Response from PHAST – Public Health Action Support Team

on

Healthy Lives, Healthy People: the strategy for public health in England.

We welcome the opportunity to comment on the proposals for public health in England, on this white paper and its related documents, but it is also necessary to consider them in the light of the overall NHS changes proposed.

There are massive opportunities to improve the health of the population by various of the mechanisms proposed. The challenge will be in the delivery of the changes to ensure that benefits are achieved and disadvantages are mitigated.

PHAST – **Public Health Action Support Team – is**, we believe, **the only public health focussed Social Enterprise** already established. We have been successful, over the few years of our existence, in delivering public health services to a range of clients and populations. We are disappointed that there is little focus on alternative models of PH delivery and would be pleased to meet with you to discuss our approach.

We are pleased that the public health white paper 'Healthy Lives, Healthy People' recognises the importance of public health issues in England and that it recognises that the public health function has **three domains**:
health improvement - including inequalities and wider social determinants of health
health protection – including infectious diseases, environmental hazards and emergency preparedness
health services – including planning, efficiency and effectiveness, audit and evaluation.
However the white paper focuses on prevention and protection and hardly mentions health services, failing to recognise the important role public health professionals play in designing, planning and ensuring equitable access to efficient and effective health services. This omission also fails to recognise the importance of health services themselves to people's health, particularly in terms of population assessments and equitable access to effective services. Indeed, if new forms of NHS commissioning are to tackle 'the unsustainable rise in emergency admissions' described by the Nuffield Trust in 2010 as 'the single biggest problem facing the health service in England', NHS commissioning bodies including GPCCs will need public health expertise to build on and develop further preventive approaches (Blunt, Bardsley & Dixon, 2010).
http://www.nuffieldtrust.org.uk/publications/detail.aspx?id=145&PRid=714

In terms of health improvement, in the white paper there is also a narrow interpretation of this focussing mainly on individual health behaviour. This approach is also evident in the outcomes framework document

We are pleased too, that the white paper is also the government response to **'Fair Society, Healthy Lives' - the Marmot Review** and that the white paper supports many of the Marmot proposals, including the life course approach, and in doing so recognises the importance of the 'causes of the causes' and that wider determinants need to be tackled to enable people to become healthier.
The proposed transfer of public health to local authorities (LAs) is welcomed in this respect as many of the LA responsibilities impact profoundly on health eg housing, education, environment, leisure, transport etc.
Many PH practitioners have been working 'across' to their LA for some time to address these issues, hence the frequent development already of 'joint' DPHs . There needs to be a recognition that in order to address the three domains of public health, PH, whilst it is/was part of the NHS, had to 'work across' to LAs , equally given the current proposals, PH will need to 'work across' to the NHS in order to address the three domains of PH. Without this recognition and acknowledgment there will be fragmentation and duplication.
The responsibilities of the various bodies need to be articulated more clearly.
The PH function does not have the capacity to afford such duplication and nor would it provide an efficient and effective PH service. It is already obvious that the current proposed changes are causing disruption, as does any major reorganisation.

Consultation Question: ROLE OF GPs AND GP PRACTICES IN PUBLIC HEALTH.
a) Are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?

We are pleased to see that both **QIPP and QOF** will remain as mechanisms to focus and incentivise prevention and outcomes, respectively. They will both need careful maintenance and development to ensure their suitability. Maintaining and building on these approaches, modifying suitably for the new regimes will be important.

There appears to be a **mismatch in the populations covered** as outlined in various policy documents and in response to questions. We are pleased that the white paper recognises that "the NHS has a crucial role to play in public health… ensuring that health services meet the needs of the whole population…") (para 4.46.) Our understanding is that the majority of commissioning for health services will be undertaken by GPCC, however there appears to be some confusion as to whether GPCC will be responsible for patient lists or populations. There are a number of contradictory statements and understandings and these need rapid clarification.
If GPCC are only responsible for their 'list' patients then those responsible for NHS commissioning (the national board and GPCCs) need to explicitly take account of those not on lists and have plans to (1) get people engaged in primary care and on lists and (2) provide health care for those who do not or cannot engage. This is a fundamental issue that needs to be addressed.
There is particular risk of not 'matching the needs of the whole population' and it is likely that the more disadvantaged, disaffected and seldom heard groups – who are likely to have more health needs- will be doubly disadvantaged and will not have their 'needs' provided for in the commissioning process.

