Faculty of Public Health

Of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

UK Faculty of Public Health evidence submission to the House of Lords Select Committee on the Long-Term Sustainability of the NHS inquiry

About the UK Faculty of Public Health

1. The UK Faculty of Public Health (FPH) is committed to improving and protecting people's mental and physical health and wellbeing. FPH is a joint faculty of the three Royal Colleges of Public Health Physicians of the United Kingdom (London, Edinburgh and Glasgow). Our vision is for better health for all, where people are able to achieve their fullest potential for a healthy, fulfilling life through a fair and equitable society. We work to promote understanding and to drive improvements in public health policy and practice.

2. As the leading professional body for public health specialists in the UK, our members are trained to the highest possible standards of public health competence and practice – as set by FPH. With close to 4,000 members based in the UK and internationally, we work to develop knowledge and understanding, and to promote excellence in the field of public health. For more than 40 years we have been at the forefront of developing and expanding the public health workforce and profession.

Headline Messages

I. The NHS must remain a universal healthcare system; open to all, free to all, and funded by all through general taxation;
II. Poverty is the major cause of inequality in health and in NHS service usage;
III. Prevention of long-term conditions is far more cost effective than treating illness as it occurs;
IV. The 20% cut to public health funding[1,2] must be reversed, and ring-fenced public health grant maintained beyond 2017/18;
V. It is a false distinction and false economy to consider NHS and public health funding as separate;
VI. The NHS must accept either a decline in quality and standards of patient care, reduce demand by restricting access to services and treatments – or increase health funding;
VII. Public health expertise must be embedded by legislation within CCGs and NHS England, including at Board level;
VIII. The specialist workforce dedicated to working with CCGs and the wider NHS on health care public health must be strengthened;
IX. Rapid action must be made on the 12 upstream priorities of FPH's manifesto; [3]
X. Hospitals will not cope with a fall in the numbers of doctors from outside the UK;
XI. Better alignment between public health and clinical practice is needed if we are to achieve the necessary shift to prevention;
XII. Efforts must be made to increase co-working and collaboration between the NHS, local authorities, employers, the voluntary sector, and communities in all their diversity;
XIII. The Government must ensure that any trade negotiations post the EU Referendum include clear and strong public health exceptions and define health as broadly as possible.

[1] HM Treasury, Spending Review and Autumn Statement 2015: documents, November 2015, http://bit.ly/1QHVv9k
[2] Department of Health, Local authority public health allocations 2015 to 2016, November 2015, http://bit.ly/1UbECTG
[3] UK Faculty of Public Health, Start Well, Live Better A Manifesto, March 2015, http://bit.ly/1wDfDv0

4 St Andrews Place • London • NW1 4LB • Tel: 020 3696 1466 • Fax: 020 3696 1457
Email: *enquiries@fph.org.uk* • Website: *www.fph.org.uk* • Registered Charity No: 263894

Introduction – Prevention is better than cure

3. FPH welcomes this opportunity to provide written evidence to the House of Lords Select Committee on the Long-Term Sustainability of the NHS inquiry. Public health is the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals.

4. It is well established that the determinants of health – and ill health – cannot be influenced by health policy on its own, and are determined largely outside of the NHS. People with a higher socioeconomic position in society have greater life chances and opportunities to lead a flourishing life. The more opportunities and access to opportunities people have, socially and economically, the better their health.

5. This link between social conditions and health must not be a "footnote to the 'real' concerns with health" – but the main focus.[4] It is absolutely critical that public health, which, under the Health and Social Care Act 2012, moved to local authorities from the NHS, must be seen as part of, and not distinct from, the comprehensive package of health and social care.

6. Prevention of long-term conditions is far more cost effective than treating illness as it occurs. Focusing on prevention can reduce high long-term treatment costs and improve health outcomes – avoiding premature deaths and ensuring a more sustainable NHS. In 2010, 70% of the NHS budget was spent on long-term conditions – yet only 4% cent of the health budget spent on prevention. This is rapidly decreasing as public health funding is being decimated.

7. Truly achieving a "radical upgrade in prevention and public health"[5] requires more than reversal of cuts to public health funding alone. It requires a healthcare system grounded in public health principles and a public health framework with strong primary and community care relationships.[6]

8. It requires equitable, upstream social and economic policy at national and international level[7] to address the unequal distribution of power, income, goods, and services – and consequent unfairness in the immediate circumstances of peoples' lives – access to healthcare, education, work and leisure; homes, communities – and chances of leading a healthy life.

