

**Public Health Review  
Implementation**

**Service Development Subgroup**

**INTERIM REPORT**

**January 2006**

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## **1. INTRODUCTION**

### **1.1 Background**

The Department of Health, Social Services and Public Safety (DHSSPS) commissioned a Review of the Public Health Function in Northern Ireland. The Review began in July 2003 and was published in December 2004. The report provided recommendations on the future shape of public health delivery in Northern Ireland.

An Implementation Group, chaired by the Chief Medical Officer, Dr Henrietta Campbell was established in March 2005 to develop an action plan to take the Review's recommendations forward. The following Sub Groups were established:

- Health Improvement and Knowledge Management Sub Group
- Health Protection Sub Group
- Service Development Sub Group
- Workforce Planning, Training and Education Sub Group

### **1.2 Terms of Reference for Service Development Sub-Group**

To consider the recommendations contained in the Summary of the Review of Public Health Function in Northern Ireland relating to Service Development and provide to the Implementation Group:

- A Project Plan by end of September 2005
- An interim Progress Report by end of December 2005
- Final Action Plan/Report by end of March 2006

The review recommendations are high level and in drawing up the Action Plan and Reports the Sub Group will:

- Consider the Review recommendations and determine how best they might be achieved, identifying a range of short, medium and longer term actions, identify the timetable, resource requirements, barriers to implementation and actions needed to ensure effective achievement of the Review recommendations for Service Development.

There were no recommendations in the Review relating specifically to service development.

The Review of the Public Health Function in Northern Ireland describes service development in the following way:

*“The contribution of Public Health professionals, particularly those working in HSS Boards to the development of local and regional health and social services. It is recognised that Public Health professionals contribute to this area through a range of activities, which include:*

- *Quality*
- *Clinical effectiveness*
- *Efficiency*
- *Service planning*
- *Audit and evaluation and*
- *Clinical governance”*

### **1.3 Service development subgroup membership**

**Chair:**

Dr David Stewart, Director of Public Health, Eastern Health and Social Services Board

**Members:**

Ms Heather Clarke, Director of Dental Services, Southern Health & Social Services Board

Barny Heywood, Chief EHO, Western Group

Pamela Hannigan, Allied Health Professional Commissioner, Northern Health & Social Services Board

Dr Colin Hamilton, RMSC, Western Health & Social Services Board

Dr Carolyn Harper, Public Health Consultant, Northern Health & Social Services Board

Dr Terry Bradley, Eastern Health & Social Services Board

Dr Diane Corrigan, Public Health Consultant, Southern Health & Social Services Board

Mr Mark Timoney, Senior Principal Pharmaceutical Officer, Department of Health, Social Services and Public Safety

Dr Margaret Boyle, Senior Medical Officer, Department of Health, Social Services and Public Safety

Mrs Deirdre Webb, Assistant Director of Nursing, Eastern Health and Social Services Board

**Project Manager:**

Dr Jackie McCall, Specialist Registrar, Eastern Health and Social Services Board

**1.4 Project Methodology**

The Project was initiated with the Service Development Sub Group. A Project Initiation Document was developed which described the Project Objectives, Project Scope, Outline Project Deliverables and/or Desired Outcomes and the Initial Project Plan.

## **2. OBJECTIVES, SCOPE AND PRODUCTS**

### **2.1 Objectives**

1. To document the roles required and the skills required to perform these roles within the multidisciplinary public health workforce.
2. To undertake a scan of current issues that may impact on service development roles within public health
3. To elicit the views of current practitioners and other stakeholders as to how the service development functions could be strengthened.
4. To examine options to ensure that scarce public health expertise is used effectively and efficiently
5. To develop an action plan identifying short, medium and longer term actions for enhancing the service development function of public health.

### **2.2 Scope**

To consider the service development functions of the multidisciplinary public health workforce within the HPSS including DHSSPS.

### **2.3 Constraints**

Timescale. Final Action Plan and Report to be completed by end of March 2006.

The Sub Group was asked to implement the recommendations relating to service development as agreed in the Executive Summary of the Review of the Public Health Function.

### **2.4 List of products**

- P1 Project Initiation Document
- P2 Public Health Roles Review Report
- P3 Scan of Current Issues in Service Development

- P4 Report on Current Service Development Activities
- P5 Report on Stakeholder Assessment Workshop
- P6 Evaluation of Options
- P7 Report to Steering Group on Proposed Way Forward
- P8 Action Plan

### **3. DESCRIPTION OF THE ROLES OF PUBLIC HEALTH IN RELATION TO SERVICE DEVELOPMENT**

#### **3.1 *Introduction***

The aim of this section is to document the roles that the public health workforce undertakes in service development including inputs to strategic planning, commissioning and operational management.

#### **3.2 *Roles of public health staff in Northern Ireland***

##### **3.2.1 Public Health Staff**

The term ‘public health staff’ can be used narrowly to describe staff who work within Public Health Departments or more broadly to describe staff who directly or indirectly do work that improves the health of the public. The broader use of the term can include anyone working in health and social services or organisations who partner with health and social services to address public health issues.

