NHS Shared Services Programme – Public Health (SSP – PH)

Report to support the Public Health Reform Commissions – June 2018

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Purpose

The purpose of this paper is to provide highlights and lessons from the outputs of the work conducted to develop the Shared Service Programme - Public Health (SSP-PH), on behalf of NHS Boards Chief Executive (BCE) Group since May 2016. At its meeting on the 12thJune 2018 the BCE noted the progress made on this programme and agreed that the outputs should be used to support the relevant Commissions issued by the Public Health Reform Programme Board.

This report highlights the key findings and learning from the three main workstreams which had reached the option appraisal stage of the SSP-PH:

- Workstream A – delivering the out of hours, health protection on-call arrangement;
- Workstream B – supporting national and regional health service planning (with special reference to specialist service commissioning / decommissioning and support for the introduction of new medicines); and
- Workstream C – the development, maintenance, and analysis of public health intelligence.

These three workstreams are relevant and aligned with the following Commission briefs issued by the PHR Programme Board, respectively:

- Protecting Health Commission
- Improving Services (high quality health & social care services) Commission
- Underpinning Data & Intelligence Commission

We have created this report for the commission's leads and PHR Executive Team. We trust that by encompassing the last 2 years of hard work of SSP-PH in this report, will benefit them by:

1. building on the information generated through a well-developed engagement process
2. having an insight to the potential solutions/options identified to achieve the desired outcomes (effectiveness, efficiency & sustainability) in delivering the public health services in the relevant workstreams
3. knowing who was involved and what activities were undertaken in the relevant workstream
4. looking at the options appraisal in detail in the embedded file (further material) and the Common Criteria developed for Option Appraisal (Appendix A)
5. focusing on the concise 'learnings' we have pulled under each of the workstream

Background

Originating in the work of the 2015 Public health review for Scotland, the SSP-PH focused on selected, priority functions of public health for which national and local NHS Boards are accountable. The overarching aim of the programme was to explore options for the selected public health services which could be shared whilst still maintaining an effective, efficient and sustainable contribution to protecting health, preventing poor health, and driving equitable population health improvement in Scotland. The priority shared areas spanned the public health functions of health protection, health improvement and healthcare public health, underpinned by health intelligence. The priorities, identified in the 2015 Review of Public Health in Scotland and confirmed through stakeholder engagement, were approved by the NHS Chief Executive Group and ratified by the Scottish Directors of Public Health Group.

There were originally 6 workstreams which reduced to 4 as other Scottish Government initiatives eliminated the need for 2 of those 6 (screening and knowledge services). Workstream 6, a developmental workstream, sought to identify potential options for more strategic change in delivering public health at regional level; the findings of this workstream will be provided separately.

The working groups within all the workstreams of the SSP-PH engaged with a broad range of public health and inter-agency stakeholders to develop sustainable options for the Public Health system in Scotland.

The main purpose of this report is to prove a form of “hand-over” document on the work of the three workstreams for each of the Commissions. The following information will be provided for each workstream:

- the workstream leads;
- the workstream stakeholder involvement;
- main activities undertaken;
- options identified;
- results of the option appraisal / preferred option (if one identified); and
- any wider learning identified by the workstream

In addition to this, all workstreams agreed a common set of criteria to be used for the option appraisal process. These have been included in Appendix A at the end of this document.

Workstream A

Delivering the out of hours, health protection on-call arrangement

Leads	Workstream: Tim Patterson, DPH, NHS Borders & Syed Ahmed, Clinical Director, NSS Public Health & Intelligence (May 2017 - March 2018) Margaret Hannah, DPH, NHS Fife & Phil Mackie, Lead Consultant, ScotPHN (April - June 2018) Regional (on behalf of SDsPH): West – Gillian Penrice, CPHM, NHS Greater Glasgow & Clyde East – Margaret Hannah, DPH, NHS Fife North – Ken Oates, CPHM, NHS Highland
Involvement	Elisabeth Smart, NHS Highland Pip Farman, NHS Highland / NoSPHN Lynne McNiven, NHS A&A Richard Othieno, NHS Lothian John Logan, NHS Lanarkshire Nigel Calvert, NHS D&G Diana Webster, NHS Grampian Louise Wellington, NHS Lothian Lindsey Murphy, NHS Lothian Lynn Byres, NHS Grampian/HPPN Fiona Browning, NHS Grampian/HPPN Colin Ramsay, NHS PHI HPS Daniel Chandler NHS Tayside / CPHM (CD&EH) Jenny Wares NHS Highland /Specialist Registrars
Activity	• Working Group Meetings - 9/6/17, 7/7/18, 4/8/17, 15/9/17, 19/1/18 • Option development workshops were held in the West, East and North of Scotland in September and October 2017 and further refined in 2018. • The governance was revised to ensure SDsPH, who have key responsibility for OOH locally, were included in decision process. • Option appraisal took place 27 April 2018
Options identified	• status quo; • enhanced status quo; • sub-regional rota by mutual agreement between boards; • regional rotas - formal; • one integrated national rota.
Results of option appraisal / Preferred option	• The preferred option focusses on developing an enhanced status quo model. There was limited consensus about the strengths, weaknesses and final future shape of service provision; however, it was agreed that services should be developed through a stepped progression, with a necessary