9. FPH's manifesto, *Start Well, Live Better*, [8] outlines 12 evidence and based practical actions that will contribute to securing the NHS's long-term sustainability, through commitment to preventative action – strongly aligned with the Five Year Forward View. FPH further supports:

   - A tobacco levy – a cost-effective way to guarantee resources regardless of public finances.[9]
   - Giving Hospital Trusts a £200million target to reduce avoidable procurement and agency staff commissioning costs.[10]
   - Giving NHS Trusts a £200million target to reduce 'interventions of limited clinical value'.[11]
   - Addressing unacceptable country-wide variation in quality of care.[12]

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[4] Fair Society, Healthy Lives, The Marmot Strategic Review of Health Inequalities in England, post-2012, 2010. http://bit.ly/1hs5CeE
[5] NHS England, *Five Year Forward View*, October 2014, http://bit.ly/1IvuwY5
[6] FPH draws attention to efforts in Scandinavia to embed public health as a foundation block of the health care system
[7] FPH notes the ground-breaking Welsh Government, Well-being of Future Generations (Wales) Act 2015, http://bit.ly/1Q2zMtf and also draws attention to the
[8] UK Faculty of Public Health, Start Well, Live Better A Manifesto, March 2015, http://www.fph.org.uk/start_well%2c_live_better_-_a_manifesto
[9] Action on Smoking and Health, Smoking Still Kills: Protecting Children, Reducing Inequalities, 2015, http://bit.ly/1ICDuko
[10] FPH draws attention to Lord Carter's Review of Operational Productivity in NHS Providers, 2015, http://bit.ly/1fe92oU
[11] FPH draws attention to the Academy of Royal Colleges report, Protecting resources, Promoting value: A doctors guide to cutting waste in clinical care, November 2014, http://bit.ly/1kOOz6D
[12] FPH draws attention to the Dalton Review, Examining new options and opportunities for providers of NHS care, December 2014, http://bit.ly/1G6AptI

Major cuts to public health and social care

10. Subsequent to the £200 million cut to the ring-fenced public health grant announced in 2015, the Comprehensive Spending Review 2015 (CSR) unveiled further real terms cuts by 3.9% each year to 2020/21 (a cash reduction of almost 10%). This follows the 12% already cut from the national social care budget since 2011;[13] and estimated real-term reductions in local government funding and income of 37% and 25%, 2010-15. 32% is also to be cut from Department of Communities and Local Government funding by during this CSR.

11. Statutory public health functions may also change post-2017, with serious implications for critical health and public health services provided by local authorities, e.g. already fragmented sexual health services, health visitor services and fulfilment of new local responsibility for children 0-5 years. All of these non-mandated services are already at most serious risk, in turn placing risk to the sustainability of the NHS.

12. We cautioned in 2012 of the risks to adult and child safeguarding posed by the Act.[14] Yet, as a consequence of the Act, today, in 2015 a key component of the very services designed to ensure safeguarding of vulnerable children from serious risk – is now itself not safeguarded. With 0-5 services now not mandated, FPH reminds the Select Committee of the 2011 Munro Review of Child Protection[15] which outlined the importance of a child centred system. The recommendations of the Munro report remain relevant today.

13. We further strongly support the cross-party 1001 Critical Days manifesto.[16] This important vision for the provision of services in the UK for the early years period, puts forward the moral, scientific and economic case for the importance of the conception to age 2 period, and should be a key consideration when considering the sustainability of the NHS.

14. Safeguarding does not end at 5 years. Local authorities have responsibility for children 0-19 and adults – responsibility across the life-course. This is about a coordinated, system wide approach, linked with social care and all of the other elements of the system. FPH urges Government to ensure that these important services are fully funded and protected.

15. FPH is also concerned that the CSR signals the grant's replacement with a retained business rate model. Eventual redistribution may particularly hurt deprived local authorities striving to address greater health needs and wider health inequalities. Should the ring-fence be removed, the National Audit Office warns PHE's ability to influence and support public health outcomes will be tested.[17] We strongly advocate long-term maintenance of the ring-fenced public health grant beyond 2018.

NHS and public health funding must not be considered as separate

16. FPH welcomed the former Prime Minister's commitment to increase NHS spending in real terms every year in this Parliament, rising to at least an extra £8 billion a year by 2020. We further welcomed his recognition that the costs of obesity, smoking, alcohol and diabetes necessitate: "a completely new approach to public health and preventable diseases – prevention, not just treatment. Tackling causes, not just symptoms."[18]

17. The Secretary of State for Health affirmed that assurance. Alongside welcoming NHS England's Five Year Forward View's (FYFV) call for a "radical upgrade in prevention and public health",[19] a "vision" is needed, he announced, "encompassing the move to prevention, not cure, with much bigger focus on public health."[20] That vision is critical to the NHS's sustainability.

