

Association of Directors of Public Health and Royal Society for Public Health – submission to All Party Parliamentary Group special inquiry into the Public Health White Paper and opportunities for better health

The Association of Directors of Public Health (ADPH) is the representative body for Directors of Public Health (DPH) in the UK. It seeks to improve and protect the health of the population through DPH development, sharing good practice, and policy and advocacy programmes. www.adph.org.uk

The Royal Society for Public Health (RSPH) is a leading independent chartered body dedicated to the promotion and protection of collective health and well being. Its membership consists of a wide range of cross disciplinary practitioners who have an interest in public health. RSPH communicates extensively about topical public health through its journals, forums and events and advises on policy development at national and international levels.

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Both ADPH and RSPH have a strong track record of collaboration with other stakeholders in public health, including those working within the NHS, local authorities and other sectors.

The ADPH and RSPH welcome the opportunity to contribute to this inquiry by the APPG. We recognise that the Public Health White Paper and the associated changes raise huge opportunities for public health, but with such changes there are also risks. In this submission, we seek to highlight key issues that we believe will need to be addressed to ensure real improvements in health outcomes and the reduction of health inequalities.

Response to Inquiry questions

1) What are your views on the extent to which proposals will achieve positive changes to people's health leading them to be empowered citizens?

Government should accept that personal behaviour modification is necessary but insufficient to deliver its public health goals. While regulation and legislation should not be used lightly, they should not be discarded as tools for the delivery of improved population health in England. The positive short and anticipated long term health impacts of the ban on smoking in enclosed public places provides a shining example of the societal improvements which can be achieved through courageous and forward thinking governments which place the health and wellbeing of citizens at the centre of public policy.

Previous experience has demonstrated that a statutory basis for joint working is the only way to achieve cultural change within the timescales that have been outlined. The challenge for such a statutory framework is making it sufficiently robust to provide clear guidance yet flexible enough to reflect local need.

The role of the Health and Wellbeing Boards to promote partnership working is essential but must be supplemented by the power to require collaboration between agencies where this is in the best interests of residents. For example there will be areas where impact will only be

achieved through whole population commissioning. The Health and Wellbeing Board will need to ensure that this is achieved where necessary.

Health and Wellbeing Boards should ensure they monitor consultations properly and in a timely way. They should ensure that systems are in place to do proper consultation and that they are made aware at an early stage of consultations which are happening or planned. Therefore, if they become aware of problems they could be dealt with as part of the consultation process and, if necessary, they could even ask for the consultation to be carried out again. This should enable them to iron out any problems at an early stage. It may even be useful to provide a specific power for them to require a consultation to be done again. This will avoid issues needing to be escalated to the Secretary of State.

Proposed representation of HealthWatch on the Health and Wellbeing Boards is welcomed but consideration should be given to how one individual can be seen to represent the views of all residents. HealthWatch should not be the sole mechanism for engaging with the public.

Given the importance of the Joint Strategic Needs Assessment, the role of the Director of Public Health in relation to the Health and Wellbeing Board will be extremely important, and the Director of Public Health should act as a principal advisor to the Board for public health advice across the three public health domains of health improvement, health protection, and health care service planning and commissioning.

The Director of Public Health should have the ability to highlight to the Secretary of State, local communities and other interested parties where there is a serious threat to the health of the population and where appropriate local action is not being taken, despite the efforts of the Health and Wellbeing Board.

We welcome the fact that public scrutiny is recognised as an essential part of ensuring that government and public services remain effective and accountable. A formal health scrutiny function will continue to be important within the local authority. Indeed, when the PCTs cease to exist and responsibility and funding for local health improvement activity is transferred to the local authority, this role will be even more crucial.

The core purpose of the Director of Public Health is to act as an independent advocate for the health of the population and to provide leadership for its improvement and protection. As such it should be a high-level statutory role bridging Local Authority and NHS responsibilities for health and well-being for a defined population. As the leader of the local Public Health System, Directors of Public Health should ensure that better health outcomes are delivered through the provision of authoritative influence across all the Directorates within the Local Authority; the NHS; voluntary organisations and the business and industry sector.

There should be a statutory requirement for top tier and Unitary Local Authorities to appoint a Director of Public Health with the appropriate professional training and accreditation needed to lead the health and wellbeing agenda. In order to maintain professional standards such appointments should be made through professional Appointment Advisory Committees (AACs).

