



Department of  
**Health, Social Services  
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AN ROINN

**Sláinte, Seirbhísí Sóisialta  
agus Sábháilteachta Poiblí**

MÄNNYSTRIE O

**Poustie, Resydënter Heisin  
an Fowk Siccar**

## **HEALTH AND SOCIAL CARE REFORM**

### **DHSSPS**

#### **Modernisation and Improvement Programme Board (MIPB)**

#### **PHA - Health Protection**

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## **Introduction**

This paper has been developed by the Project Board of the Regional Agency for Public Health and Social Wellbeing (the Agency) project and will form a section of its operational framework. It has been developed in liaison with a wide range of stakeholders and has been endorsed by the Agency Project Board.

It has been approved by the Modernisation and Improvement Programme Board and is now free for circulation to HSC staff and other relevant stakeholders. A copy of the paper will be placed on the Health and Social Care Reform section of the departmental website -

[www.dhsspsni.gov.uk/index/hss/rpa-home.htm](http://www.dhsspsni.gov.uk/index/hss/rpa-home.htm)

This paper has been developed as a follow on to the Health Protection paper passed by MIPB in November 2008. It specifically considers the nature of the future relationship with the Health Protection Agency and discusses current arrangements and options for the future in the context of the requirements of the new Health Protection (HP) service in Northern Ireland as outlined in the previous paper.

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***Modernisation and Improvement Programme Board***

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## **Executive Summary**

The purpose of the paper is to consider the nature of the future relationship with the Health Protection Agency and discuss the various options. It considers the current arrangements and what will be needed in future. The new Health Protection (HP) service in Northern Ireland will be required to provide:

- frontline services covering the spectrum of health protection (as currently undertaken by Consultants in Communicable Disease Control currently working in Health and Social Services Boards);
- regional surveillance and support (as currently undertaken by CDSC (NI) and the Healthcare Associated Infection Surveillance Centre (HISC)); and
- “national” surveillance whereby NI data is forwarded to London for inclusion in UK and ultimately in international systems.

Three options for the delivery of Health Protection services within Northern Ireland are set out with their perceived advantages and disadvantages. The options are:

- Option 1 – all Health Protection staff employed by the RAPHSW with a SLA/MOU with the HPA for specified services and the Health Protection lead having an honorary contract with HPA.
- Option 2 – some staff employed by HPA (i.e current CDSC staff) and other staff employed by the RAPHSW with a SLA/MOU with the HPA for specified services;

- Option 3 – all staff working within the HPA and the Health Protection lead being a joint HPA/ RAPHSW employee.

Option 1 is the recommended option because it delivers strongest local accountability to the Minister and to the Chief Executive and Director of Public Health (DPH) of the RAPHSW.

In order to ensure that “strong links between the new Health Protection service, the HPA and local government environmental health departments would be retained and developed.”, it will be essential that there is a robust SLA/MOU with HPA in terms of access to a range of services, not least of which is support and advice for management of critical incidents. The DPH through the HP lead in the RAPHSW should be responsible for the development and performance management of the SLA/MOU. The Department will continue to need to have access to the HPA for specialist advice for policy development and Ministerial case work, this will need to be covered in any new SLA/MOU. It will also be important for Northern Ireland to continue to have a member on the HPA Board as nominated by the Minister and for the Department to continue to have observer status.

## **Introduction**

1. The purpose of the paper is to consider the nature of the future relationship with the Health Protection Agency and discuss the various options. It has been prepared for the RAPHSW Project Board. It does not address the other issues related to the establishment of a health protection service for Northern Ireland, which are covered in a separate paper which has already been considered and endorsed by MIPB.