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[13] ADASS, Budget Survey – Executive Summary, July 2014, http://bit.ly/1EPAnTw
[14] UK Faculty of Public Health, Health and Social Care Bill – Risk Assessment Summary, 2012, http://bit.ly/14BaH2u
[15] The Munro Review of Child Protection: Final Report A child-centred system, 2011, http://bit.ly/1mJRdAL
[16] The 1001 Critical Days Manifesto, 2013, http://www.1001criticaldays.co.uk/the_manifesto.php
[17] National Audit Office, Public Health England's grant to local authorities, December 2014, http://bit.ly/1NQZiLj
[18] The Prime Minister's Office, PM on plans for a seven-day NHS, May 2015, http://bit.ly/1ILwxk3
[19] NHS England, Five Year Forward View, October 2014, http://bit.ly/1IvuwY5
[20] The Rt. Hon. Jeremy Hunt MP, Making healthcare more human-centred and not system-centred, July 2015, http://bit.ly/1HzUmrx

18. It is a false distinction and false economy to consider NHS and public health funding as separate. FPH has previously expressed our deep concern that the Government, while pledging "to support financially [the FYFV],"[21] has limited that commitment to NHS spending. This contradicts not only the Prime Minister and Secretary of State's commitment and vision; but conclusion of the FYFV itself – that public health investment needs "explicit support from the next government."[22]

19. It contradicts PHE's evidence-based advice to Government that "it will be neither effective nor feasible to attempt to solve an epidemic of largely preventable long-term diseases, through risks e.g. obesity, poor diet, physical inactivity, smoking and excessive alcohol consumption, by ramping up spending on hospitals, clinicians and services."[23]

20. These cuts will deliver substantial additional burdens on the NHS.[24, 25, 26, 27, 28] The value for money, cost-effectiveness of public health, and case for increased public health investment, is well established.[29] [30] [31] [32] [33] [34] [35] Severe cuts and the ring-fence's removal, will:

    1. Worsen significantly health and wellbeing of local populations;
    2. Increase inequalities across the life course, including within hard to reach groups;
    3. Compromise delegated health protection and health improvement functions;
    4. Make harder provision of population healthcare advice, and will hence;
    5. Increase the burden of preventable non-communicable disease, putting further pressure on the NHS (already spending 70% of its budget managing long-term conditions)[36], and;
    6. Contradict deficit reduction – it will increase the deficit. Every £1billion "saved" will generate at least £5billion additional NHS, social care and wider economic costs.[37]

The medical profession is united against cuts to NHS, public health and social care funding

21. The public health and medical profession were united in opposition to the £200million cut to the ring-fenced grant. The Academy of Medical Royal Colleges, representing 22 Colleges and Faculties and 200,000 members – and a broad cross section of professional bodies, including the Local Government Association and Society of Local Authority Chief Executives,[38, 39] called for the £200million cut to be reversed and no further cuts to be made. FPH's membership are again united in opposition to the CSR's decimation of public health funding.

22. Against this backdrop, FPH is concerned by the stark choice the Royal College of Physicians' (RCP) recent report, "*Underfunded. Underdoctored. Overstretched*, outlines. *The NHS in 2016*" – that the NHS must accept either a decline in quality and standards of patient care, reduce demand by restricting access to services and treatments – or increase health funding. It observes that:

[21] The Rt. Hon. Jeremy Hunt MP, Making healthcare more human-centred and not system-centred, July 2015, http://bit.ly/1HzUmrx
[22] NHS England, *Five Year Forward View*, October 2014, http://bit.ly/1IvuwY5
[23] PHE, *From Evidence into Action: Opportunities to protect and improve the nation's health*, October 2014, http://bit.ly/ZT2t3h
[24] DH consultation on public health allocations 2015-16, 2015, http://bit.ly/1hulx0H
[25] CSR 2015 consultation, 2015, http://bit.ly/1KCs2dB
[26] DH consultation on proposed target allocation formula 2016/17 http://bit.ly/1NPRfTm
[27] Update on public health funding, 2012, http://bit.ly/1Qm2aFK
[28] CSR confirmation, 2015, http://bit.ly/1lNQ63H
[29] European Journal of Public Health, *Cost-effectiveness research on preventive interventions: a survey of the publications in 2008*, April 2011, http://bit.ly/1KVlSpW
[30] NICE, *Judging whether public health interventions offer value for money*, September 2013, http://bit.ly/1NezdqF
[31] Journal of Public Health, *The cost-effectiveness of public health interventions*, September 2011, http://bit.ly/1Dv4Psj
[32] World Health Organization, *The case for investing in public health*, 2015, http://bit.ly/1DgHeG7
[33] UK Faculty of Public Health, *The economic case for investing in public mental health*, http://bit.ly/1MeYTGw
[34] Local Government Association, *Money well spent? Assessing the cost effectiveness and return on investment of public health interventions*, November 2013, http://bit.ly/1W5GkYv
[35] King's Fund, *Inequalities in life expectancy Changes over time and implications for policy*, 2015, http://bit.ly/1gZMCZZ
[36] Department of Health, Improving the health and well-being of people with long term conditions, January 2010, http://bit.ly/1FScD4I
[37]Professor Simon Capewell, University of Liverpool, 2015
[38] Academy of Medical Colleges, Letter to the Chancellor of the Exchequer, October 2015, http://bit.ly/1Me3gm9
[39] Signatories to the AoMRC letter included: The UK Faculty of Public Health, The Association of Directors of Public Health, British Dental Association, NHS Confederation, Chartered Institute of Environmental Health, Local Government Association, London Councils, Royal College of Nursing, Society of Local Authority Chief Executives, UK Health Forum

- **Funding has not kept up with demand** – in 2015, NHS England estimated that if no action was taken the gap between demand and funding would leave a £30bn hole by 2020/21;
- In November 2015, the government committed to an £8.4bn increase in NHS funding by 2020/21 with £3.8bn front-loaded for 2016/17;
- To bridge the gap, NHS England set a target of £22bn in efficiency savings by 2020/21;
- In July 2016, an even more **ambitious efficiency target of 4%** was set for 2016/17;
- This is **unlikely to be achievable** – it's at least double the 1.5–2% that trusts have achieved over recent years, and considerably higher than the average historical saving of 0.8% per year;
- Lord Carter's comprehensive review of NHS productivity identified £5 billion-worth of savings that could be made across the NHS – short of the amount needed to close the funding gap;
- **It is likely to impact on patient care too** – already in 2015, more than eight out of ten doctors believed that efficiency savings had had a negative impact on staff-to-patient ratios;
- If the efficiency targets are met, providers will have an **underlying deficit of £2.35bn in 2017**;
- Even if hospitals achieve efficiency savings of 3–4% every year to 2020/21, they will only balance the books in 2020/21 if they also 'slow the pace of activity growth by 1% to 1.9%'.
- Missing the 3–4% efficiency target means **activity growth needs to be scaled back further**;
- Half of growth in hospital activity is due to the demands of a growing, ageing population;
- This is **now the largest sustained fall in NHS spending as a share of GDP since 1951**;
- Once adjusted for inflation, spending on the NHS in England will increase by an average of 0.9% per year, considerably below the 3.7% growth rate that the UK NHS is used to;
- Once adjusted for NHS-specific inflation, the real increase is just 0.2% per year;
- **UK public spending on health is expected to fall from 7.3% of GDP in 2014/15 to 6.6% in 2020/21** – increasing the gap between the UK and other major EU countries, e.g. Germany;
- Growth in health spending is also set to lag behind growth in the UK's economy;
- The King's Fund calculate that if health spending kept pace with the growth in the economy by 2020/21 we would be spending £16 billion more than planned on the UK NHS.

23. Indeed, the RCP state that: "Cuts to the budgets of social care and public health services and recorded hospital deficits of £2.45 billion are already impacting on patient care: growing waiting lists, patients stuck in hospital because of discharge delays, emergency departments closing their doors, and the spectre of 'rationing' treatment."

The economic impact of the EU Referendum

24. The Health Foundation further concludes that the impact of leaving the European Union will have a negative impact on the UK economy which in turn may result in an NHS budget £2.8bn lower than currently planned in 2019/20, if the government aims to balance the books overall. In the longer term, the NHS funding shortfall could be at least £19bn by 2030/31– equivalent to £365m a week – assuming the UK is able to join the European Economic Area. If this is not the case, the shortfall will potentially be as high as £28bn – which is £540m a week.

25. The Health Foundation assessment determines that if economic growth slows as predicted, funding no longer being paid to the EU would be more than cancelled out by the negative economic consequences of leaving. Therefore if the NHS were to receive an extra £100m a week from 2019/20, this would require: increased taxation of around 1p on the rate of income tax; adding £5.2bn to the expected public finance deficit; or making further cuts to other areas of public spending.

