Faculty of Public Health

of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

Response from the Faculty of Public Health to the Department of Health's consultation on the NHS Next Stage Review

Introduction

The Faculty of Public Health (FPH) is an authoritative UK-wide public health body which aims to advance the health of the population through three key areas of work: health improvement; service improvement and health protection. In addition to maintaining professional and educational standards for specialists in public health, FPH advocates on key public health issues and provides practical information and guidance for public health professionals.

FPH welcomes the opportunity to input into the development of an NHS that provides world class quality care that is **fair**, **personalised**, **effective** and **safe**.

This submission will concentrate first on general principles for the development of quality care, and then consider the seven key themes set out in the review and identify 'enablers' from a public health perspective.

KEY PRINCIPLES

Whilst we warmly welcome the drive to improve the quality of care that the NHS provides, as public health specialists we call for an increasing emphasis on finding more efficient ways to influence behaviour and preferences before people become active users of services. Within the NHS it is essential that prevention targets are given the same weight as access targets, and that the inequalities issues related to health status, access to services and health outcomes be given greater prominence.

The crucial importance of public health to the NHS and health service delivery

The public health function operates across three main 'domains':

- *Health improvement* (which is about promoting healthy lifestyles and healthy environments and encompasses issues of inequalities and the wider social determinants of health such as employment, education, community etc)
- *Service improvement* (which is about planning, commissioning and evaluation of services and interventions to ensure they are effective, of high-quality and safe).
- *Health protection* (including immunisation and vaccination, screening, injury prevention, control of infectious diseases, emergency planning, etc).

Public Health is at its most effective when these three domains of public health are closely related, when practitioners in one area have an insight into, and an understanding of, the other two areas. Within the NHS, this means that those who provide health services should also act as the promoters of better health.

It is crucial to highlight the public health contribution of commissioners and providers of health and social care. Prevention and care are part of a spectrum of community and clinical activity rather than separate endeavours. We believe it is important that the public health approach suffuses all NHS activity. Such an approach seeks to make cost effective use of

existing NHS staff and existing staff/patient encounters around the provision of routine health care to provide evidence-based and highly cost effective interventions which both improve quality of life and extend disease-free interval. They are at the very boundary of secondary prevention and chronic disease management and can be termed tertiary prevention.

We recommend continuing the integration of public health into clinical activities. Where possible we support basing all service development decisions on best available evidence – decisions on the commissioning as well as the clinical aspects of each service. This can only be achieved by introducing a public health perspective to all aspects of health services, and from aligning all those involved in patient care in their commitment to gathering and using evidence to continuously improve services – a central tenet of clinical governance.

FPH has identified 6 key areas that the NHS can focus on to improve the quality of care it provides.

1. putting the reduction of health inequalities at the heart of NHS delivery objectives
2. systematic collection of high quality data to inform evidence-based decision making
3. education and training in public health for all health professionals
4. effective public health interventions in health service delivery, by hospital, mental health and primary care trusts.
5. adequate resource for public health specialists to act as champions for public health across the full breadth of NHS activity.
6. provision of better incentives to deliver on public health in the form of performance management and targets

Six areas to focus NHS improvement

1. Reduction of health inequalities

The NHS has a crucially important role to play in reducing health inequalities in all its services and settings, from health promotion at one end of the spectrum to palliative care at the other. Public health skills and expertise are crucial to a proper understanding of health inequalities, analysing the health needs of disadvantaged groups, and planning and delivering services to meet those needs.

2. High quality data

It is essential to improve integration of primary and secondary care so that patients get the right treatment in the right place. A key enabler for this is the development of shared records which can not only support the care of patients wherever they are seen, but also provides data which can identify whether patients move along the best practice care path across all sectors. More generally, the systematic collection of high quality data is crucial to the development of the evidence base for what works at a population level.

3. Education and training

A national workforce plan is essential, to include all those with a public health interest as highlighted in the CMO's report on *Strengthening the public health function*. A broad range of people require public health awareness and competencies: we support developing the roles of public health professionals in practice, including within the voluntary sector and community development; of those within the NHS and local government as a whole; and also supporting those 'with an interest', such as local authority members with scrutiny responsibilities.

4. Effective public health intervention

The role of the healthcare sector is significant in contributing to improved health and health protection, in addition to its diagnostic and curative role. It is vital to encourage hospital trusts to play their part in the broader public health agenda. Links between public health

specialists (including health protection) and medical and clinical directors should be strengthened and common training and competencies introduced. Joint appointments between acute trusts and PCTs could also facilitate effective public health leadership in the acute sector. A business case should be developed for public health skills in hospitals, based on financial and business benefits to give some hard examples of how public health can be cost-effective within the acute sector. Infection control is a major public health issue through which a strategic public health view within trusts can be developed.