	move towards an ‘enhanced status quo’ option to improve resilience as a matter of course. • This model is recognised as addressing the necessary issues concerning service resilience and consistency, whilst also allowing further refinement towards informal regional, formal region or national arrangements if those are required.
Learning	• Current services could and should be improved by a levelling up of the provision across Scotland to remove service variations. • Irrespective of what else happens, the criteria identified in relation to the ‘enhanced status quo’ should be met. • Any move to either informal or formal regional arrangements, or a national arrangement for on-call would need to be based on reaching the “enhanced status quo” model as a basic “building brick”. • The views of the specialist registrars should be better understood in order to better inform changes to the landscape of health protection.
Further material	Document identifying the final options considered and the ‘pros’ and ‘cons’ of each  2018_06_15 Workstream 1 Optio

Workstream B

Supporting national and regional health service planning.

Leads	Graham Foster, DPH, NHS Forth Valley Maggie Watts, DPH, NHS Western Isles (Carol Davidson, DPH, NHS Ayrshire & Arran, until March 2017)
Involvement	Sara Davies, Scottish Government Brian O'Suilleabhain, NHS A&A Gordon McLaren, NHS Fife Karen Ritchie, HIS Daniel Connolly Fiona Murphy, NSS NSD Mike Winter, NSS NSD Gerry McCartney, ScotPHO Hugo Van Woerden, NHS Highland Josephine Pravinkumar, NHS Lanarkshire Pip Farman, NHS Highland
Activity	• Working Group Meetings – 14/3/17, 4/5/17, 21/6/17, 17/7/17, 18/8/17, 15/9/17, 20/10/17, 6/2/18 • Workstream leads met with Marion Bain, Public Health Reform Team – 28 November 2018 • Based on wide consultation, the Working Group produced a paper 'Strengthening the healthcare public health contribution to regional and national planning in Scotland'. • The options paper describes how the current HCPH function could be enhanced in the short term, as a step towards creating a formal, national MCN for HCPH or HCPH function in Public Health Scotland.
Options identified	• status quo; • development of Health Care Public Health (HCPH) capacity in NHS Boards not participating in national or regional planning; • continuation of existing informal network for HCPH; • continuation of existing informal network for HCPH to include all NHS Boards; and • Structured approach with obligate Managed Clinical Network (MCN) for HCPH.
Results of option appraisal / Preferred option	No option appraisal was undertaken.
Learning	• Making more effective use of the existing health care public health is possible through formalising the existing ScotPHN collaborative approaches. • Developing more structured approaches beyond this was difficult given the competing pressures towards national and regional (NHS) planning/commissioning and support for more

	local IJB based community health and social care planning/commissioning. • A national focus for health care public health is needed to provide the necessary leadership and co-ordination. • Whilst no option appraisal was undertaken, an obligate network was considered to be a viable way forward.
Further material	Final report on strengthening HCPH: 2018_05_23 HCPH Paper.docx

Workstream C

Development, maintenance, and analysis of public health intelligence

Leads	Gerry McCartney, ScotPHO Lead, NHS Health Scotland Hugo Van Woerden, DPH, NHS Highland
Involvement	Pip Farman, NHS Highland Maggie Watts, NHS Western Isles Josephine Pravinkumar, NHS Lanarkshire Karen Ritchie, HIS Gordon McLaren, NHS Fife Arfan Iqbal, NHS A&A Clare Campbell, NHS Fife Colin Fischbacher, NSS PHI ISD Elspeth Russell, NHS Lanarkshire Emma Hogg, NHS Health Scotland Gareth Brown, Scottish Gov Garth Reid, NHS Health Scotland/PHENS Jillian Evans, NHS Grampian Manira Ahmad, NSS PHI ISD Martin Higgins, NHS Lothian/SHIIAN Martin Malcolm, NHS WI Neil Craig, NHS Health Scotland Philip Johnston, NHS NSS Rory Mitchell, ScotPHO
Activity	• Working Group Meetings – 22/3/17, 21/4/17, 17/5/17, 14/6/17, 3/7/17, 5/7/17, 17/7/17, 9/8/17, 5/9/17, 8/11/17, 9/12/17, 10/1/18, 7/2/18, 8/3/18 • Option Appraisal – 25 May 2018 • a survey of public health intelligence resources and tasks/methods faced • piloting new ways of bringing together public health intelligence support and connecting to live examples • enhancing collaboration on data profiling being progressed: two open data platforms; sharing resources; move to fewer profiling websites and deduplication
Options identified	• obligate public health intelligence network; • single employer public health intelligence service; • voluntary public health intelligence network; • PHI national/local hybrid model; and • creation of a central resource with a national focus and local autonomy.
Results of option appraisal /	• the obligate public health intelligence network was identified as the preferred option at the formal workshop in May 2018

