, the public health workforce will also continue to sit at a national level within Public Health Scotland where remits are exclusively national.</p> <p>Unresolved</p> <ul style="list-style-type: none"> • Environmental Health – this requires stakeholder consultation in order to incorporate the input and expertise of the professionals involved. • Academic Public Health. • Public Health Practitioners based in Local Authorities. • Alcohol and Drug Partnerships (currently hosted by statutory sector but no one preferred model)
<p>If not in the model, where would PH functions sit?</p> <ul style="list-style-type: none"> - Local - Regional - National - Other/Hybrid? 	<ul style="list-style-type: none"> - The use of a network approach enables staff to work at different levels according to need. Employment with local NHS Boards, and supplemented by some contracts with Public Health Scotland, enables local accountability whilst also achieving the benefits of improved deployment against shared priorities through national coordination. - Nationally contracted sessions will be agile (supported by IT) where needed. • Currently there are legislative barriers to bringing in EH to work in NHS Boards. Further consultation with environmental health professionals is required to determine where best they feel that this function should sit in order to achieve optimal

	functioning.
<p>Where does this model deliver the greatest impact on population health?</p>	<ul style="list-style-type: none"> • It is acknowledged that public health reform is not about any one organisation and the benefits will be achieved through greater collaboration and partnership working. Therefore, one of the key issues to address is how to work more effectively together in order to achieve population health gain and reduce health inequalities. In light of how the obligate network approach is currently working well in some areas, consideration should be given to learning from such models and replicating across other areas. The strengths of this approach are that the benefits of a network would be achieved without the significant risks of destabilising the current system that could arise from structural change. • This model would promote a cohesive approach to prevention that values the input of all organisations. Removing the specialist public health workforce from NHS Boards could risk the NHS being distanced from the preventative agenda and could create a more divisive system with prevention only being viewed as the role of Public Health Scotland for example. • Obligate networks could be used to deliver local, regional and national work and appropriate for all domains of public health, and implementing new ways of working. This model will make best use of the skills and expertise of the specialist workforce. • There are already effective relationships and partnerships in place which could be built on which would allow more rapid progress on the issues at hand. • Supporting obligate networks should be formalised in job descriptions. • This approach would strengthen national focus and influence as well as local delivery and collaboration with staff holding national contracts also continuing to hold local contracts. • The NHS Boards have responsibility for the health and public health of their populations and can provide evidence-based independent health advice for their populations. Continue to build on strong relationships. • No fragmentation; avoids duplication. • Continuous engagement with non-specialist workforce who might have limited contact and professional support from public health. • Learn from good practice, for example the North of Scotland Public Health Network, SHPN and the HCPH network (underpinned by the assumption that all strive for continuous improvement). • Reprioritising of resource for health improvement/preventative spend.
<p>Strengths?</p>	<p>Whole system approach</p> <ul style="list-style-type: none"> • There is already a wealth of experience, knowledge and

trusted partnerships in place which can be continuously developed.

- Enables work across all of the domains of public health and prevents fragmentation of the specialist workforce.
- Enables the delivery of local services and programmes where they are needed most – most likely to tackle health inequalities.
- Connections with NHS influencers and decision makers.
- One of the main partners in each of the 32 CPPs and thus able to work in partnership to improve population health and reduce inequalities through collectively addressing the wider determinants of health.
- Ease of clinical data flows. Less disruption & easier to maintain access to key NHS services.
- Existing NHS workforce has a good understanding of systems and processes which could be built upon.
- Able to align and/or integrate nationally, regionally and locally where required to meet need.
- Potential to build local capacity/budget to deliver on national objectives (resource could be funded centrally or top sliced from PH budgets).
- Enables the maintenance of public health standards and supports public health training.
- Makes best use the existing flexible workforce with generalist skills supported by agile working
- Although variation is recognized, there is already excellent partnership working at local and national levels, for example, Blood-Borne Virus Managed Clinical Networks and Environmental Health Liaison Groups. The members of these groups work in partnership to address common goals and have input from a range of partners from within and out with the NHS.
- Action on health care services and joint services enable people to maintain quality of life, wellbeing and independence in addition to enabling a longer term and preventative perspective through planning with other partners.

Specific domain issues

- Can be overlooked: Health improvement delivers clinical services or programmes.
- Although there is no one perfect model for the totality of the public health function, this model provides the best fit for Health Care Public Health, Screening and Health Protection because of the more clinically focused nature of the work of these domains, the NHS governance arrangements and the established trusted relationships.
- This model promotes working within and across the public health domains which other models do not.