The Director of Public Health's professional status is necessary in order to ensure their advocacy role on behalf of their population, for instance as expressed through the independent DPH Annual Report - an important vehicle for providing advice and recommendations on population health to both professionals and public – providing added value to other key public health intelligence and information such as that provided through Joint Strategic Needs Assessments (JSNA). The Director of Public Health will only be able to fulfil his/her functions effectively and efficiently if supported by an appropriately qualified multidisciplinary workforce, providing all the skills necessary to support the local authority in fulfilling its obligations and enabling it to meet the outcomes established in consultation with Public Health England.

2) GP consortia are expected to help improve individual's health behaviour, what specific and practical initiatives do you see needing to be implemented in order to achieve this?

In setting priorities and in measuring success, commissioners require access to good, standardised data to describe their populations and compare them with those around them. This "benchmarking" is an important commissioning function. Good benchmarking data and tools are emerging, available at PCT and Local Authority levels. However, if consortia are not coterminous with Local Authorities and the boundaries of consortia shift over time as practices join or leave, then effective benchmarking becomes less feasible.

Public Health oversight of and public health input to commissioning at all levels will be essential to achieve real improvements in population health outcomes and the reduction of health inequalities.

To support effective commissioning decisions that will bring real improvements in population health and a reduction in health inequalities, GP consortia will require access to and collaboration with:

- Health and Well-being Boards;
- well-resourced and professional local Public Health teams, including public health commissioning expertise, that are co-located with the DPH, providing the skills and experience to input to local service planning and commissioning, and to deliver Public Health programmes and advice across the health economy, supported by access to high quality local and national data and scientific evidence base;
- cross-agency / sector needs assessments (JSNA);
- Public Health information and intelligence providing relevant and timely intelligence;
- Public Health England nationally for evidence-based advice to support commissioning and service quality.

GP consortia should work closely with Local Authorities and local commissioning plans should be subject to scrutiny and comment by the Health and Well-being Board – and to greatest effect would also be signed off by the Board.

Consortia should be expected to develop commissioning plans which reflect population need as identified in the Joint Strategic Needs Assessment and with the aim of reducing health inequalities.

Commissioners should be required to demonstrate the use of a strategy covering high quality, universal services, targeted services for communities of interest at greater risk especially deprived communities and tailored services for people with multiple and complex needs. This should be underpinned by evidence base, public health intelligence and needs assessments, as well as an assessment of the community assets available to improve and protect health.

Also needed is the demonstration of excellence in managed entry of new drugs, technologies and public health interventions. We recommend the promotion of Health Impact Assessment (HIA) and Health Equity Audit as necessary components in commissioning service change (capital or design) alongside equality and diversity impact assessment.

The NHS Commissioning Board must ensure that consortia work in close collaboration with Directors of Public Health and the Public Health Service and Local Authorities to ensure that specialised services are delivered at the appropriate geographical level. Where joint commissioning structures are established to provide more effective and efficient services for large population areas, the Commissioning Board should ensure that Directors of Public Health are involved to ensure that population health gain is maximised.

Consortia should demonstrate to the Commissioning Board that they and their constituent practices have proper processes in place to ensure that they are playing an active and evidence based role in population health improvement and prevention of illness.

Directors of Public Health will also commission health improvement services through the local ring-fenced public health budgets.

3) There have been many opportunities for schools to incorporate health education and yet this has been patchy because it is not part of the national curriculum, do you believe it should be a curriculum obligation and what should be covered if it were?

Health education in schools should be a core component of the national curriculum. It should cover healthy behaviours and the causes of health and ill health. The programme of healthy schools standard accreditation and support to schools has helped to raise the issue of health and wellbeing as part of the underlying ethos of school and Directors of Public Health would like to see this work further developed and supported so that the health of the next generation can be supported.

We would like to see more emphasis on Children's Services within the new system frameworks and in particular the encouraging of schools to actively take up their public health role.

Teachers of Personal, Health and Social Education (PHSE) should be equipped with a minimum set of skills and knowledge, and recognised as such. This area of the curriculum is too important to leave to chance. Given the sensitivity of some of the subject matter and the impact on children's emotional and physical development, greater emphasis should be given to teachers' professional development and the teaching and learning support required for them to be safe and effective.

