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By email:

Llywodraeth Cymru
Welsh Government

16th July 2018

Dear Huw

COLLABORATIVE ARRANGEMENTS FOR MANAGING LOCAL PUBLIC HEALTH RESOURCES – CLOSURE OF ACTION 1A

I'm writing to you in your capacity as SRO for the programme of actions responding to the above WAO review.

Welsh Government took on an action that was agreed as part of Public Health Wales' management response, namely:

> *"1a) In the context of the Wellbeing of Future Generations Act, Welsh Government to establish a mechanism to describe the public health leadership system, including the respective roles and responsibilities for the specialist public health system and to develop options for consideration by all relevant bodies on an operational model for specialist public health at a local level"*

These interlinked tasks were primarily discharged through the establishment of a small Task and Finish Group (with representation from Welsh Government, Public Health Wales, and Health Boards) as well as through the holding of a limited set of bilateral discussions.

A high level description of roles and responsibilities within the Public Health system in Wales

The task and finish group considered the features of an optimum public health system, informed by relevant literature, and then mapped those features within a Welsh system and context. The output provided a description of roles and responsibilities within the Welsh system. The output was shared with the Public Health Directors Leadership Group, and feedback from its members has been incorporated into an updated version attached at Annex A.

Operating models for specialist public health at a local level.

The Task and Finish Group also considered the key enablers required to ensure the system works optimally as well as the assurance needs of the system. These factors informed a high-level discussion of the pros and cons of various operating models for specialist public health at a local level. A summary of those options and the discussion of them is provided at Annex B.

Those discussions, as well as a limited number of bilateral discussions I held, informed my advice to the Cabinet Secretary. In summary, I did not see there being a compelling argument for organisational change to our current model of specialist local public health: I did not see the potential benefits significantly outweighing the benefits that could be achieved through

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improving the current system. All the organisational changes would carry significant risks that would be detrimental to performance in the short to medium term. The Cabinet Secretary for Health and Wellbeing concurred with this view.

There is significant scope for ongoing strengthening of the current system both through more formal mechanisms for collaboration and through more rigorous system assurance. These improvements should be our primary focus in the short to medium term. This does not preclude us from returning to the question of alternatives models in the future.

The management response to the WAO has been helpful. The actions within in have taken us forward and there is already improved collaboration between PHW and Health Boards. There is also scope for Welsh Government to be clearer about our expectations of the public health system and more systematic in our follow through against them.

I will be sharing this letter with the Public Health Directors Leadership Group and see that as the appropriate forum to track an ongoing improvement plan to further strengthen the system.

Yours sincerely

DR FRANK ATHERTON

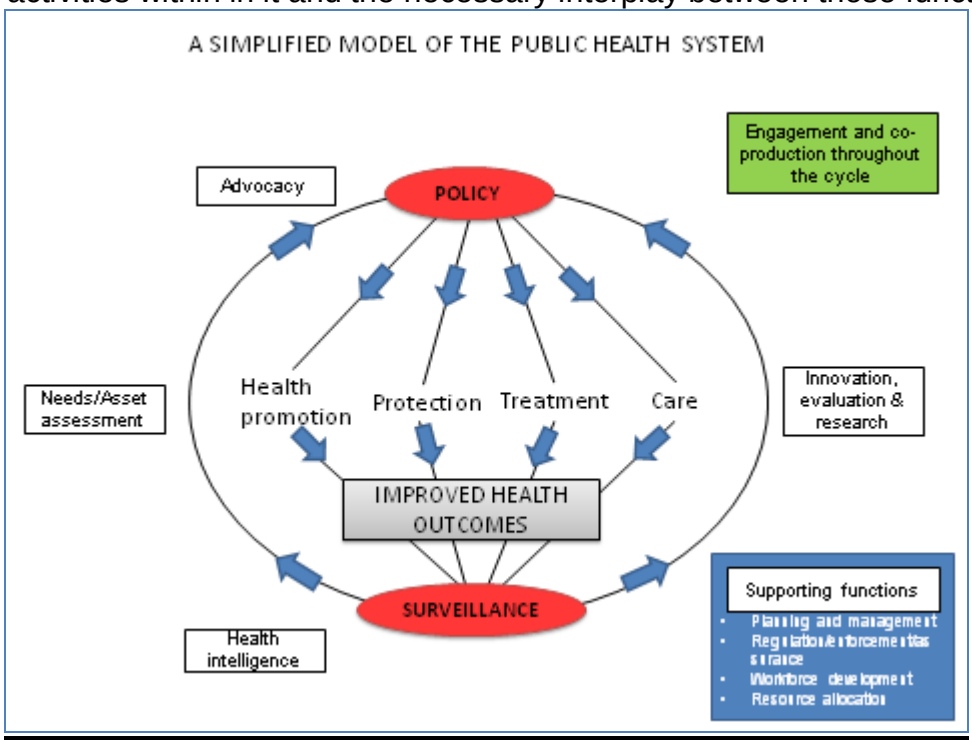
Copy: Andrew Goodall
Irfon Rees

ANNEX A

A model of the Public Health System

There are a number of functions and activities involved in promoting and protecting health and well-being, preventing ill-health and prolonging life. The interaction of these components forms a 'public health system'. The extent to which the functions and activities interrelate effectively, are appropriately resourced, and undertaken using appropriate skills and expertise, determine how well functioning a public health system is. System leadership and stewardship is required to ensure this is the case.