Perceptions/Marketing

	<ul style="list-style-type: none"> • Value of working within the NHS system particularly with acute/primary care and seen as trusted partner. • From a public perspective, the NHS has a strong brand and is largely highly valued and trusted by local populations. • The creation of a national body through Public Health Scotland will provide a strong national voice and create a single national brand/identity. <p>Sustainability</p> <ul style="list-style-type: none"> • Supportive structure to develop the next generations of Public Health Registrars/students/learners. • Provide local workforce with capacity/budget to be involved in national work. • Enables flex for surge capacity. • Supports a 'once' for Scotland approach whilst also retaining local accountability. • When compared to a central model, this approach is likely to be best able to support and address the needs of remote and rural populations. • NHS budgets are huge and public health has a better opportunity for influencing NHS spends and priorities working from within the system. • The workforce is in a position to bring about long term changes on account of understanding and influencing service infrastructures. • Supported by an already skilled specialist and generalist workforce. • The model already enables partnerships with local CPPs and H&SCPs. <p>Public involvement/ownership</p> <ul style="list-style-type: none"> • Every contact with a patient/client has the potential for being a public health intervention. Reach could be in the millions each year and also engage with those most in need. • The public highly value the NHS and there are already good examples of working in partnership with communities. • Local accountability because of public appointments. <p>Other</p> <ul style="list-style-type: none"> • Provide a system for evolution and not revolution and arguably easier to manage. Reform doesn't necessarily require wholesale change, rather it should build on the strengths of existing systems. • Less disruptive to staff and therefore less likely to impact on services particularly where there is patient/public interface such as health protection.
Weaknesses?	<p>Whole system approach</p> <ul style="list-style-type: none"> • Directors of Public Health might have less influence if not based within a national model but can be mitigated through

local governance arrangements.

- There is currently variation across Boards, some of which will be necessary but some unwarranted. There is already work underway to look at unnecessary variation but additional work is required. Much of the unwarranted variation could be addressed through the aforementioned approaches to collaborative working, clear shared priorities and effective leadership.
- One of the weaknesses aimed at this model is that it is compromised or dominated by the demands of the acute health system resulting in less focus on preventative public health. Whilst the tension is acknowledged, the challenges of focusing on prevention is a shared issue affecting the public sector as a whole rather than just the NHS.
- It has been reflected that there is not enough focus on the social determinants of health. The NHS model is not solely responsible for this though and greater collaborative working across the whole system against national priorities in addition to greater advocacy work to achieve more upstream national policy could help to address this concern.
- Challenge to build the momentum for transformation within such a complex organisational structure. Similarly, this is perhaps not exclusively a concern of the NHS. The use of obligate networks has the potential to support transformational change and reform.
- Some Local Boards don't feel local because of multiple Local Authority / CPPs areas and IJBs/H&SCPs don't identify with regional NHS geographies.
- It is perceived that it can be a challenge to engage on national policy. However, the strong leadership and collaborative approaches towards shared agendas resulting in development of Local Outcome Improvement Plans will address this.

Perceptions/Marketing

- Barrier of NHS label; work of public health might be seen as health services and not population based.
- Across Scotland, Public Health leadership has been variable and in some areas reduced.
- Reduced Public Health visibility although this might change as a result of the collective ambitions of PH reform including that of PHS.
- It is felt that the current system is complex and poorly understood therefore making it difficult for partners to engage around priorities. However, the collective ambitions of PH reform including that of the development of PHS are likely to address this.
- Given the size and complexity can be slow to change, however, this can be addressed through performance

management.

Sustainability

- Considered by some to be fragile because of pressures on NHS services and demographic changes with not much potential for resilience although this is perhaps less of a specific NHS issue but more of a public sector issue.
- It is felt that public health is not given priority over financial choices against acute care although the challenge of investing in preventative spend is a wider challenge and not specific to the NHS alone. This can be addressed through financial planning and protected preventative spend.

Public involvement/ownership

- It is felt that there is poor community/public engagement in some areas. This is mitigated through ongoing partnership with local community planning.
- It is perceived across some areas to limit wider ownership of health across Public/Third sectors although conversely there are excellent examples of shared ownership and partnership working so this is therefore not a systemic issue.
- It is acknowledged that partnership working with CPPs /IJBs and H&SCPs is variable but this can be mitigated through agreed public health priorities and governance.

Specialist workforce

- It has been reported that environmental health is not linked as well as it could be with variation and fragmentation. However, given the effective partnerships in many areas this is perhaps a place specific issue not a systemic problem. Having said this, the environmental health workforce has faced significant reductions in recent years although this is less of a weakness of the NHS model.