For this report, three main categories are considered to be included within the term “Public Health Staff”:

- Staff with a postgraduate qualification in public health e.g. Membership of the Faculty of Public Health, Masters in Public Health. Until recently, Faculty Membership was restricted to doctors and dentists, but is now open to anyone who meets Membership standards. A number of staff hold an MPH, particularly nursing staff, allied health professionals and health promotion staff
- Staff who work to public health principles, but who may not have a formal qualification. Through experience, interest and their professional role these staff bring a public health focus to service development e.g. staff in Nursing, Pharmacy, Social Services departments in Boards

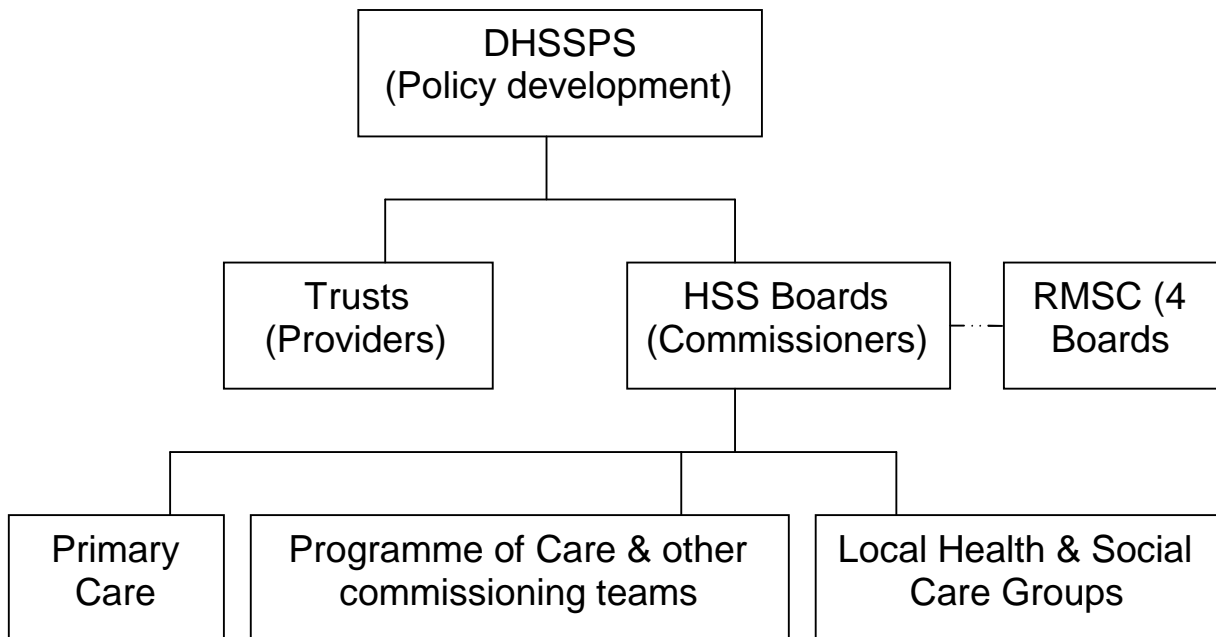
- Staff who are integral to the service development process, but who, perhaps because of their own professional backgrounds, would not necessarily see themselves as public health staff e.g. staff in Planning, Finance and Contracting departments in Boards.

Some public health service development functions are common to all three staff groups, some fall primarily to public health staff with a formal qualification. This paper describes the range of service development functions and the structure within which staff work.

### 3.2.2 Current Organisational Arrangements

Figure 1 shows the current organisational arrangements for Public Health input to service development.

**Figure 1 Organisational structure – service development**



In broad terms, DHSSPS develops policy for health and social services in Northern Ireland. The four Health and Social Services Boards commission services for their resident populations in line with Departmental policy and local Board strategies for services.

Boards secure the services they wish to commission through service and budget agreements with Trusts. Trusts provide services and Boards monitor actual activity and costs against service and budget agreements. However, Trusts are accountable to the Department for their performance against Departmental targets, particularly those outlined in the annual Priorities for Action Programme.

Service developments in Primary Care, while integrated within wider service development activities are also driven by the Primary Care units within Health and Social Services Boards.

### **3.2.3 Programme of Care & other commissioning arrangements**

To cover the wide range of services which Boards must commission, three Boards have established a Programme of Care based approach with multidisciplinary Programme of Care (POC) teams covering such areas as :

- Acute services
- Maternal and child health
- Mental health services
- Care of the Elderly services
- Services for those with learning disabilities
- Services for those with physical disabilities
- Health Promotion

The Western Board, however, has recently moved to a client/patient-based approach with multidisciplinary commissioning teams for:

- Adults
- Children

The Northern Board does not have an Acute POC Team as such. Instead, it has a number of topic specific group e.g. renal group, cardiology, trauma and orthopaedic groups. It also uses time-limited groups to look at specific topics e.g. urology, COPD services and rheumatology.