The following is a simplified model of a public health system, providing an overview of the functions and activities within in it and the necessary interplay between those functions:



Optimal functioning of the system relies on each function of the system being informed by and responsive to preceding activity in the cycle. Failure to do so can result in system failures – e.g. nugatory work; poor VFM through duplication of effort; policy based on partial information; poorer health outcomes.

The public health system in Wales – organisational roles and responsibilities

Welsh Government primarily acts as the system steward:

- Determining **policy and priorities**, leading to the production of statute, advice, plans or instruction.
- **Allocating resources** in line with those priorities
- Setting the system direction and assurance adherence through **regulation, enforcement, assurance, accountability**
- Commissioning policy **evaluation** when deemed necessary
- In the context of devolved responsibility, undertaken **advocacy** on priorities requiring UK action.
- **Surveillance** - through commissioning of national surveys

Public Health Wales is Wales' national public health organisation. Undertaking statutory functions, it has a **national** role in providing evidence-based leadership in the development of public health strategies and in the coordination of public health activities:

- Leads the public health **surveillance** system, and undertakes and provides **health intelligence** to provide information for action nationally and locally
- Undertakes **evaluation** and analysis of health status and **public health research** to guide policy and programmes,
- Undertake **policy advocacy**
- Translates policy into organisational and system wide **plans**
- Undertake and/or inform/provide assistance to national **prevention** and health promotion programmes
- Develop and implement actions to **control** public health problems and outbreaks
- Provide support and assurance to improve **quality of care and treatment**
- Support the ongoing development of a skilled **public health workforce** in Wales
- **Horizon scanning** for new and emerging threats to population health

Health Boards in Wales, with partners, have statutory responsibilities in relation to assessing and planning to meet the health and well-being needs of their local populations:

- **Planning, leading and management** of local health and wellbeing activity, in line with national policy and priorities and local needs assessment, working with partners as necessary
- Local **needs and asset assessment** both to inform national policy, advocacy and local delivery of priorities
- Delivery of **prevention and control** programmes, in line with national policy and priorities and local needs assessment
- Undertakes **public health advocacy**
- Translates policy into **organisational/partnership plans**
- Contribution to the **surveillance** system
- Leads the **local approach to healthcare public health**
- Delivery of high quality **treatment and care** for their local populations
- Partnership working

Local Authorities in Wales, with partners, also have statutory responsibilities in relation to the well-being of their local population.

- Civic and community leadership role
- **Planning and management** of defined local health and wellbeing services
- Contribution to **prevention and control** programmes, in line with national policy and priorities and local **needs assessment**
- Delivery of some aspects of **care** for their local populations
- Population advocacy
- Public protection **enforcement** activity

ANNEX B

The current model

In broad terms Health Boards (HBs) are responsible for improving the health of their defined local populations, a responsibility they can only discharge effectively by working in partnership with the public and a range of national, regional and local partners. HBs are required to appoint a Director of Public Health (DPH) to spearhead the local efforts to improve population health. Public Health Wales has a national role in providing evidence-based leadership in the development of public health strategies and in the coordination of public health activities. It provides specialist public health resources at national, regional and local level, including to HBs and their DsPH.

DsPH are responsible for directing and managing the work of their local public health team. Members of the teams are primarily employed by PHW but may be complemented by Health Board resource. The structures of those teams vary across the Health Boards.

We often refer to their being *distributed leadership* across the public health system in Wales, recognising that Welsh Government, Public Health Wales, Health Boards and Local Authorities should all have key public health leadership roles. This is to be expected given the distribution of health determinants and the levers to influence them. While it is important to have clarity and understanding of roles and responsibilities, it is equally important that we do not use the delineation of roles to entrench siloes. Rather, it is by these system actors finding optimum ways of working in partnership with each other, and using the Future Generations ways of working, that will allow for the move from transactionalism to transformation.

A high bar needed for the case for change

The WAO found there to be significant scope for improving the governance arrangements in place for local specialist public health resource and made a number of interim suggestions for how collaboration between PHW and Health Boards could be improved. The management response identified a broad suite of actions, focusing on greater clarity of roles and responsibilities, improved relationships and system capacity and capability.