Assumptions?

- This option is recognised as being materially different to the status quo because of the value gained in the approaches described.
- It is assumed that any new proposals for networks will draw on the experience of those that are working well and seek feedback.
- The feedback from each of the commissions will also be incorporated into the development of the final model.
- PHS will provide strong national leadership and will be supported by all organisations that will be working in partnership.
- Existing workforce often leads or contributes to a number of Public Health Priorities/domains within NHS Boards and leads/supports numerous networks.
- Contribution of the national workforce is clear for example Local Intelligence Support Team analysts, Information

	<p>Services division and Healthcare Improvement Scotland.</p> <ul style="list-style-type: none"> • Aware that all examples cited (such as the Health Protection obligate network and HCPH) can continuously improve. • IT solutions available to enable agile working. • Rural and remote impact assessment carried out at the developmental stage of the options and on the final option. • Other partners would join the obligate networks that have been proposed to enable the collaborative approach.
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Note about the Scottish Health Protection Network (SHPN)

The Scottish Health Protection Network (SHPN) is a highly regarded and jointly owned obligate network. This model could be replicated across other areas of public health practice in order to achieve the changes required to support greater partnership working and reduce duplication of effort. The SHPN has recently expanded the definition of SHPN as an entity and as an ‘obligate network’ as detailed below¹:

“The SHPN has a structure, governance and operational management arrangements designed to enable national and local health protection organisations, across sectors and disciplines, to work together cooperatively to promote and support a cohesive ‘health protection service for Scotland’. As an obligate network, the SHPN is based on key principles of joint ownership, comprehensive engagement, consensus decision making and pragmatism. Decisions once made through member consensus are then implemented across Scotland allowing for pragmatic adaptation, clinical judgement and acknowledgement of the local and national context. The network thereby promotes a shared model of collective leadership for the health protection function, balancing local and national service needs and priorities.”

Initial analysis of Option 3 against assessment criteria:

Efficient – best use of resource	<ul style="list-style-type: none"> • 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 – Maximum impact on population health	<ul style="list-style-type: none"> • 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 – presence across the public and third sector to mobilise and deliver	<ul style="list-style-type: none"> • Not transformational in presentation • Collaborative working/good buy in
Resilient – capacity to maintain delivery	<ul style="list-style-type: none"> • On call
Ease of establishing model?	<ul style="list-style-type: none"> • Health Protection is an afterthought in all other models apart from Option 3. • 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

Volunteers	Paul Dowie, Jenny Wares & Lorna Boyne
What will the specialist workforce do?	<ul style="list-style-type: none"> • They will contribute (expertise, evidence, experience) as part of the multidisciplinary approach to influencing national priorities and action. • They will support the shaping of support that will advance the implementation of national priorities through national, regional and local effort - achieving a coherent national approach and then local approaches that are coherent with national approach (whilst valuing asymmetry – one size doesn't fit all). • They will have a key role in understanding and responding to local needs and circumstances and be local advocates exerting local influence across CPP services • Map and support the alignment, prioritisation and deployment of the SPHW collective capacity against National & Local priorities • Use internal and external professional and wider network relationships to build a collective understanding of how specialist public health can support and benefit action on priorities • Provide clear direction that others can understand, maximising the collective 'power' of the identity and credibility of the PHS and its good relationships across the whole system. • Support effective communication of needs, what works etc up and down between National, Regional & Local internal and external and multi-disciplinary interactions. • Leveraging the benefits of working closely to identify what's missing currently by being together in one organisation. • Contribute to accelerating health improvement through a stronger governance & accountability framework that is better informed, focussed and less fragmented. The whole is more than the sum of the parts within SPHW individual professions and across the teams.
Where will they be located? (organisationally)	<p>The other options should provide some of the key points that indicate the range of location options and their strengths, weaknesses etc.</p> <ul style="list-style-type: none"> • Employed Nationally but with local accountability – local democratic accountability of PHS needs to be addressed as much as staff location and how this would interact with national SG/COSLA accountability. Need to be able to influence upwards. • Director of Public Health role is key – does this need be located in shared governance and accountability and therefore be a joint appointment (learning from IJB Chief Officer roles; Police Scotland local policing divisions) • Connectedness and relationships are key characteristics – especially into local systems and levers. • Subsidiarity – presumption to have local close working relationships especially with CPPs, LG Services, IJB's that have many of the levers for improving public health. The SPHW is already collocated at a local board level and in many areas works extremely well in partnership with partner agencies. Presumption that over time being in (32ish) local