## **Background**

2. The components of a high quality Health Protection Service for NI include:
  - a “one stop” shop for health protection covering the spectrum of health protection (communicable disease surveillance and control, environmental hazards surveillance and control, response to chemical incidents and emergency preparedness), capable of managing the majority of health protection issues arising in NI and only requiring back up (from outside NI) for the rare and unusual;
  - the application of evidenced based practice or, if the evidence is incomplete, consistent with current professional practice;
  - a uniform level of service and professional practice and health protection response based on common standards and protocols throughout NI;
  - robust governance arrangements with explicit standards, roles and responsibilities linked with evidence of continuous

- evaluation of practice. This would include accreditation against nationally derived standards and benchmarking against other health protection services within the UK;
- a strong and skilled consultant led multidisciplinary team using available skill mix to best effect including contributions from Environmental Health Officers, veterinarians and pharmacists;
  - front line staff being supported by timely surveillance information and epidemiological analysis provided by the surveillance section/unit – surveillance being information for action;
  - a sub unit covering all health care associated infection issues;
  - a recognised training programme which includes all staff, based on assessed needs linked to national training developments in health protection;
  - staff enabled to take on regional and national roles, if desired;
  - strong links with the Health Protection Agency and with similar organisations in Scotland, Wales and the Republic of Ireland;
  - strong links with academic institutions, both local and further afield: to facilitate research in health protection particularly in addressing local issues; and input to relevant training; and
  - a main base co-located with other public health colleagues, with an incident room and capabilities for 24/7 operations, physically accessible either by public transport or car and with videoconferencing facilities.

## **Health Protection Agency**

3. The HPA was established as a special health authority (SpHA) in 2003. On 1 April 2005, the Agency became a non-departmental public body, replacing the HPA SpHA and the National Radiological Protection Board (NRPB) and with radiation protection as part of health protection incorporated in its remit. The Agency's role is to provide an integrated approach to protecting UK public health through the provision of support and advice to the NHS, local authorities, emergency services, other Arms Length Bodies, the Department of Health and the Devolved Administrations. The HPA has a large network of approximately 3000 staff based at three major centres (Colindale, Porton and Chilton) and regionally and locally throughout England. There is a small central office based in London. The Health Protection Agency Act 2004 ensures that the radiological protection advice and cover which had been provided to Northern Ireland through the National Radiological Protection Board will continue to be available from the HPA. To that end, there is specific provision in the legislation for a member of the Board of the Agency to be appointed by the Department of Health, Social Services and Public Safety (DHSSPS).

## **Current position**

4. Since its establishment in 1999, CDSC(NI) staff have been employed by the HPA (formerly PHLS) to provide a regional communicable disease epidemiology service for Northern Ireland. The DHSSPS has a service level agreement (SLA) with HPA for this work. Under this SLA, a business plan is agreed annually and robustly monitored between the HPA and DHSSPS. Dr Paul Darragh, Consultant in Public Health Medicine, Eastern Health and Social Services Board, is the current NI member of the HPA Board as nominated by the Minister and Dr Elizabeth Mitchell, Deputy Chief Medical Officer, has observer status. DHSSPS is invited to participate and input on the development of the HPA Corporate and Business Plans.
  
5. The current arrangements have significantly contributed to the development of health protection here and enabled Northern Ireland to fulfil its national and international surveillance and reporting obligations. Many of the surveillance developments implemented in Northern Ireland in recent years such as those for healthcare associated infection would not have been so readily implemented had there not been an HPA presence here. Similarly the networks developed by CDSC (NI) with GB health protection services have enabled it to draw on this expertise for the rare and unusual incidents e.g. problems in decontaminating endoscopes and waterborne outbreaks of cryptosporidiosis.

6. Recent events, in particular the recent case of rabies, have highlighted, yet again, the importance of our linkage with the HPA. Help from the HPA would have been offered in any event concerning the rabies incident. However the prompt and coordinated action both locally and nationally was aided by CDSC(NI) having a clear insight into HPA structures and networks to gain expert advice as early as possible. CDSC(NI) was able to provide EHSSB with all the relevant protocols from the HPA extra/intranet and set up the teleconference with the various parts of the HPA and VLA.
7. It is important that these networks and understanding of the HPA will not therefore be lost if CDSC(NI) is no longer part of the HPA. The value of being part of the national organisation can often be underestimated as there are a number of softer and intangible benefits such as the networking and knowledge of the system - issues which are hard to reflect in MOUs and difficult to operate/manage if outside the HPA.
8. Other strong links also exist between the HPA and Northern Ireland and these have worked extremely well in the past. Other services provided by HPA for Northern Ireland include reference microbiology services (funded on a test by test basis by submitting Trust hospital laboratories); support in responding to chemical incidents (through SLAs with each HSS Board); support in responding to incidents involving radiation; and facilitation of emergency preparedness exercises (funded as and when required). In addition, HPA

provides support and advice to DHSSPS on a wide range of policy areas including ionising and non-ionising radiation, chemicals, drinking water and air quality. HPA is also a training provider and has been commissioned to provide training locally in respect of a range of health protection and emergency preparedness matters. DHSSPS, NI Regional Medical Physics Agency and the Radiation Protection Division of HPA have a Memorandum of Understanding. A funding relationship also exists between DHSSPS and the Chemical Hazards and Poisons Division of HPA.