One of the crucial issues for people's health is to ensure that the full pathway is being commissioned and delivered. **The pathway** covers:
wider determinants – prevention- screening and diagnosis- treatment – rehabilitation - care .
The proposed changes both to the NHS, social care and PH need to ensure that this full spectrum is covered and seamless, both in terms of commissioning and provision. At the present time the proposals appear somewhat piecemeal and there is a serious risk of fragmentation, and people falling down the 'gaps'.
We recognise that the Health and Wellbeing Board (HWBB) is seen as the mechanism to draw things together at a local level. However the complexity of the commissioning arrangements at national, sub-national and local level and between different responsible bodies (eg as in table A of the Funding and Commissioning routes consultation – see also PHAST response to the Funding and Commissioning routes consultation) , we consider there is a very real risk of fragmentation and omissions and duplications. In the present economic climate when all parts of the public sector have to make significant savings, there will also be a risk of cost shifting and games playing between organisations. We are already seeing some LAs suggesting that the new ring-fenced public health budget will be used to fund activities which are currently already funded by LAs.
There needs to be absolute clarity as to who is responsible for what and streamlined mechanisms by which they can be held to account.

Consultation Question: Public Health Evidence
b) What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?

PHAST sees this as a crucial area and has a number of comments and suggestions to make. We would be happy to discuss and expand on these. We have extensive expertise in this area and set out at the end some aspects where we could assist.

1. First and foremost there needs to be an **information and intelligence strategy** so that the best use is made of existing information and intelligence sources and also that new requirements are identified and implemented in a structured way. This needs to build on the work already undertaken and in existence and link to both information systems in NHS and LAs
2. We need to make sure that existing sources of information and intelligence are readily accessible to users. Plans for maintaining and updating key sources should be in place. There is currently a multiplicity of primary and secondary sources of information (eg over 70 systems producing surveillance information) so a streamlining and rationalisation process is required. Work on surveillance was undertaken in 2009 through the 'Informing Healthier Choices' programme (DH) and should form the basis of further work.
3. It will be vital to retain existing information flows during the reorganisation and to ensure they remain available to all users. There is a high risk that as more organisations are created and new people fill slots, existing data are lost and that these are not identified until it is too late. As an example PCTs currently receive data that will be vital to retain for the future.
4. There will be an educational task required to help new and existing users find the necessary information and learn how best to use it. They will also need

access to specialist Public Health and analytical skills to support commissioning and other activities. In addition there has been (rightly) a lot of emphasis on developing modelling tools to assist local decision making. Again a considerable number of modelling and related tools (eg prevalence modelling) were developed through the 'Informing Healthier Choices' programme. This programme has now been completed but there is risk that this is 'hidden' and it requires further promulgation to the relevant and 'new' audiences, such as GPCCs. There should now also be a focus on supporting users to make best use of such tools for commissioning and other activities.

5. Current public health analysts should not be lost to the system by default as their skills will continue to be needed. As posts are cut there is a risk that those not specifically identified as public health will be cut and vital expertise will be lost.
6. As new organisations are created and new people fill posts it will be important to emphasise the importance of adhering to national information standards and definitions for data produced by the Information Centre so that local organisations may properly compare themselves to each other and also so that the public is able to make choices.

We in PHAST were contracted to deliver the programme **'Informing Healthier Choices'.** This developed an extensive array of 'tools', evidence, intelligence, training modules etc. Unfortunately the programme was curtailed and further promulgation is required. The products, including disease prevalence modelling, population profiles, health impact assessment and training modules etc, would be of benefit to both PH and to GPCCs.