	<p>collocated 'partnership teams' would be beneficial.</p> <ul style="list-style-type: none"> • Perception that there could be closer working of teams at a local, regional, national levels that can create a less fragmented workforce and for example combine resources & evidence. However, it is not clear within this model where the SPHW would be deployed and thus it cannot be assumed that there will be closer working through the implementation of this model. • Balance with risks of fragmenting limited specialist national/regional (14 NHS territorial boards, 3 NHS regions, City deal regions) resources. A key role of regional and national will be to have an enhanced flexibility, versatility and agility to work/redeploy across boundaries to respond to national incidents or respond to local pinch points. • Any local/regional/national deployment model must make use of the most effective leaders wherever they are and be able to use local levers to feed powerful national voice. • Any model must have the ability to evolve. Revolution may be overly disruptive and hardwire a new but equally inflexible model that constrains PHS is implemented and learns. • Locations – still to be decided (Regions, all localities, arranged by priority/outcomes) • Structural employment issues still to be investigated
<p>Who will join them and who will they work with?</p>	<ul style="list-style-type: none"> • They will have a key role in understanding and responding to local needs and circumstances and be local advocates exerting local influence across Community Planning Partnership services • Work as closely as possible and necessary 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 to improve efficiency & effectiveness • A particular challenge with Environmental Health – risks to community re governance/locally elected member and sufficient valuing of local democratic accountability (different culture and perceptions of NHS and LG accountability and governance)
<p>How do we ensure specialist skills are retained and developed?</p>	<ul style="list-style-type: none"> • Establish clear career pathways throughout the SPHW • Build on UKPHR & FPH work
<p>What's in the model?</p> <ul style="list-style-type: none"> - Health protection - Screening - Health Care PH - PH Intelligence - Health Improvement 	<p>My understanding of this option is that it assumes that Local Public Health teams (some of the people in these teams may be outside the scope of SPHW and in other teams – for example data analyst roles that are in some e-Health teams) and LG Environmental Health teams will become part of PHS. As would Health protection, Screening, Health Care PH, PH Intelligence, Health Improvement. To be explicit, the discussion text below assumes that NSS staff (such as LIST) that are deployed locally will continue to be deployed locally regionally.</p> <ul style="list-style-type: none"> • 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

<p>If not in the model, where would PH functions sit?</p> <ul style="list-style-type: none"> - Local - Regional - National - Other/Hybrid? 	<ul style="list-style-type: none"> • Where does PH leadership at more local level go e.g. DPH roles? Director of Public Health role is key – does this need be located in shared governance and accountability and therefore be a joint appointment (learning from IJB Chief Officer roles; Police Scotland local policing divisions)
<p>Where does this model deliver the greatest impact on population health?</p>	<ul style="list-style-type: none"> • Some may perceive this model to provide better opportunity to develop local critical mass and closer working and support for local action. (assuming joint accountability is achieved at a national and local level between SG and LG spheres of government) • Will advance the implementation of national priorities through national, regional and local effort - achieving a coherent national approach and then local approaches that are coherent with national approach (whilst valuing asymmetry – one size doesn't fit all). • Some may consider this model to provide a better understanding and responding to local needs and circumstances and using this to exert national and local influence • Better alignment, prioritisation and deployment of the SPHW collective capacity against National & Local priorities • Workforce planning and development could maximise the opportunities to strengthen and retain the right specialist skills, especially in more specialist areas, and their deployment at a national regional and local level. • Authority at a national and local level • Less duplication, more efficiency • More immediate access to internal and external partners of expertise, evidence and underpinning data and intelligence.
<p>Strengths?</p>	<ul style="list-style-type: none"> • 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. Consistent with other CP partners (Police, Fire and rescue etc) where national organisations must have an effective local delivery & presence and provide access to national resource and support at a local level. • Increased versatility • Flexible and adaptable • Improved co-ordination • Creative disruption of bringing a wider range of perspectives together into the one organisation. • Greater resilience/deployment of resource • Clearer and easier professional governance • Standards may be easier to maintain in teams • Management of PH training easy • Coherence through national – regional – local • Opportunities to strengthen career options for workforce • Perception of reduced fragmentation • Work across all domains of public health • Might offer development opportunities • PH voice & identity louder • PH as strategic influencer • Sound credible voice