Regardless of the organisational arrangements within which commissioning teams work, the teams are all multidisciplinary with representatives from all relevant disciplines including medicine, nursing, allied health professionals, pharmacy, social services, primary care, information, planning, contracting and finance.

### **3.2.4 Regional Medical Services Consortium (RMSC)**

RMSC is the forum where the four HSS Boards agree service developments in regional acute services e.g. cancer, specialist drugs. Collectively the four Boards consider service development proposals for regional specialties and allocate funding against agreed priorities. The collaborative approach in RMSC reduces the risk of inequitable provision of regional services. Sub-specialisation arrangements within RMSC are discussed later.

### **3.2.5 Local Health & Social Care Groups (LHSCGs)**

LHSCGs commission a specified range of services for a defined population within Board areas. They are Committees of the HSS Boards and are therefore accountable to them. Their work programmes and commissioning plans must therefore be consistent with Board Corporate Plans and strategic direction. Public health

staff have different arrangements for involvement with LHSCGs in different Board areas.

### **3.2.6 Other service development related activities**

Public health staff lead, or contribute to a range of other activities which indirectly inform service development e.g. regional groups on implementation of the Consultant Contract and Junior Doctors Working Time Directive, Professional Advisory Groups including Prescribing Forums, Nursing and Medical Advisory structures and probity work in general medical and dental practices.

### **3.2.7 Subspecialisation in Northern Ireland**

Public Health staff involved in service development have subspecialty knowledge and skills through their Programme of Care responsibilities. In addition, within regional commissioning, RMSC members are nominated to lead on individual services. The nominated lead keeps up-to-date with developments in their respective services and acts as the first point of contact for providers and RMSC itself. This arrangement helps to reduce duplication of effort while ensuring that specialist knowledge is maintained and services are kept under review.

### **3.3 *Commissioning functions***

Public Health staff on POC and other commissioning teams provide some key functions most notably:

- Development of an overall strategy which outlines the broad strategic direction for services including integration across primary, community and secondary care
- Development of redesign and investment plans for individual services which describe in more detail current service provision, current demand on services, the gap between demand and capacity, and recommendations for redesign of existing services and need for additional investment. This capacity/demand analysis and needs assessment is a core Public Health skill

- Identifying, collating and presenting evidence of good practice, drawing from a range of sources including published literature, modernisation initiatives and national guidelines
- Promoting continuous quality improvement and modernisation by bringing a data-driven, evidence-based approach to service development plans
- Appraising service development proposals from Trusts, giving a view on appropriateness, cost-effectiveness, impact on patient care and regional targets
- Setting priorities. The funding demand for service development and redesign far outstrips any additional funding available. It is therefore necessary for Boards to prioritise their annual programme of investments. Public Health staff have a key role in advising Boards on service development priorities
- Monitoring Trust performance against service and budget agreements. In most Boards, Public Health staff attend contract monitoring meetings between the Board and Trusts. These monitoring meetings typically focus on Trust performance against contract volumes, Trust cost pressures and other operational difficulties in providing services commissioned. However, in the Northern Board, Public Health staff and other staff with a clinical background typically do not attend these contract monitoring meetings and the lead is taken by staff from Contracting, Finance and Information. The advantage of attending these meetings is that Public Health staff have a better understanding of operational difficulties in delivering services. The main disadvantage is that they then get drawn into issues which may be considered to be a Trust responsibility
- In addition, Directors of Public Health in particular, meet with District Council members, Members of the Local Assembly and local political parties to present and discuss Board strategic service plans

### **3.4 Skills Required in Service Development**

All Public Health staff who are involved in service development require the following skills:

- Leadership and change management
- Analytic skills and focus on data-driven commissioning
- Ability to identify, collate and present evidence-based practice
- Awareness of developments in clinical practice, including new technologies and drugs
- Ability to evaluate existing services, identify service needs and prioritise service development

There are a number of specific skills which Public Health-trained staff bring to the commissioning process:

- *A population-based approach to commissioning.*

Public Health staff are trained to consider service development across a wide range of services, sectors and organisations. Individual clinical staff in Trusts can provide guidance on the needs of their specific services and patients but when considering the relative prioritisation of one service over another may have views influenced by their own professional perspective. By contrast, Public Health staff are trained to consider the different perspectives of clinical staff, service users and other stakeholders and to take these perspectives into account in finalising service development priorities.

- *Brokering, managing conflict and facilitation skills, with clinical credibility*

Service development is as much about redesign of existing services as it is about deployment of additional investment. Delivering redesign of existing services requires buy-in from

clinical staff in Trusts. Getting clinical staff commitment to service redesign is extremely challenging, particularly when redesign involves change across disciplines, Trusts and across primary, community and secondary care. Public Health staff are well placed to help bringing a resolved view where opinions differ strongly. They are typically viewed as a neutral broker with no personal agenda and they also bring the clinical credibility that clinical staff in Trusts look for when discussing service redesign and improvement.