9. To date, non communicable disease aspects of health protection are less advanced in NI than in parts of GB and any new arrangements will need to ensure this knowledge, skills and service gap is urgently addressed. This will enable issues such as IPPC applications and environmental concerns of landfill sites to be more effectively addressed.

## **Assumptions**

10. The new HP service in Northern Ireland will be required to provide:
  - frontline services covering the spectrum of health protection (as currently undertaken by Consultants in Communicable Disease Control and other public health colleagues);
  - regional surveillance and support (as currently undertaken by CDSC (NI) and the Healthcare Associated Infection Surveillance Centre (HISC)); and
  - “national” surveillance whereby NI data is forwarded to London for inclusion in UK and ultimately in international systems (WHO and ECDC) and to European bodies such as EISS (flu surveillance) and EARSS (antimicrobial resistance surveillance).
  
11. The overarching objective has to be to establish organisational arrangements that can deliver the best quality of service for Northern Ireland. This service should be demonstrably as good as that available elsewhere in the UK.
  
12. A single Health Protection service for NI will bring substantial benefits, as has been noted by experience in GB.
  
13. There must be strong local accountability through the Minister to the Northern Ireland Executive and Assembly whilst ensuring that there is robust support for the health protection function when required.

## Options

14. Three options for the delivery of Health Protection services within Northern Ireland are set out below with their perceived advantages and disadvantages. Broadly the options are to have the HPU as part of the HPA but with a close working agreement with the RAPHSW or develop the Unit within the RAPHSW but with a close working agreement with the HPA.

***Option 1 – all Health Protection staff employed by the RAPHSW with a SLA/MOU with the HPA for specified services and the Health Protection lead having an honorary contract with HPA***

<b>Advantages</b>	<b>Disadvantages</b>
<ul style="list-style-type: none"> <li>- All working from one location with option of local office for some sessions</li> <li>- Using same standards/policies</li> <li>- Single management structure</li> <li>- Enables sub specialisation</li> <li>- Improves sharing data/communication</li> <li>- Good critical mass</li> <li>- Enables surge capacity from specialists</li> <li>- Easier for rotas</li> </ul>	<ul style="list-style-type: none"> <li>- Weakening of direct HPA link as currently exists</li> <li>- “don’t know what you don’t know” with potential to increase gap in professional practice and expertise between HP professionals locally with GB</li> <li>- Greater effort needed to maintain professional networking and ascertain new developments etc in GB and assess application in NI</li> <li>- Potential weakening of the HPA link may slow development of environmental surveillance and emergency preparedness arrangements</li> <li>- Potential loss of specialist IT support to labs and the HPU which could reduce surveillance efficiency and effectiveness.</li> </ul>

15. Building and developing the Health Protection service within the RAPHSW, with close and effective relationships and mutual support from the HPA, offers a better opportunity to develop local accountability and local engagement but could diminish engagement from NI in the wider health protection

work of the HPA. This option would need therefore to be supported by robust arrangements for governance and management of the relationship with the HPA (and other UK bodies) to ensure the quality of service provision is comparable to that elsewhere in the UK. Greater time and effort will be required in this model for local health protection specialists to maintain their links with GB counterparts and to keep apprised of new professional developments, standards and practice. Otherwise there is the risk that progressively “we will not know what we do not know” and the standard of health protection practice will fall behind that of GB.

16. It should be noted that under current arrangements staff at CDSC (NI) are not considered to be a RPA affected grouping and have therefore been previously denied opportunities to apply for posts in the new health organisations. The earlier decision to classify CDSC(NI) as not being RPA affected would need to be urgently reviewed, should Option 1 be accepted as the way forward.