A strategy is required to identify opportunities for creating more public health posts in mental health trusts, including the training of the mental health workforce in public health skills. There is a need to increase knowledge and awareness within public health of the mental health agenda and the contribution public health can make to it.

The primary care setting represents an ideal but underused opportunity to engage the population through a range of public health interventions. The director of public health is key to the improved delivery of public health across PCTs and local authorities. Equally there are important roles for Strategic Health Authorities in setting and monitoring public health standards relevant to health improvement and protection.

5. Increased resource for public health teams

Directors of public health must be adequately supported at PCT and local authority level to enable them to serve their communities more effectively and to offer the support to health professionals (particularly local practitioners) in making prevention and health improvement a part of their daily work and ensuring they are able to make their contribution to health protection when required, for example in delivering immunisation and responding to outbreaks of infection and emergencies. Particularly lacking is sufficient public health specialist capacity to support effective commissioning of high quality and safe services. Preliminary data from the latest workforce survey for public health consultants, conducted in autumn 2007, shows a reduction of 30% since 2003.

Substantial funding must be put in place for upstream public health programmes as a matter of urgency. This should encompass programmes to tackle inequities and inequalities across maternal and child health, young people's health and older people's health, with particular emphasis on reducing smoking prevalence, improving nutrition, preventing obesity, improving sexual and mental health, and tackling alcohol misuse.

6. Incentive

There must be a clear, accountable and visible delivery platform for taking forward the public health agenda. Within the NHS it is essential that prevention targets are given the same weight as access targets and that the inequalities issues related to access and choice be given greater prominence. We believe that the new financial flows and tariffs should be applied to public health programmes and that the commissioning function be strengthened to emphasise prevention in all areas of work. Our performance management systems need to reward behaviours and interventions that meet the public health agenda. We must support the implementation of public health interventions where effectiveness is well proven.

This is the clear direction of government policy made explicit in the Prime Minister's New Year speech. Whilst the FPH welcomes the recent announcement by the Prime Minister to prioritise prevention of ill health through the implementation of population screening programmes for diseases such as coronary heart disease and diabetes, it is critical that any such interventions do not exacerbate health inequalities. Government must ensure that any such screening programmes are both evidence-based and effectively targeted at those groups most at risk but which are least likely to uptake interventions or use health services.

SPECIFIC EXAMPLES

Below are specific examples of where public health can contribute to the seven key themes identified in the Review.

Quality improvement

Information and measurement

- Improved standardised protocols and systems are required for measuring quality in its main dimensions: safety, effectiveness, equity, user satisfaction. Improved data capture, improved data quality, faster analysis and feedback of key metrics to teams and individuals, built into appraisals and training.

Incentives

- Standards should be derived from these metrics and built into performance assessments of service units and key managers, and linked to performance-related pay.

- Quality should be the main driver for commissioning. Payment-by-results should mean payment by quality as well as by episode, procedure etc. A quality coefficient should be applied.

Safety

- Safety should include interface issues (eg. poor communication between hospital and GP; inadequate links with social services; insufficient patient information on use of medicines or lifestyles) as well as specific interventions or care packages within the hospital or primary/community care.

- Safety should include a culture of openness within the workforce and users of the service. Both staff and patients must feel free to point out inadequacies and failures without fear of retribution. Making suggestions or complaints must be made easy. However, a balance must be struck between whistle-blowing and creating a climate of fear and overly defensive practice.

- The substantial body of research around all aspects of patient safety should be more systematically fed into policies, procedures and training programmes. Better use of the evidence base.

Patient satisfaction

- The NHS should put more of its R&D funding into researching the patient experience and determinants of patient (and carer) satisfaction.

- Get the simple things right: friendly, considerate staff; clear communications; good signage; welcoming atmosphere; a warm, upbeat approach; pleasant, nutritious meals; help with feeding. This means investing in more staff with the time to attend to patients; better training in dealing with patients and carers. Treating patients as people, not a production line. It should also mean more use of trained volunteers, including patient groups, faith groups and senior school students.

Role of organisations

- Commissioners: More commissioning for quality. More joint commissioning between PCTs/PBC consortia and local authorities. Providers: quality should drive everything; more quality metrics in appraisals.

Public Health input

- Public Health is about the health and healthcare of populations, including patient population(s). More use should be made of Public Health specialists in the hospital setting. Public Health specialists are specifically trained in: assessing the health needs of populations and groups; analysing health inequalities and equity of access to services; assessing effectiveness and appropriateness of interventions and procedures; planning services and reconfigurations; evaluating whole systems, etc. These skills should be better brought to bear in commissioning and providing.