Within the key action for Welsh Government was a commitment to develop options on an operational model for specialist public health at a local level. Implicit in the task is the recognition that there are different ways to structure specialist public health at a local level, as well as different mechanisms for ensuring any given model operates effectively.

The Task and Finish Group considered both issues. When considering the desirability of alternatives, the Group recognised that imposing structural change (e.g. changes to employment arrangements, in some instances requiring legislative change) carried significant risks. These include:

- Risk of distraction from what is already a very challenging agenda that includes responding to the parliamentary review, evolving and maturing PSBs, local government reform, development of PHW's 10 year priorities – as well as day-to-day delivery;
- Risk of damaging existing partnership arrangements;
- Risk of generating dissent, disagreement and half-hearted implementation;
- Risk of de-stabilising a valuable workforce

- Risk of diluting resources

It is therefore important that we set a high bar to be reached if making the case for structural change, and the perceived benefits would need to significantly outweigh the potential benefits that could be achieved by strengthening the current model.

The alternatives considered
The task and finish group considered the potential alternative operational models for specialist local public health resource, and had a brief discussion of the potential pros and cons of each option (naturally some of these were contested):

a) Transferring DsPH from Health Boards to Public Health Wales (would likely require some legislative change)

Pros
- Reduces the tension of dual accountability
- Facilitates more joint working between DsPH
- Potential for greater alignment between national priorities and local delivery
- Gives options for covering different regional foot prints

Cons
- Limits DsPH ability to influence HB resource/approach/direction
- Presentationally difficult – taking public health and prevention out of HBs
- Destabilises existing partnership arrangements

b) Local Public Health Teams transferring to Health Boards

Pros
- Simplifies local landscape – coherence, prioritisation
- Strengthens message that Health Boards need to be deliver against broader population health priorities
- Stronger local team identity

Cons
- Risk of fracture between national and local priorities
- Costly change process with risk of losing good staff
- Limits career progression opportunities for public health professionals within those teams
- Staff opposition (this was contested – would need further testing)

c) DsPH being jointly appointed by HBs and LAs (a suggestion in a previous CMO report)

Pros
- Potential to strengthen partnership working
- Bring a greater preventative focus to LA work – many of the levers for change do sit in local government

Cons
- Potential for fragmentation and conflicting pressures
- Potential for financial resources to be diluted

- Bad timing – local government reform

d) Local Public Health Teams being a pooled resource between local partners

Pros

- Greater potential to align around PSB priorities

Cons

- Existing difficulties in pooling budgets even in very discreet areas
- Lack of stability and maturity of current partnership arrangements
- Scepticism that it would work in practice

The case for strengthening the current system

In considering the alternatives, it was agreed that doing nothing also carried risks. The current model, unchanged for nine years, has deficiencies – some of which were identified in the WAO report.

Our model of distributed leadership carries both benefits and risks. Working effectively, our existing system should lead to greater cross-sectoral ownership of public health challenges leading to high quality decision making and high levels of motivation and enthusiasm. It should be more responsive to population needs and understanding of place, underpinned by a shared understanding of the evidence of what works and high quality health intelligence. It should allow us to be more entrepreneurial, generating innovation and ideas, and allow our diverse public health leaders to be visible, to role model, to grow and to learn from one another.
But a distributed leadership model also carries risks that need to be mitigated. Without a clear vision, priorities and set of values there is a risk of fragmentation. Without clarity of organisational roles there is a risk of internal competition and poor accountability. Without agility in our processes, decision making can be slow. As well as the above, our model is also dependent on the right leadership behaviours: good levels of trust must be built and maintained; our leaders need to be visible and engaged; there needs to be buy-in to a system vision and model; and there needs to be an openness to constructive challenge. All our leaders have a personal role in making the system work as well as focusing on their organisational responsibilities.

Recognising the above, the task and finish group agreed the need to focus on the key enablers to system effectiveness:

- Clarity of national expectations and alignment between them and local priorities
- Established processes for prioritisation
- Access to the breadth of necessary skills (e.g. epidemiology, behavioural science etc)
- Effective mechanisms to co-produce with local populations/understanding of place
- Effective collaboration between partners
- Effective mechanisms to influence resource allocation
- Effective mechanisms to influence cross-sectoral commissioning and decommissioning decisions
- Access to tools for evaluation
- Access to good data and analytics
- Access to workforce development
- Clear communication across the system

We would also need stronger mechanisms to assure ourselves that system effectiveness is improving, such as through:

- Improvement against agreed national outcomes
- Evidence of robust planning and reporting
- Evidence of co-ordination and co-operation between local partners
- Evidence of co-ordination and co-operation between regions
- Evidence of co-ordination and co-operation between local and national
- Effective use of evidence and evaluation
- Appropriate use of peer review and audit
- Development of organisational public health standards