	<ul style="list-style-type: none"> • 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 using the collective ability of local – regional – national expertise • Will be a partner in CPP (in the Community 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
<p>Weaknesses?</p>	<ul style="list-style-type: none"> • Staff may not be able or willing to be redeployed to a different area. • Depending upon implementation, this model could risk distancing public health activity from NHS Boards. • Securing buy in and change to the statutory position of Environmental Health – currently duty of LA. • Perception of potentially reducing local democratic accountability if this is not addressed as part of the model. • Managing national, regional and local stakeholder expectations and perceptions in a shared accountability framework e.g. Potential for resource being concentrated on urban areas (negative impact on rural areas whilst possibly maximising impact on Scotland’s priorities) • Potential loss of independence – too much accountability • Lack of democratic accountability? • Governance & accountability – • NHS Boards & councils etc. stop doing prevention as see this as role of PHS to deliver as they have all the resources etc!?!? • Some may perceive there to be a risk from this model of destabilising the established good working relationships and partnerships that already exist in Scotland. Some areas of public health are already working extremely well in partnership across boundaries towards shared agendas such as the Scottish Health Protection Network which utilises an obligate network approach. This approach emphasises the need to work collectively through joint ownership and is based on shared values and goals rather than structural change. • Underestimate need for change in non – PHS partners e.g. Councils (Burn on SPHW) also the same applies to the maintaining the support and input of NHS HB colleagues which can be challenging already with regard to IJBs and CPPs. (Underestimate resistance within NHS to change) • Visible/local • Might encourage command control and the National could easily override local. • Potential to become internally focused, especially in the first two years as the changes are implemented and embedded. Thereby undermining the essential whole system relationship maintenance and building. • May become an ‘Ivory Tower’ that is unable to translate

	<p>robust and credible influence into locally appropriate action. Pushing one size fits all approaches.</p> <ul style="list-style-type: none"> • Potential for unclear Accountability: who, SG or COSLA or to Health board, must be clear • Central belt led perception, especially if locally not visible, well resourced and responsive. • Presumption of organisational centralisation rather than subsidiarity • Ensuring integration of PH at local level, especially if local presence is limited. Small number of staff working with a diverse and wide range of local partners and could still be seen as separate from related local services (SW, Adult care, Education, Planning, transport, third sector) • Over reliance on being corporate rather than being focused on impact. • May be seen as purely advisory without sufficient authority to 'call out' local inaction etc
Assumptions?	<ul style="list-style-type: none"> • National and local joint accountability between SG/LG is effectively operationalised. • Public Health Scotland is partnership and collaboration oriented, recognises, values and evidences the impact that the work of other partners is contributing to improving public health. • Effective internal and externally transparent approach and processes for setting priorities and balancing resource allocation and support at a national, regional and local level. • Effective translation of diverse range of local needs and priorities into support offers and interventions that respect that one size does not fit all. • That all partners participate and fulfill their responsibilities within community planning and collaborate effectively nationally and locally to make best use of limited resources to effectively strengthen whole system working. • PHS is highly accessible at a local level and that opportunities for the co-location of PH teams with other local LG/NHS/IJB/CP teams are pursued. • The OD of the PHS, including terms and conditions, will promote responsive, collaborative, flexible, agile and mobile ways of working and culture.

Initial analysis of Option 4 against assessment criteria:

Efficient – best use of resource	<ul style="list-style-type: none"> • 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 – Maximum impact on population health	<ul style="list-style-type: none"> • 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

	<ul style="list-style-type: none"> • 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 – presence across the public and third sector to mobilise and deliver	<ul style="list-style-type: none"> • 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 – capacity to maintain delivery	<ul style="list-style-type: none"> • 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 model?	<ul style="list-style-type: none"> • 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

Note from volunteers:

Regional hubs would be part of a tiered approach to the organisation and delivery of public health in Scotland and is a model that sits alongside local and national levels. This was a key element in our consideration of Regional Hubs. In no way were they THE solution. Regional hubs would be a link into key regional agendas, e.g. City Deals and Regional Delivery Partnerships across Scotland. It is crucial that a whole system approach be achieved by having key enablers with the skills to link public health priorities into the agendas of these partnerships. Regional hubs operating within the wider Scottish context could bring a unique perspective to national public health, e.g. remote and rural in the North of Scotland and be an important boundary spanner between local and national public health planning and delivery. Therefore a key characteristic of this model is the ability to have visible and formal collaboration with other public sector organisations in pursuit of better public health, including local authorities, universities and colleges. Another distinguishing feature is the prominence of leadership bringing greater influence and impact throughout the health system. .