As part of this PHAST made a **proposal for a single portal - 'a Public Health App' –** to bring access to all of these, plus existing intelligence, such as that in PHOs, cancer registries, surveillance, PH library for evidence etc, together. This was not taken forward but **we would be pleased to share with you the proposal and discuss how this could still be taken forward and how further promulgation of this extensive and expensive resource could be achieved. There is a real risk of 'reinventing the wheel'.**

The public health programme in **NICE including PHIAC** (Public Health Interventions Advisory Committee) has been productive and robust in producing evidence based guidance and recommendations on a variety of PH topics. As it is recognised that PH is not merely the domain of NHS and that public health is improved by action across many sectors, this advice needs to be suitable for and mandated to be taken up by all those sectors. We consider that the recent reductions to the PHIAC portfolio, even stopping some reviews in midstream, such as "Preventing unintentional road injuries to under 15s: education and protective equipment" is a retrograde step, fails to recognise the wider social determinants of public health and reduces the opportunities for evidence based action to improve public health across sectors, and particularly through LAs' responsibilities. Indeed some of these topics relate strongly to inequalities (such as the example above, where we know that there are markedly higher rates of childhood injuries in lower socioeconomic groups. With the precedent of evidence accepted in the Marmot

review, PHIAC and the PH programme in NICE needs to cover wider social determinants.

Information from multiple sources needs to be available to all. There needs to be a change in **culture to 'sharing' information** and PH needs to maintain access to NHS data, information and intelligence.

c) How can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness and tackling inequalities?

All aspects of research evidence are important.
We welcome the proposed **School of Public Health Research,** which needs to have a wide remit (see above), including research on all methodologies to achieve change and on wider determinants. We are pleased to see the continuation of NIHR (para 4.85) focussing on PH research and recognising the importance of working with 'partners whose actions affect public health' - we assume this means all partners and includes those necessary to address the wider determinants and health service aspects of PH.
There are major opportunities with the appointment of the new CMO – Professor Dame Sally Davies – continuing also to be Director of R&D.
The culture of 'evidence base' is however much stronger in NHS than in LAs which will need to be addressed.
Much effective work has already been undertaken in the areas you identify as 'gaps' eg in London major changes were made to 'wider determinants' policies eg transport and planning, by utilising such tools as rapid evidence reviews and health impact assessments. (Atkinson.S 'Governance for Health in London:Utilizing the Health Impact Assessment' in Vlahov.D et al 'Urban Health:Global perspectives' Wiley USA. 2010.)
These examples of good practice should be collated and shared. There should be recognition of and **incentivisation not only of innovative practice but also of 'copyism'** (albeit there may need to be some local modification).
Culture of evaluation and 'sharing' needs to be engendered rather than a 'competitive' approach, if the best is to be made of scarce PH skills.

PH support is recognised as needed across both NHS (GPCCs , Commissioning boards and in acute trusts) and LAs. However with 'separate' PH support there is a **risk of fragmentation and duplication.** These need to be guarded against by PH working across boundaries as it always has done, to use the public health resource efficiently and effectively.
Benchmarking is a tool that can be used to help such an approach. This was successfully used previously along with 'mutual audit' by RDPHs.(Regional Directors of Public Health) to benchmark and share practice between regions.

The proposals in para 4.88 for an annual review of what works, a single web-based system (see Question *b* above, as PHAST has already undertaken initial design proposals for single portal etc) and encouraging innovation and peer sharing are all good.

d) What can wider partners nationally and locally contribute to improving the use of evidence in public health?

Wider partners and alternative models are necessary for PH.
PHAST (Public Health Action Support team) is, we believe, the only specifically PH focussed **Social Enterprise** (SE). PHAST has been a successful SE fulfilling PH, community and population needs since 2006.
Whilst the voluntary sector has been mentioned (eg para 4.81) in the white paper, SEs have only been mentioned in relation to community provider services (para 4.94) and it is not recognised what role SEs may provide for PH delivery or surge capacity. PHAST would be pleased to discuss this further with you.