Preferred option	
Learning	• This workstream concluded that an obligate network was their preferred model, having explored other approaches to collaboration. • It is clear that this workstream benefited from the previous recognition that collaborative approaches to improving quality and reducing duplication was a helpful way of working across the broader landscape for public health intelligence. • On the basis of this work, the SSP workstream group has agreed to continue to meet to discuss better ways supporting the process of mobilising intelligence and supporting workforce development. • Existing national and local leadership for collaboration afforded by the ScotPHO-sponsored Public Health Information Network for Scotland (PHINS) will continue.
Further material	Final report on option appraisal  2018_06_03 SSR public health intelliger

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Appendix A

Shared Services- Public Health Programme

Common Criteria for Option Appraisal

Common criteria will ensure consistency of process and coherence of decisions across the option appraisals undertaken by all workstreams involved in SSP-PHP. In reviewing the areas suggested from the four groups, a distinction can be made between proposed criteria which capture a quality by which an option can be described (e.g. efficiency) and those which describe a desirable outcome from the option (e.g. reduce variation). Clearly, these are closely related; a more efficient service may be one which has reduced unnecessary variation (without prejudicing necessary variation).

In setting out these common criteria, an attempt has been made to capture the broad area of the criterion and to characterise the outcomes in a way that can be used to help in forming a judgement of the options. The underlying assumptions that have been made are that the options chosen will result in a PH system which is more coherent (through local, regional and national), resilient, sustainable, and better governed.

The criteria

Criterion	Possible outcomes
Effectiveness	• Improved access to PH function • Reduction in variation in PH functions • Improved quality /consistency of PH functions • Timely response to incidents • Clear accountability for PH • Clear governance for PH • Enables effective relationships
Efficiency	• Improvement in scope of PH functions delivered • Reduction in unnecessary duplication • Maintaining standards of work (impact, value etc) • Optimal use of local assets • Optimal use of specialist expertise across four domains of PH • Manageable sphere of influence
Sustainability / Resilience	• Provides better support to the workforce – skill mix, career progression

	• Provides flexibility to allow new ways of working to evolve • Provides quality learning and training environments • Stabilises local health economies – urban & rural sustainability
Service Level	• Clarity of functions covered, nationally, regionally, locally
Sensitive to rural and remote public health	• R&R issues are fully acknowledged within PH function • In line with potential Islands Act (if Bill becomes Act) which may place requirement on public bodies to consider impact on island communities.

Feasibility	• Changes considered to be compatible with:
	  ○ other PH/sector system changes
	  ○ legal requirements of service
	  ○ HR
	  ○ Training and workforce career development
	• Changes acceptable to staff
	• Ease & cost of implementation

Population centred	• Acceptability to public • Acceptable to stakeholders • Degree of ownership & local influence
Risk	• "First do no harm" – safety in incidents considered and no harm to existing population health gains • Does not increase health inequalities • Capacity of workforce to deliver • Destabilisation of delivery of PH function as significant change could reduce organisational memory. • Destabilisation of delivery of PH function as the attractiveness of the speciality to new entrants is reduced. • Doing nothing

Explanatory notes

Effectiveness

'Improved access' – responsive to local, regional and national needs.

The costs associated with each potential option should be considered ie would the option cost more or less than the status quo.

Efficiency

'Unnecessary duplication' – it is recognised that there will continue to be a degree of 'necessary duplication' eg to ensure impact or buy-in with decision making processes at different levels.

‘Maintaining standards’ – some reports and some work undertaken on a ‘once for Scotland’ basis may be hindered by poor implementation (or lack of impact) by not being able to easily play into the priorities and decision making process of decision makers eg the NHS Boards and all linked IJBs.

Sustainability/Resilience

‘Provide better support to the workforce’ – this should also consider whether the methods of staff recruitment and retention will be able to sustain long term implementation of agreed options.

Population centred

There should be clarity over the population served and therefore the acceptability to the public.

Risk

Financial risk should be understood and acceptable.

Workforce risks should be understood. The need to involve staff in decision making is required.

General

Every option should be measured against the need to maintain strength for an integrated speciality and in speciality training to provide future leadership in that speciality work. Particular care is required locally to no destabilise integrated PH arrangements locally.

Application

In putting forward this consolidation of the common criteria, two specific comments were made regarding the way in which the criteria should be used in the option appraisal process. These were:

- each criterion will need to be operationalised by the specific workstream to identify (and provide clarity on) what constitutes a 'good', 'intermediate' or 'poor' option; and
- additional criteria for specific workstreams may be needed, though they would require very specific justification.

These seem to be capturing a similar concept about how the criteria should fit the services considered by the workstream. In this regard, it is proposed that the former – that workstreams operationalise the criteria to their options – will provide the necessary workstream specificity without risking the workshops view that “common” criteria were desirable.