Volunteers	Carol Stewart, Jillian Evans & Irene Beautyman
What will the specialist workforce do?	<p>This is about developing regional centres for population health that have visible and high impact leadership. This model is not a bureaucratic 'add-on' or unnecessary layer, but brings critical mass to increase profile, presence and impact of public health whilst still being closely connected and identified with current Board populations. In particular it enables:</p> <ul style="list-style-type: none"> • Continued local working and good relationships where they exist now • Increased workforce resilience where some Boards/systems are vulnerable • Greater ability to influence at a regional level through visionary PH leadership, particularly influencing decisions relating to economic development and inclusive growth • Effective co-ordination of PH efforts across the region, helping to achieve greater scale and impact • Enhancing, developing and growing the very specialist PH functions of health intelligence, health protection and environmental health and health improvement • Developing a mature relationship and collaboration with populations about health surveillance and research • Providing a resilient infrastructure that allows time for PH practitioners to work 'out there', and cultivate local relationships • Ensuring greater equity and access to specialist skills across all areas of PH • Enhancing and cultivating local public health leadership • Improving and enhancing progressive workforce development and succession planning • Implementing new approaches to modern public health surveillance • Maximising the potential of relationships, expertise and motivation for greater regional research and innovation
Where will they be located? (organisationally)	<ul style="list-style-type: none"> • 3 centers of population health – general agreement around three hubs • Part of a tiered model with local, regional and national • Possibly operating as a virtual network • Needs further understanding of defined legislative regions

<p>Who will join them and who will they work with?</p>	<ul style="list-style-type: none"> • New partners in other public sector organisations, particularly local authorities, HSCPs, Universities, Criminal justice • Local Authority – discussion focused on importance of local input. Regional and LOCAL level that workforce spend time in local government while being employed by PHS. Part of the working week needs to working side by side as part of, for example, Community Planning Teams or Spatial Planning Teams to realistically get understanding and buy in to the benefits of a whole system approach for all partners and how best to take action locally to achieve it. •
<p>How do we ensure specialist skills are retained and developed?</p>	<ul style="list-style-type: none"> • This is all about retaining, developing and making best use of specialist skills. It is a model for workforce resilience without destabilising local systems (Board & locality) therefore: • Local boots on the ground to allow skills in all regions and: • Combining wider public sector skills locally for active learning on how service design and delivery impacts on prevention
<p>What's in the model?</p> <ul style="list-style-type: none"> - Health protection - Screening - Health Care PH - PH Intelligence - Health Improvement 	<p><u>Health Protection:</u></p> <ul style="list-style-type: none"> - Improve how we work currently/ efficiencies - Greater potential for resilience - Local ownership <p><u>Screening:</u></p> <ul style="list-style-type: none"> - Working across boards and focus on prevention - Some local board level delivery - Potential for greater resilience - Regional coordination <p><u>Health care public health:</u></p> <ul style="list-style-type: none"> - Mainly local because of relationships and local knowledge but - Move to regional services e.g. cancer <p><u>Public health intelligence:</u></p> <ul style="list-style-type: none"> - Local teams within a regional alliance + PHS <p><u>Health Improvement:</u></p> <ul style="list-style-type: none"> - Local Teams - Regional Coordination - Prevention as well as Protection - Environmental Health - Regional specialists
<p>If not in the model, where would PH functions sit?</p> <ul style="list-style-type: none"> - Local - Regional - National - Other/Hybrid? 	<p>All included.</p>
<p>Where does this model deliver the greatest impact on population health?</p>	<ul style="list-style-type: none"> • 3 Centers of Population Health including other public sector partners – a visible collaboration driving change and impact in planning and delivering public health (NB <i>need to define what the three regions are</i>) • Regional coordinators playing into regional economic agenda e.g. city deal • Economic development / inclusive growth • Scaling up good practice • Research and innovation
<p>Strengths?</p>	<ul style="list-style-type: none"> • Strong prominent leadership • Ability to link and coordinate efforts of local health systems and feed efficiently into national work (eg No SPHN is a good example)

	<ul style="list-style-type: none"> • Improved capacity and resilience of local health systems (eg on call, screening & other specialist skills) • Could resolve recruitment challenges in North of Scotland • Strategic endeavors with public sector partners will help to address the wider, social determinants of health • Critical mass of ph skills and capacity enables greater reach into other healthcare work at regional level • Increased capacity for senior leadership to engage and influence city/region working with local authorities and other key public sector partners and industry • Increased credibility regionally and local visibility • Local and regional identity and acknowledges the importance of existing relationships • Maximises the strengths of local work and could help to make improvements at scale • Tests of change and different ways of working in local health systems can increase innovation which a regional body could maximise • May be more efficient, effective and consistent 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 and thus have impact on promoting health priorities in their strategies and action plans in the area where resources lie.
<p>Weaknesses?</p>	<ul style="list-style-type: none"> • 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 • Are there sufficient decision making levels at regional level to merit this layer • Unclear leadership