**Option 2 –some staff employed by HPA (i.e current CDSC staff) and other staff employed by the RAPHSW with a SLA/MOU with the HPA for specified services**

<b>Advantages</b>	<b>Disadvantages</b>
<ul style="list-style-type: none"> <li>- All working from one location with option of local office for some sessions</li> <li>- Continues with the HPA physical presence in NI</li> <li>- Has worked well since inception in 1998</li> <li>- NI HPA staff can bring to attention of the HP lead national/professional developments for consideration within NI</li> <li>- Maintains current professional networks</li> <li>- Maintains specialist IT support to labs and the surveillance unit</li> </ul>	<ul style="list-style-type: none"> <li>- Two sets of staff working to different management arrangements within the same location</li> <li>- Different organisational cultures, standards, processes, IT systems etc</li> <li>- Creation of “them and us” attitude</li> <li>- Loss of some economies of scale (e.g. admin and information support)</li> <li>- Smaller critical mass</li> <li>- Reduces surge capacity and resilience</li> <li>- May restrict data sharing/collaboration</li> <li>- May limit those wishing to take on regional/national roles</li> <li>- May cause confusion as to who inputs into the commissioning process</li> </ul>

17. Option 2 to continue with the current split arrangements, with some staff being part of the HPA and some in the RAPHSW

is not considered to be appropriate and would mitigate creating a strong health protection team. It worked well in the past in the old structures but would not under the new proposed arrangements. It is therefore not recommended.

**Option 3 – all staff working within the HPA and the Health Protection lead being a joint HPA/ RAPHSW employee**

<b>Advantages</b>	<b>Disadvantages</b>
<ul style="list-style-type: none"> <li>- Single organisation structure</li> <li>- HP lead can direct all HPA local resources</li> <li>- Good critical size</li> <li>- embedded within the national organisation</li> <li>- More explicit working to national standards and practices</li> <li>- Easier to bench mark local practice with GB through joint audits, peer reviewed “accreditation” visits</li> <li>- Easier to establish and maintain professional networks and links with GB counterparts.</li> <li>- Better access and opportunity for NI HP staff to national training and relevant resources and for personal and professional development</li> <li>- Day need fewer professional and non professional staff than in a totally independent unit - HR/finance could be outsourced from HPA</li> <li>- Maintains specialist HP IT support</li> </ul>	<ul style="list-style-type: none"> <li>- Perceived lack of local accountability</li> <li>- May distance NI HP colleagues from general public health colleagues and other staff working in the RAPHSW</li> <li>- Different IT systems from RAPHSW</li> </ul>

18. The option of the Health Protection service being an integral part of the HPA has advantages particularly in identifying, applying and maintaining best professional practice and a more effective use of resources. However, this option

diminishes local accountability. This could be counteracted by the health protection lead having a joint appointment with the HPA and the RAPHSW thereby ensuring the Chief Executive and DPH can direct the local health protection resource.

19. It should be noted that the preference of the CDSC(NI) is to remain within the HPA and for there to be a HPA physical presence in Northern Ireland However, they have stated that they will work with public health colleagues to ensure that, whatever arrangements are in place, Northern Ireland gets the highest standard of health protection possible..

## **Conclusions and Recommended Option**

20. The proposal for a single Health Protection service for NI, incorporating the existing health protection bodies, provides an exciting challenge and an opportunity to refashion health protection services into a structure that is capable of delivering high quality health protection to the population of Northern Ireland.
  
21. Option 1 is the recommended option because it delivers strongest local accountability to the Minister and to the Chief Executive and Director of Public Health (DPH) of the RAPHSW. The DPH will have statutory responsibility for communicable disease control and there must be a clear line management responsibility for local Health Protection staff.
  
22. As described in the Minister's proposal "strong links between the new Health Protection service, the HPA and local government environmental health departments would be retained and developed." whatever option is chosen. . It will be essential that there is a robust SLA/MOU with HPA in terms of access to a range of services, not least of which is support and advice for management of critical incidents. The DPH through the HP lead in the RAPHSW should be responsible for the development and performance management of the SLA/MOU. The Department will continue to need to have access to the HPA for specialist advice for policy development and Ministerial case work, this will need to be covered in the new SLA/MOU. It will also be important

for Northern Ireland to continue to have a member on the HPA Board as nominated by the Minister and for the Department to continue to have observer status.

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