4) The public health white paper wants to ensure recommendations from the Marmot Review are implemented, such as enabling children, young people and adults to maximise their capabilities and have control over their lives, how would you tackle this problem?

The evidence from Sir Michael Marmot's review is unequivocal; governments have to act on the proximal causes of disease and ill-health if they are to be effective in improving health and reducing health inequalities. This will require genuine cross-government action on a range of issues and sectors. The recent establishment of a Cabinet sub-committee on public health is to be welcomed as a possible way to promote this cross-government working.

Health inequalities will only be reduced with action on the wider determinants of health. Many of these are affected through Local Authority based services and commissioning (eg Planning, Housing etc). Tackling the main social and behavioural drivers of health inequalities is something that can only be done in collaboration with Directors of Public Health within Local Authorities. There is an added complexity in two-tier authorities where District Councils lead on many of the major determinants of health (such as Environment, Housing, Planning etc). ADPH recommends that there is an obligation on District Councils to work towards a reduction in Health Inequalities.

Effective collaboration with Public Health England will be crucial in reducing inequalities and dislocation between the services will be potentially disastrous. Evidence shows that success is most likely to result from the application of a wide range of complementary approaches, ranging from behaviour change strategies to the use of all those policy instruments available to Government, including regulation and fiscal incentives.

Robust structures will be required to ensure that GP consortia are active and effective partners in the planning and delivery of public health measures, particularly those geared to reduce health inequalities.

Perhaps the greatest challenge to the new NHS will be how to put prevention at the heart of commissioning. Given that the new structure will put health care and prevention into separate organisations with different outcome frameworks, geographical boundaries, cultures and systems for accountability, there are considerable risks.

The combined cost to the NHS of smoking, alcohol and obesity has been put at £11bn, roughly 10% of the NHS budget, with half of that cost attributed to smoking alone. Failing to engage primary care effectively in preventative medicine will impose burdens to the public in terms of ill-health, consortia in terms of a heavier work load and the NHS as a whole in terms of unaffordable costs. Ensuring that the two new services (public health and health care) work together effectively must be of the highest priority.

With the establishment of Health and Wellbeing Boards, it will be important to ensure that there remains a duty to cooperate through Children's Trusts, with a shared governance focus through the Health and Wellbeing Board for both children and adults.

5) a) How can you see public health information being provided in order to effect behavioural change to reach targeted populations at the optimum time?

b) Would this have more impact if there was a national campaign at the same time?

Whether information is provided nationally or locally is a decision which should be based on the evidence of effectiveness. The importance is in the availability of accurate, timely, and accessible integrated information at all levels. Retaining the existing Department of Health Information Standard will help ensure the accuracy and quality of information and health education materials made available to the public.

Public Health England should provide public health expertise and input to public health information, through robust:

- Information and intelligence functions – observatories etc
- Screening and other QA programmes
- Audit and evaluation
- Health Protection national functions; emergency planning
- Investment in the Public Health workforce (specialist and practitioner) – both practice and development
- Investment in the Public Health academic function

An important aspect that needs further consideration is how best to structure and maintain clear lines of accountability, communication and access between Public Health England, Public Health teams working within Local Authorities, and the GP consortia.

Key and immediate issues of concern

The process of transition itself carries risks, and it will be important to recognise and mitigate those risks to ensure current and longer term success.

The most serious and pressing concern is the impact of **current (and future) local financial savings and consequent risks to public health capacity and capability to support effective commissioning** – as a depleted service will be unable to respond effectively to public health priorities.

ADPH and RSPH have significant concerns that the loss of local public health capacity and capability will seriously risk the success of the envisioned reforms. This is an issue that needs to be recognised by government and urgently addressed by government, PCTs, Local Authorities, SHAs and GP consortia as they work together on transition.

Association of Directors of Public Health

Lockton House
Clarendon Road
Cambridge CB2 8FH
Tel. 01223 725308
president@adph.nhs.uk
www.adph.org.uk

Royal Society for Public Health

3rd Floor Market Towers
1 Nine Elms Lane
London
SW8 5NQ
rparish@rsph.org.uk
www.rsph.org.uk