Innovation

- Innovation is important – but should never be at the expense of quality or getting the basics right. Cost-benefit analyses must include opportunity costs in terms of quality. Mere cost-effectiveness analysis is not enough.

- NICE assessments and guideline development needs to be speeded up – with more use of interim reports.

- Public Health specialists are specifically trained to assess the evidence base for emerging interventions and procedures and their expertise should be made better use of.

Workforce

- All healthcare professionals and practitioners should receive at least a basic level of training in public health skills and competencies. A comprehensive multiprofessional Public Health Skills & Career Framework has been developed by the Faculty of Public Health and others in partnership with Skills for Health which covers all skills and competency levels (Level 1 to Level 9). Details of this can be found at: www.skillsforhealth.org.uk/page/about-us/news-articles/public-health-skills-and-career-framework

- The UK Voluntary Register of Public Health Specialists (UKVRPHS) should be made statutory, alongside the GMC, GDC, and other registers. Details can be found at: www.wmpho.org.uk/ukvrweb/about/?c=1&catTitle=Introduction

- The specialist Public Health workforce has been steadily declining over recent years, exacerbated by successive reorganisations. Preliminary figures suggest that the number of Public Health specialists has dropped by 30% since 2003. There is an urgent need to expand the number of substantive posts in the NHS and partner agencies. Public Health specialists are specifically trained to lead or contribute to high-quality health protection, health improvement and service improvement. More posts are particularly needed in commissioning agencies, local authorities and acute trusts.

Leadership

- All managers and clinicians should have at least a basic understanding of their role from a population perspective, and possess basic public health skills and competencies. The PH Skills & Career Framework cited above can form the basis of this. This is especially important for leaders who are expected to have more strategic role. Part of this is the skill set required to work effectively across a range of disciplines, professional groups or sectors. Team-working and partnership working are fundamental to public health.

- The National Public Health Leadership Programme is open to professionals from a variety of disciplines, professions and sectors, who have recognised that their role

has the potential to impact on the health of the public – even where 'the public' is a group of patients. Details of the Leadership Programme can be found at: www.imperial.ac.uk/medicine/about/divisions/ephpc/pcsm/nphlp

- Public Health is a multidisciplinary professional specialty, with a five-year postgraduate specialist training programme formally recognised by PMETB. Accredited specialists are registered with the GMC, GDC or UKVRPHS (UK Voluntary Register of Public Health Specialists) depending on their professional background. Whilst the main feeder profession remains doctors, there are increasing numbers of nurses, pharmacists, general managers and others joining the specialty. Further details on specialist training for Public Health can be found at: www.fph.org.uk

Primary & community care strategy

- Primary care commissioners and providers should work more closely with their public health colleagues in analysing practice populations, uncovering inequities in provision, developing preventive programmes, developing behaviour change skills, commissioning lifestyle support services (such as smoking cessation, community dietetics and exercise facilitation), and evaluating outputs and outcomes..

Informatics

- There is a network of Public Health Observatories across the country, one per Region, collecting, analysing and interpreting a vast amount of information of crucial importance to delivery of health and social care, and health protection and improvement. NHS commissioners and providers should be made more aware of this extremely useful resource. Further details can be found at: http://www.apho.org.uk/apho/index.htm
- Public Health specialists are specifically trained in epidemiology, demography, informatics and statistical methods. Public Health specialists and Public Health information officers are, or should be, key players in planning, prioritising, commissioning and evaluation of services.

- The FPH, through its Information and Intelligence Committee, is linked closely to work being conducted by the PH observatories, NHS Information Centre, National Electronic Library for Health, Connecting for Health, and others in developing and improving information systems and datasets.

Systems & incentives

- We now have a complex system with complex incentives – practice-based commissioning, payment by results, choose-and-book, foundation status, annual health-checks, health scrutiny committees, national programme for IT, etc. These initiatives, laudable in their own right, were not always developed in close liaison with each other. They are sometimes pulling in different directions and moving at different speeds. This has created tensions and barriers.

- The NHS is organic rather than mechanistic. It is not a matter of simple inputs here, leading to predictable outputs there. Rather than further radical changes, we now need to let this complex organism settle down, find its way, smooth its rough edges, consolidate. The current systems and incentives should be sufficient to allow the improvements being raised through this consultative process. The NHS desperately needs a period of stability – to be allowed to get on with the job.

Further comments

FPH is aware of excellent work which has already been fed into this review. In particular we commend: *Healthcare for London: a Framework for Action* by the Staying Healthy Working Group Report.

Further information

For further information about the Faculty of Public Health please visit our website: www.fph.org.uk or contact Lindsey Stewart, Policy Officer at lindseystewart@fph.org.uk or 020 7935 3115.