We consider that the current approach of **'responsibility deals'** is disappointing and flawed. While it is important to engage with all partners to deliver public health outcomes, it is not appropriate to allow partners who have vested and conflicting interests (such as supermarkets and the alcohol industry) to dominate the decision making, ignoring the robust evidence available. There is clear evidence of how to engage appropriately and how industry has undermined PH benefits in the past eg from the tobacco industry. These should be taken into account and the 'responsibility deal' mechanism reconsidered.
The recent decisions by the 'responsibility deal on alcohol', is a clear example of allowing the drinks industry to dictate policy, with the development of pledges without specific targets or sanctions. This example already proves that the mechanism will not address the important PH issues facing England and alternative mechanisms for partnership must be found.
Change will not be achieved by a narrow focus on individual behaviour alone, but on addressing the social determinants and influencers on that behaviour.

Consultation Question: REGULATION OF PUBLIC HEALTH PROFESSIONALS
e) We would welcome views on Dr Gabriel Scally's report. If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary regulation for public health specialists?

We do not agree that there should be voluntary regulation for public health specialists. All Public Health professionals should be recognised as having specific training and qualifications and all require robust **statutory regulation**.
PH professionals have a population as their 'patient' instead of individual patients or clients. The action and advice of PH professionals affects these 'populations' in just the same way as individual health care workers advice affects the patient. In fact PH actions could be of more effect as they cover a whole population, many people. In this way PH is no different to other professionals and they should be regulated in a similar way. Likewise PH is multi-professional so all professionals in PH require similar regulatory mechanisms.

This statutory regulation should be undertaken by the appropriate body, depending on the registration of the practitioner eg GMC for doctors, GDC for dental PH practitioners etc and we would suggest the **Health Professions Council** for other public health specialists. Arrangements developed over the past several years for the

development of public health as a multi-disciplinary profession, should be maintained and built upon.
It is essential that DsPH are trained consultants in public health with the necessary registrations with the Faculty of PH and that they lead the PH function in LAs which will include those currently working in environmental health and on wellbeing agendas. This will allow structured career pathways to develop.

We are pleased that there is a **detailed workforce strategy** to be developed by autumn 2011 (para 4.90) and that there is a recognition that 'scarce public health skills' (para 4.95) need to be retained. However our experience is that this timescale needs to be escalated as there are already major changes taking place in anticipation of these changes and public health skills are already being lost in the overall financial reductions within the NHS and LAs.

Additional comments/ Cross cutting issues:
We note that the government is consulting separately on **education and training** with a focus on "patient needs driven by healthcare provider decisions and with strong clinical leadership" (para 4.98). This approach could be seriously detrimental to PH training which needs to be mainstreamed but would not fit with those principles. Particular consideration needs to be given to PH training with strong PH leadership.

Top 5 issues in implementation:

1. Clarify the position about who is responsible for which populations and ensure the GPCCs are responsible for commissioning for the whole population. (see Q a)
2. Clarify each organisations' responsibilities and ensure there are no overlaps or gaps and that 'cost' or 'responsibility' shifting cannot take place. Ensure that the proposed 'system' covers the whole pathway as efficiently as possible (see Q a)
3. Build on existing data, surveillance, information, intelligence and evidence, bringing it together in a single access point. Not reinventing the wheel and utilising what already exists to inform 'new' audiences and be further developed. (see Q b)
4. Utilise the PH skills and capacity to best effect, by not fragmenting but making simple and easy transfers to new organisations(eg LAs) and enabling the PH capacity to be spread and utilised across differing organisations eg across both GPCCs and LA. Maintain the requirements for properly qualified DPHs and their teams to undertake the professional public health work for which they are trained and qualified. (see Q c and e)
5. Incentivise the delivery of the required population outcomes, including reducing inequalities. This has to be focussed and ensure that the overall system has suitable incentives and not disincentives. The three domains of PH need to all be considered. This should include the mechanisms outlined in the NHS white paper and through acute and foundation trusts.

PHAST would be pleased to discuss further with you the points in this response. We believe we have a unique perspective as the only public health focussed social enterprise and can bring valuable experience to bear on these proposed changes. Please see also PHAST responses to the consultations on the Funding and Commissioning routes and to the Outcomes Framework.

Prof Sue Atkinson CBE, MB BChir, BSc, MA, FFPH.
Chair of PHAST – Public Health Action Support Team

Dr Eugenia Cronin MSc, PhD, FFPH, FRSPH
Consultant in Public Health

Richard Willmer BSc FRSS
Health Information Analyst.

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