	<ul style="list-style-type: none"> • 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? <p><u>Dependencies:</u></p> <ul style="list-style-type: none"> • People in health boards in regional hub enabling national links to regional level • 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
Assumptions?	<p>A local and national level of PHS would still be needed. To feed into preventative regional work would need skills potentially beyond those currently in specialist workforce to act as key enablers/ bridges into national and local government at national, regional and local level.</p> <p>Need to bear in mind that the models of delivery for the health improvement teams are currently very different across Scotland. Not all currently employed by NHS</p>

Initial analysis of Option 5 against assessment criteria:

Efficient – best use of resource	<ul style="list-style-type: none"> • Balance between Geography/population • Depending on delivery, could be duplication • Coordinated workforce critical mass
Effective – Maximum impact on population health	<ul style="list-style-type: none"> • 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 – presence across the public and third sector to mobilise and deliver	<ul style="list-style-type: none"> • Ability to influence at a more strategic level • Opportunity to adopt and influence rest of system to work this way
Resilient – capacity to maintain delivery	<ul style="list-style-type: none"> • Positive resilient • Could be more effective for much of PH system
Ease of establishing model?	<ul style="list-style-type: none"> • 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

Hybrid Options

The development of potential Hybrid Options was undertaken by;

- Ruth Campbell, Public Health Nutritionists
- Paul Dowie, Improvement Service
- Martin Higgins, Consultants/Specialists with health improvement remit
- Gerry McCartney, Health Scotland
- Paul Southworth, Specialty Registrars
- Jenny Wares, Consultants/Specialists with health protection remit

Methods:

We identified and extracted the key strengths from across the existing models (1-5). We then discussed what a new model(s) would look like if it was to achieve as many of these strengths as possible. This generated a clarification of option 4 and two new options.

Specialist PH workforce options summary

Option outline	Strengths	Weaknesses
Option 1: Local authorities PHS staff stay in PHS Screening to PHS? Health protection regional	Influence in LAs and CPPs – good for health improvement and some aspects of health protection	(Loss of) influence on NHS – tricky for healthcare PH and aspects of health protection. Could be better for some primary/social care depending on IJB
	Democratic and local accountability and connections	Greater budget pressures within LAs than NHS
	Would look and feel different – opportunity is new	Large scale change
	Shift LAs to a greater population health focus	Could leave resource thin as spread over 32 local authorities – costly to replicate x32. Role of DsPH unclear. Also possible that there is unnecessary duplication and unwarranted variation
	Local PH team identity	Screening needs a close NHS relationship
		Potential political interference
		Loss of links to clinical data
		Negative experience of PH move to LAs in England
		Dilution of specialist PH workforce

Option 2: IJBs Screening not explicit Health protection not in IJBs	Influence on primary and social care and acute care through directions	Accountability is muddled
	Accountability through two key partners: NHS and LA	Confusing to separate health protection and environmental health
	Would look and feel different	Budget pressures greater than NHS acute but less than LA
	Shift to population health and social determinants focus in IJBs	Degree of change is big
	Links to HB and LA data (LIST link)	Could leave resource thin as spread over 31 IJBs – costly to replicate x31. Role of DsPH unclear. Also possible that there is unnecessary duplication and unwarranted variation
	Status of IJB in CPPs unclear	Status of IJB in CPPs unclear
Option 3: NHS Boards and obligate networks Obligation – could top-slice Board budget to fund work identified as national priority	Less structural change	Identity not consistently high
	Potential for more collaboration and less duplication	Could be perceived as carrying on with current approach bar a tweak – not a reform
	Potential to co-ordinate between national and local work	Maintains inequality in resources across Scotland
	Closer relationship with Boards	Tension between obligate network and local work: who decides if national priority is obligate work or PHS work?
		Would sufficient local resource be released for national projects?
		Potential for trickier relationships with LAs and CPPs
		Obligate networks would need to be established for and within each PH domain
Option 4: PHS employ centrally and deploy locally	Deploy according to need	CEOs might want to retain local control/direction/prioritising
	Flexible to needs in due course	Unclear governance and accountability to local partners
	De-duplicates and	How would local offer be