- *Analytic skills*

Public Health staff are trained in needs assessment and bring population-based analytic skills that others do not necessarily have. They typically lead the design of needs assessment; they understand the limitations of data sources and can interpret and present the results of analysis in a meaningful way to a wide range of audiences. Public Health staff therefore promotes a data-driven approach to commissioning and to the evaluation of services.

- *Health improvement and health protection skills*

Service development, from primary prevention through to tertiary care provides important opportunities to take forward the overriding public health goals of securing and improving the health of the population. Clinicians and service managers play crucial roles in both health improvement and health protection and an integrated public health approach can utilise public health skills effectively in pursuit of these goals.

## 4. GUIDANCE ON COMPETENCIES IN RELATION TO SERVICE DEVELOPMENT

### 4.1 *Faculty of Public Health*

The Faculty of Public Health has established competencies for the 10 key areas of public health practice which cover the three domains of public health, namely health protection, health improvement and service development. These 10 key areas of practice apply to all Faculty members including Consultants in Public health, Specialist Registrars in Public Health, Public Health Specialists and professionals on the UK Voluntary Register.

**Table 1. The 10 key areas of public health practice**

1.	Surveillance and assessment of the population's health and well-being
2.	Promoting and protecting the population's health and well-being
3.	Developing quality and risk management within an evaluative culture
4.	Collaborative working for health
5.	Developing health programmes and services and reducing inequalities
6.	Policy and strategy development and implementation
7.	Working with and for communities
8.	Strategic leadership for health
9.	Research and development
10.	Ethically managing self, people and resources

A number of the key areas of practice are of particular relevance to taking forward the public health role in service development.

The Faculty of Public Health is currently exploring the potential for a new subspecialty in healthcare public health. A project is underway to define the knowledge, skills and competencies needed by both specialists and generalists working in this area of public health. A workshop was held in December 2005. The outputs of this workshop will form the basis of a document to go to Faculty Board in the spring of 2006, considering the options for securing and implementing this new sub-speciality.

#### **4.2 Specialist Services Commissioning**

Competencies have been proposed for Specialist Services Commissioning.<sup>1</sup>

Guidance on Specialist Services Commissioning (SSC)(March 2003) emphasised that Public Health Practitioners should be included in SSC teams. The Public Health competencies required are as follows:

- Surveillance and assessment of the health of the population
- Managing, analysing and interpreting information and statistics
- Professional advice
- Developing and influencing policy
- Communicating with the public: public health advocacy
- Prioritising in health and health care
- Developing quality and an evaluative culture
- Education and research

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<sup>1</sup> ph.com June 2005. Faculty of Public Health Medicine.

- Other skills such as conflict management, negotiation, mediation, courage.

### **4.3 *Public Health Nursing and Service Development***

The standards of proficiency for Public Health Nursing underpin the ten public health competencies. They are grouped into four domains:

- Search for health needs
- Stimulation of the awareness of health needs
- Influence on policies affecting health
- Facilitation of health enhancing activities

## **5. PUBLIC HEALTH ROLES IN SERVICE DEVELOPMENT IN UK AND REPUBLIC OF IRELAND**

### **5.1 Service development roles in the UK**

#### **5.1.1 Service development roles in England**

In England there is an ongoing process of reorganisation. “Commissioning a patient-led NHS<sup>2</sup>,” outlines the process for improving commissioning. This includes consideration of the optimal configuration of Primary Care Trusts (PCTs), Care Trusts and Strategic Health Authorities (SHAs), with changes being completed by December 2008. Public health practitioners are mainly involved in service development at PCTs and SHAs.

The National Specialist Commissioning Advisory Group (NSCAG) commissions very specialised services for England which need to be provided in a small number of centres and planned and funded on a national basis.

#### **5.1.2 Service development roles in Scotland**

A recent article in ph.com describes the current arrangements for service commissioning in Scotland and how public health practitioners contribute to this function:

*“Planning services in Scotland is mainly the responsibility of the 15 health boards. However, some services (breast screening programme and tertiary/ quaternary services) are commissioned by the National Services Division (NSD) . A national planning exercise is also underway to advise on strategies to secure a sustainable configuration of health services in Scotland for the long term. The views of both regional and health board planners are offered.*

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<sup>2</sup> Commissioning a Patient-Led NHS. Department of Health 2005.  
<http://www.dh.gov.uk/assetRoot/04/11/67/17/04116717.pdf>

## **Regional Planning**

*The NHS in Scotland does not have a formal 'regional tier' however the health boards do have a statutory duty to plan over board boundaries to ensure sustainability of services. This has become formalised and has led to the appointment of three director level posts to work with the three regions in Scotland. Traditionally boards have worked together to ensure access to regional specialist services. They are now realising the potential benefits of working together to plan other services e.g. unscheduled care and capacity to deliver waiting times targets.*

*More controversially there is now a desire to consider the best configuration of secondary care services e.g. cardiology. At its best regional working should enable service and workforce planning across a region which should allow populations to access a wide range of sustainable services. The engagement of public health specialists in the planning often adds a sense of balance and perspective to the views of the specialists delivering the services. At its worst regional planning could work in a parallel universe to that inhabited by board planners and those delivering NHS services. This is why regional planning needs to be everybody's responsibility because patients aren't hindered by boundaries (nor should we be!).*

## **Board Level**

*Public Health provides a breadth of perspective in commissioning and may compliment managers focused on one part of a problem. Setting up a back pain service, for example, could be easily restricted to the immediate care element. A wider view would include the links to prevention, primary care, secondary care, the appropriate diagnostic facilities, psychology, and employment issues. Public health will only succeed in ensuring the broad perspective is used in planning services if it moves beyond the "Needs Assessment" approach and understands (and pushes!) the buttons to ensure implementation.*

*These include:*

- 1. The political (and sometimes the Political) imperatives (e.g. waiting times) and ensuring the plan addresses these*
- 2. Persuading individuals with local decision-making clout*
- 3. Identifying funding to support the plan*
- 4. Ensuring inclusion in the Health Plan*

*Developing networking skills is vital. Job stability is a large contributor, and does not necessarily conflict with finding out what is happening in other places — short secondments and visits are all perfectly possible. Email groups sharing experience will enhance and share knowledge. Once funded, public health has a role in ensuring that providers carry through the broad approach, that the right connections are made between different parts of the NHS, local authority and voluntary organisations, to deliver the vision in the needs assessment and develop the service even beyond that.*

***Jennifer L Armstrong — CPHM, National Services Division***

***Heather Knox — Regional Coordinator, West of Scotland Regional Planning Group***

***Caroline Morrison — CPHM, NHS Glasgow”***

**(Source ph.com June 2005**

**[http://www.fph.org.uk/policy\\_communication/downloads/publications/phcom/phcom05/phcom\\_june05.pdf](http://www.fph.org.uk/policy_communication/downloads/publications/phcom/phcom05/phcom_june05.pdf)**)

### **5.1.3 Service development roles in Wales**

In Wales, there is one body responsible for all tertiary specialised commissioning in Wales known as “Health Commission Wales”. It has an annual budget of £490 million (14% of NHS Wales's annual budget) with 8 Specialised

Commissioners, a Chief Executive, Director of Finance, Director of Corporate Affairs/Commissioning, Medical Director (consultant in PHM) and Deputy Medical Director (consultant in PHM) and a head of Clinical Governance reporting to the Medical Director. There is a Non-Executive Chair who is one of the Pro-Vice Chancellors of Cardiff University.

There are 22 Local Health Boards (LHBs) in Wales and they have the commissioning responsibility and the money for primary and secondary care commissioning and are totally financially divorced from Health Commission Wales. The LHBs have no financial stake in HCW, as its budget is top-sliced every year from NHS Wales's annual budget.

(Source: Ash Paul – personal communication)

## **5.2 Service development roles in the Republic of Ireland**

Prior to the recent re-organisation and the setting up of the Health Services Executive the Public Health Service Development role was carried out in effect both in the Department of Health & Children and in the Health Boards. Although the Department of Health & Children had been mostly involved with Policy, it also became involved in operational issues.

In the Boards, by contrast, there was significant expertise in terms of needs assessment, skills etc, to perform the Service Development roles adequately. Without appropriate Policy or Strategic guidance such developments tended to be on an ad hoc basis and thus could not contribute coherently to national service development.

Since the Health Services Executive has been set up, some of the Service Development skills have begun to be centralised more appropriately and strategic thinking has been facilitated. However, some of the Public Health recruitment has not been directed at attracting specialists in

Service Development for their expertise and therefore it may take some time for a centre of excellence to develop in the area of Service Development. The idea is that this will facilitate the work in the remaining Public Health Departments in the periphery of the Republic who will be guided by, and work with, the HSE Headquarters.

## **6. CURRENT ISSUES FOR PUBLIC HEALTH SERVICE DEVELOPMENT ROLES IN NORTHERN IRELAND**

### **6.1 *Introduction***

An environmental scan of issues which will impact on the service development roles of public health practitioners was carried out by the Project Team and quality assured at a series of five focus groups held in the four Boards and DHSSPS.

### **6.2 *Demographic and epidemiological issues***

Over the next 25 years there will be significant changes in the demographic and epidemiological profile of the population at regional and local levels. Public health practitioners have a responsibility to ensure that service development strategies and plans are in keeping with predictable changes in the population profile and flexible enough to cope with unexpected changes. Particular issues identified during the environmental scan included:

- The impacts for services of an increasing elderly and a falling child population
- Increasing immigration leading to more racial diversity
- Emergence of new disease and threats such as antibiotic resistance
- Changes in chronic disease trends such as a major rise in diabetes if obesity patterns do not change
- Rises in public expectations as to the levels and quality of services to be provided

### **6.3 *Clinical developments***

Developments in technology, drugs and the organisation and delivery of clinical practice are having wide impacts on service delivery. Public health practitioners involved in service development need to be up to date with these changes and need to ensure that they have close working

relationships with clinical colleagues from different professions and disciplines. They also need rapid access to evidence on the impact of these changes and developments in order to provide effective guidance on priorities for service development.