	reduces variation	demonstrated
	External people would find their way more easily	Co-ordinating too many people
	Greater profile and PH identity	Rural and remote work would need to be mandated
	Helpful to have all the expertise within the PHS resource	Risk of influence in Boards being diminished
	Use all the skills and knowledge of locally based staff	
	Strategy is more coherent	
	Training would be easier, clearer career paths and development opportunities	
	Budget resource protected	
	Big change	
Option 5: Regional Everything is regional (3). Some bits of PHS in regional	3 big hubs of PH expertise, economies of scale	Doesn't align with many structures eg NHS, LAs. Lack of regional parties
	Acute service planning/regional structures/City Deal	Links to acute and local challenging
	De-duplication of some models, reduces variation	Duplication
	More manageable than national scale	Regions aren't really common areas with common problems – artificial
	Less fragmented	
	Training would be easier	
	Signifies change	
	Academic links	

Results:

The key strengths from across models 1-5 were identified as:

- a. Ability to influence local authorities/CPPs
- b. Ability to influence acute NHS services
- c. Ability to influence primary and social care
- d. Accountability to NHS structures
- e. Accountability to local interests – including local authorities and local communities
- f. Less duplication and more co-ordination
- g. The ability to deploy staff according to need
- h. Reduction of unwanted variation in practice/service
- i. Flexibility to change over time
- j. Less disruptive change
- k. Demonstrable reform
- l. Protects/optimises public health resources
- m. Facilitates public health training and career development
- n. Access to NHS and local authority data
- o. Strong academic links
- p. Manageability of the organisation

The group thought that option 4 could achieve many of the strengths above, but particularly if the following could be clarified:

- All staff would be contracted to PHS
- Staff would then be deployed to local structures (NHS boards, local authorities, IJBs, as appropriate)
- SLAs would be produced to agree and reassure local structures of the provision of public health input

Two new options were also suggested that the group thought would be likely to achieve many of the strengths above. These are described below.

Option 6 – Dual contracting to Public Health Scotland and Health Boards

Description

This option would keep staff who are currently contracted within territorial NHS boards with those contracts, but would also contract those staff jointly with PHS.

Strengths

The main rationale for this model is to provide a means of co-ordinating and de-duplicating across health boards through shared workplanning and resource pooling via PHS. This could facilitate a reduction in unwanted variation and deployment according to need. It would retain clear lines of influence and accountability to health boards.

Weaknesses

This model would not enhance local accountability and could be perceived as centralising. Co-ordination of staff across Scotland will be challenging. It may require protection of rural provision to avoid centralisation. There may be tensions between the two employing authorities in agreeing workplans and priorities and management arrangements may also be complicated as a result. This latter issue could be mitigated by having one of the contracts as an honorary contract and the other as the lead employer. *Local authorities and iJBs may also feel they do not see the change anticipated by PH reform under this arrangement.*

Option 7 – Contracting to Public Health Scotland and Health Boards and/or Local Authorities

Description

This option would contract all staff to Public Health Scotland, and also to Health Boards and/or Local Authorities.

Strengths

The main rationale for this model is to provide a means of having greater influence accountability in/to local authorities whilst retaining the influence and accountability to health boards. It would also facilitate the co-ordination, de-duplication, deployment according to need and reduced unwanted variation through PHS. This model could also achieve many of the ambitions of reform by facilitating greater action locally on the social determinants of health and through better co-ordination between local government and the health boards.

Weaknesses

Co-ordination of staff across Scotland will be challenging. It may require protection of rural provision to avoid centralisation. There may be tensions between the three employing authorities in agreeing workplans and priorities and management arrangements may also be complicated as a result. This latter issue could be mitigated by having two of the contracts as an honorary contract and the other as the lead employer. There is a risk of staff being overcommitted by three contracts and being unable to balance too many diverse demands.

Initial analysis of Options 6/7 against assessment criteria:

Efficient – best use of resource	<ul style="list-style-type: none"> • 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 – Maximum impact on population health	<ul style="list-style-type: none"> • 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 – presence across the public and third sector to mobilise and deliver	<ul style="list-style-type: none"> • CPHO as part of SMT – Provide Local Leadership
Resilient – capacity to maintain delivery	<ul style="list-style-type: none"> • Wider reach, Development for staff • Critical mass • Less upheaval • National work more planned • Less disruptive and more palatable
Ease of establishing model?	<ul style="list-style-type: none"> • CPHO in local looking after PH services • CPHO locally employed – to gain buy in • CPHO would strengthen local leadership

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