#### **6.4 Strategic developments**

A long list of planned strategic developments was identified during the environmental scan and many of these require input from practitioners with public health expertise. There will be a need to prioritise the strategic agenda and to identify how to ensure that scarce public health skills are best utilised to achieve agreed strategic goals and targets. The developments identified included among others:

- A Healthier Future
- Developing Better Services
- Investing For Health
- Priorities For Action
- Primary Care Strategy
- Community Pharmacy Strategy
- Oral health Strategy
- Mental health and Learning Disability Review
- Appleby Report
- Hall 4 Report on Services for Children
- Specific strategies on areas such as Chronic respiratory disease, Diabetes, Trauma, Obesity, Healthcare Acquired Infections and Sexually Transmitted Diseases
- Regional Cancer Framework
- Implementation of NICE and CREST Guidance
- Regional Information and Communications Technology Strategy

## **6.5 *Priority Themes***

A number of key themes for service development are requiring focused input from public health practitioners at present including:

- Moving from cure and care to prevention and screening
- An increasing emphasis on developing Networks of Care
- Service Modernisation including new delivery models such as ambulatory care, elective centres, and managed care for chronic diseases
- A increased focus on quality and safety
- Improving service efficiency, performance management and developing Health Economies
- Whole System Thinking

The analytic and change management skills of public health practitioners are very relevant to help take these themes forward.

The financial environment looks likely to be very constrained for the foreseeable future and there will be a clear focus on the effectiveness and efficiency of interventions. There is a need to ensure that public health practitioners are utilising skills appropriately in this environment.

## **6.6 *Public Health Developments***

Participants at the Focus Groups identified a number of specific developments affecting the Public Health Workforce of particular importance in designing strategies for effective deployment in relation to service development including:

- Establishment of Public Health as a multi-disciplinary activity
- Developments in training including the new Faculty examination arrangements and the Voluntary Register

- The potential development of sub-specialisation in health care related public health
- Developments in knowledge management such as the National Electronic Library for Health
- The increase emphasis on population health within NICE
- The recognition of the need for integration of the three domains of public health (health improvement, health protection and service development) and to underpin these with effective health intelligence

### **6.7 Organisational Developments**

Over the next five years, following decisions on the Review of Public Administration, there will be very significant changes in the organisational arrangements within which public health practitioners operate in Northern Ireland. These are considered further in Section 8 below.

A number of other organisational changes of importance to the service development roles of public health were identified during the environmental scan including:

- The establishment of HSSRIA
- Regional developments in Clinical Audit
- The establishment of closer links to NICE and local processes for considering NICE guidance
- New organisational roles in the rest of the UK and in ROI

## **7. ASSESSMENT OF VIEWS AS TO HOW PUBLIC HEALTH ROLES IN SERVICE DEVELOPMENT COULD BE ENHANCED**

### **7.1 *Description of Approach***

The Project Team carried out an initial analysis of the strengths, and weaknesses of public health in relation to service development and current opportunities and threats in relation to these roles. This helped the group develop a list of questions to identify areas for action. The analysis was shared and the questions posed at five focus groups and at a Regional Review Workshop. A summary of the SWOT Analysis is presented in Figure 2.

### **7.2 *What should be the focus of public health in relation to service development?***

Participants at the focus groups agreed on the key areas of focus for public health practitioners involved in public health as including:

- Focusing on improving the health and wellbeing of the population
- Tackling inequalities
- Using and disseminating evidence
- Moving the emphasis from treatment to prevention
- Assessing the impact of proposed service changes on health outcomes
- Carrying out analysis of population need
- Carrying out service evaluation and identifying R&D priorities
- Focusing on service redesign and not just development
- Helping to develop and implement strategies, policies and guidelines
- Facilitating service changes especially across organisations
- Providing analysis to support prioritisation processes
- Working across commissioning and providing boundaries
- Identifying, assessing and synthesising relevant information
- Leading in public health specific areas such as screening
- Contributing to improvements in service quality and safety

# Figure 2

## SWOT Analysis of Public Health Roles in Service Development in Northern Ireland

### Strengths

Knowledge of the System - local & regional  
Experienced practitioners in different disciplines  
Collaborative approaches e.g. RMSC  
Recognised expertise in key areas  
Adaptability & multitasking  
Trained workforce and subject to CPD & Appraisal  
Bring objective analysis and a population perspective  
Good local networks & links to clinicians  
UK links and cross-border links  
Stable workforce

### Weaknesses

Service Development Roles not clearly defined  
High levels of Multitasking and Fire fighting  
Lack of emphasis on Research & Evaluation  
Duplication of effort between organisations  
No agreed programme of public health priorities  
Difficult to develop necessary specialisation  
Lack of expertise in some new approaches  
Under utilisation of key skills e.g. health economics  
Weak links to primary care  
Lack of coordinated regional CPD programme

### Opportunities

Increase access to knowledge e.g. NELH & NICE  
Build on new Education & Training arrangements  
RPA provides opportunity to clarify & define roles  
Exciting & challenging strategic agenda to tackle  
Strengthen Linkages to emerging networks  
Build effective links to primary & community care  
Increase role in emerging safety & quality agenda  
Build on IFH roles within Service Development  
Strengthen input of multi-professional public health  
Strengthen links to R&D agenda

### Threats

Impacts of reorganisation

- Loss of focus on priorities
- Loss of expertise & corporate memory
- Stagnation in recruitment and promotion opportunities
- Key system players focused on reorganisation

Too many issues & projects on the Strategic agenda  
Financial and workforce issues  
National uncertainty on PH Service Development roles  
Wide range of people in Service Development roles  
Operational issues deflect from long term actions

### **7.3 *What skills need sharpened to tackle the emerging agenda?***

Key points emerging at the focus groups included:

- There is a need to focus on whole system redesign and new ways of working rather than on change at the margins
- We should garner and utilise knowledge and evidence from international sources as well as make better use of UK sources
- Analytical skills need sharpened and there should be an increased focus on critical analysis and data-driven change
- Public health practitioners need to maintain knowledge of clinical developments
- Public health practitioners from different disciplines need to share a common language
- Leadership, communication and prioritisation skills will be critical to take forward the emerging agenda
- Systems thinking approaches are emerging as a core skill for public health
- An increased awareness of legal issues for service provision is likely to become important, for example on human rights
- There is a need to make better use of lobbying and influencing skills to ensure that public health goals are achieved
- Health economic skills could be more effectively deployed to help in prioritisation
- There is a need to identify surge capacity and approaches which avoid the need to deflect from important initiatives to fire fight
- Building better relationships with the media and taking more proactive media approaches

#### **7.4 *What areas of expertise could be better utilised to enhance service development functions?***

Participants identified a range of areas where public health expertise could be better utilised including:

- Avoidance of duplication of effort between organisations through sharing resources and expertise
- Developing of effective knowledge management so that sources of local expertise can be rapidly identified and accessed.
- Too many service developments are not subjected to evaluation and evaluation skills developed during training are not appropriately used
- Effective involvement of users in service development processes
- Analytical approaches to measuring the anticipated public health benefit of service developments and evaluation as to whether these benefits were realised
- Utilisation of health economic skills and presentation of information appropriately to support decision makers
- Turning evidence into practice by building on approaches from other areas such as the Institute of Healthcare Improvement in US
- Performance management on quality and assessing how services are meeting appropriate standards

#### **7.5 *How can we make the best use of knowledge to support service development roles?***

The importance of accessing, utilising, sharing and storing knowledge emerged as a key theme in relation to building more effective involvement of public health practitioners in service development. Important issues include:

- Focusing on asking the right questions
- Developing rigorous, systematic approaches to gathering evidence

- Making effective use of a wide range of professional expertise
- Allowing individuals to build up expertise in particular areas and then to use and share it across organisations
- Building better systems and approaches which avoid practitioners being swamped by data and emails
- Ensuring that there is easy access to completed work across organisations to avoid reinventing the wheel.
- Link individual practitioners into Communities of Practice so that they know where to access and share expertise

**7.6 *How can we ensure that specialist expertise is identified, available and shared across the system in Northern Ireland to avoid duplication of effort and reinventing the wheel?***

Focus Group participants made a number of suggestions as to how to share specialist expertise across the system:

- Development of formal and informal networks which are empowered to work across organisations
- Develop live communication links with up to date profiles of practitioners, their special interests and what they are working on
- Develop regional leads for specific areas and allocate them sufficient time to develop their expertise
- Develop a database of good practice
- Build a more effective regional CPD programme at which practitioners present areas of work and common issues are discussed
- Identify sources of clinical expertise and ensure public health practitioners in different organisations are aware of these
- Identify organisational and individual barriers and concerns about sharing expertise and agree how these can be overcome for mutual benefit

### **7.7 How can the public health workforce tackle urgent issues which divert public health energy from more strategic issues?**

A common theme emerging at the focus groups which underlies many of the difficulties for public health practitioners in service development is that operational issues and immediate priority requests divert attention from work on strategic action to achieve long-term public health gain. Suggestions as to how to address this issue included:

- Invest sufficient effort to tackle the root causes of recurring sources of fires
- Establish triage systems to categorise urgent requests, to distinguish the urgent from the important, and ensure that only appropriate resources are devoted to them
- Agree a limited number of high value strategic objectives and priorities
- Improve performance management systems for public health
- Inform people if their deadlines are unrealistic
- Identify any tools which help us to handle issues more efficiently and document and learn from past experience.
- Maintain an effective risk register and ensure that action from high risk areas remains prioritised
- Recognise that communications issues may lie at the heart of some urgent issues and ensure that the issue is well specified to avoid waste of effort

### **7.8 How can we ensure that the improvement of public health is the overall focus of service development?**

Focus group participants recognised the need to ensure that public health improvement underpins all service development action. Suggested actions to ensure that this happens included:

- Identifying a limited set of top service development priorities from a public health perspective and effectively lobbying to have these implemented
- Identifying key priorities within each organisation and working to ensure the organisation concentrates on these priorities
- Carrying out a diary exercise and assessing where time should be reallocated to more high value activity in terms of improving public health
- Focus on developing better ways to link service development work to improved health outcome and where services could be redesigned to maximise health gain
- Examine approaches being employed in other UK regions and in other countries
- Carry out an analysis of the different commissioning models now being used in different Board areas to identify any approaches which are being more effective in aligning service development to health improvement

## 8. IMPACT OF DECISIONS OF THE REVIEW OF PUBLIC ADMINISTRATION

### 8.1 *RPA Decisions on future HPSS Structures*

In November 2005 the Secretary of State announced the outcome of the Review of Public Administration. The new organisational structures will impact on the locations in which public health practitioners practice and on the roles they carry out in relation to service development, health promotion and health protection. The new organisational structures include:

**The Department of Health, Social Services and Public Safety** which will be accountable to the Minister for policy development.

A new **Strategic Authority** which will replace the 4 Health and Social Services Boards and include some current departmental functions. It will be responsible for implementation of policy through resource allocation, service commissioning and performance management. It may also hold the responsibility for the delivery of statutory functions.

Seven new **Local Commissioning Groups** which will be local offices of the Strategic Authority and will be responsible for ensuring that commissioning is locally sensitive. These groups will be coterminous with new **District Councils** and will link to new arrangements led by District Councils for community planning. New arrangements for linking primary care into commissioning will also be developed.

**Five new Health and Personal Social Service Trusts** to replace current Trust structures which will be responsible for the delivery of health and social care and will be accountable to the Strategic Authority for service delivery.

The new **Health and Social Services Regulation and Improvement Authority** will continue to be responsible for

the inspection and quality improvement functions it was established to undertake.

## **8.2 *Potential contributions of public health practitioners***

The working arrangements for the new organisational systems are now being developed. Nevertheless, at this early stage it is clear that the skills of public health practitioners will be of considerable value throughout the system and that the new structures provide a unique opportunity to establish arrangements to maximise the effective contribution of public health to service development.

Public health expertise will continue to be required to support policy development at DHSSPS level. The strategic planning, resource allocation and regional commissioning functions of the new Strategic Authority will require public health input from a range of disciplines, as will the functions of the new Local Commissioning Groups. The change facilitation skills of public health practitioners will be of value to support service development taking place at Trust level and to help build on the opportunities which will be created by bringing a wider range of facilities under a single management structure.

The new arrangements will also provide new opportunities to ensure service planning and commissioning is effectively linked to cross-agency working on Investing for Health goals and targets and to integrated arrangements for health protection.

## **8.3 *Relevance of Work carried out on the Project to date***

The work of this project has highlighted several key issues with the current working arrangements for public health practitioners focusing on service development. This work can help inform the development of effective arrangements to support the new system and ensure a strong emphasis is maintained on improving the health and wellbeing of the population.

#### **8.4 Design Principles for new arrangements**

The following principles are recommended for designing new arrangements to ensure effective contribution of public health to service development in the new organisational structures:

- *There should be clarity about where and how the three domains of public health are integrated within the system*
- *The new system should be designed to identify the needs of **specific** populations and develop services to meet those needs*
- *The system should be designed to enable individual practitioners to develop and to utilise appropriate specialist expertise*

This is likely to involve the creation of public health networks and the identification of public health leads for specific service areas. Public health leads would be expected to develop their knowledge base for their service area, and establish effective linkages with relevant clinicians and patient and user groups. Their expertise should be available to input to relevant processes at DHSSPS, Strategic Authority and local commissioning levels level when appropriate.

- *There should be an agreed set of service development priorities for public health practitioners to address and a project managed work programme to take these forward*
- *The system should aim to avoid duplication of effort and this will require clarity about the roles of different levels in the new system and accountability arrangements*
- *The system should be designed to identify and tackle recurrent issues which lead to fire fighting and deflection of effort from prioritised work programmes*
- *The system should be supported by effective arrangements for knowledge management*

- *Public health practitioners specialising in service development should be expected to maintain and develop their skill base in line with emerging guidance and there should be an active programme of Continuous Professional Development to support this.*

## **9. NEXT STEPS**

- 9.1 The planned next stage for the Project was to consider the issues emerging from the Products completed to date and develop an Action Plan by March 2006 to take these forward. Following the decisions taken on the Review of Public Administration the way forward needs to be placed within the new context.
  
- 9.2 The Interim Report will be forwarded to the Chief Medical Officer to inform the work of the newly established Public Health Function Project Team which has been set up as part of the HPSS arrangements to implement the decisions of the Review of Public Administration.