26. This would be compounded by Department of Health budget reductions of nearly £3bn in 2019/20 than currently planned, falling to £118.9bn from the planned spending of £121.7bn (2016/17 prices). This would be an average decrease of 0.4% a year in real terms between 2016/17 and 2019/20. It would see the health budget fall back to a similar level of spending to 2015/16.

The Health and Social Care Act 2012 (the Act)

27. In March 2012, FPH called for withdrawal of the Act and urged the Government to adopt an NHS stabilisation plan.[40] FPH's professional, evidence based analysis made clear that the Act would harm patients, undermine the public's health, lead to service fragmentation, worsen health inequalities and prevent effective health and social care integration. [41, 42, 43, 44, 45, 46, 47]

28. Regrettably, the risks to population health identified are now being realised. Detailed Evidence demonstrating realisation of these risks is found within FPH's report on the Act's impact. [48] The Act's scope and measures prompted concern from many professional bodies. FPH produced a risk assessment[49] outlining six key concerns:

    1. Loss of a comprehensive NHS and withdrawal of NHS services;
    2. Increased competition and costs;
    3. Reduced quality of care;
    4. Widening health inequalities;
    5. Risk to effective discharge of public health responsibilities;
    6. Risk to the public health workforce.

29. In 2014, we conducted a membership survey to determine whether the concerns identified were warranted, and, if so, to grade and prioritise them. The 200 members responding reflected the demographic and work characteristics of FPH's membership. Respondents reported substantial on-going concerns about the Act's scope and implementation. Most consistently rated the risks identified as still 'high' or 'extreme'. The following key threats emerged:[50]

    I. **Infrastructure for public health:**
        a. Short-term nature of 'ring-fence' for local public health budgets;
        b. Lack of access to information about the use of health services.

    II. **NHS Planning and delivery**:
        a. Loss of insight on addressing population need, effectiveness and efficiency for NHS commissioners;
        b. Fragmentation of services and poor coordination of care.

    III. **Public health workforce:**
        a. Concern about workforce fragmentation and the impact on patient and public safety because of changes resulting from Act.

30. The solutions to the challenges that we face are complex. FPH hopes this response offers a starting point for discussion. We would welcome the opportunity to present oral evidence to the Committee.

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[40] UK Faculty of Public Health, Action update, March 2012, http://www.fph.org.uk/action_update
[41] Our Strategy for Public Health in England, 2011, http://bit.ly/1NPPxl0
[42] Transparency in Outcomes, 2011, http://bit.ly/1Sp21iF
[43] Developing the Healthcare Workforce, 2011, http://bit.ly/1O6XIYj
[44] Review of Regulation of Public Health Professionals, 2011, http://bit.ly/1PFK0gH
[45] Funding and Commissioning Routes, 2011, http://bit.ly/1ktOLin
[46] Response to the Health and Social Care Bill committee, 2011, http://bit.ly/1PcDvUq
[47] Response to the Communities and Local Government Committee inquiry on the future role of English local authorities in health issues, 2012, http://bit.ly/1OtEhJo
[48] UK Faculty of Public Health, Membership survey report on the impact of the Act, 2015, http://bit.ly/1FFjzlj
[49] UK Faculty of Public Health, Health and Social Care Bill – Risk Assessment Summary, 2012, http://bit.ly/14BaH2u
[50] UK Faculty of Public Health, Membership survey report on the impact of the Act, 2015, http://bit.ly/1FFjzlj

Consultation questions

The future healthcare system

Question 1: Taking into account medical innovations, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

31. Efforts must be made to increase co-working and collaboration between the NHS, local authorities, employers, the voluntary sector, and communities in all their diversity. The challenges, beyond economic ones, facing all of these groups, not just the NHS, must be approached in a 'whole systems' manner.

32. Targeted prevention needs to be clearly defined as focused interventions that:

    i. Assess the risk to the individual;
    ii. Provide early and timely intervention;
    iii. Provide specific interventions according to the needs of the patient/user;
    iv. Prevent unnecessary hospital admission and support timely hospital discharge;
    v. Prevent unnecessary admission to residential or institutional care;
    vi. Avoid dependency through targeted rehabilitation and recuperation;
    vii. Focus on rehabilitation and help for people to improve their social functioning;
    viii. Provide low-level support for people most at risk of losing their independence;
    ix. Maximise independent living.

33. There must be a concerted, continuous, focus on prevention; health and care systems need to approach prevention in a sophisticated manner – Primary, Secondary and Tertiary prevention are all important to this aim.

34. Investment in maternity and family health needs a social, as well as a medical, focus. Targeted interventions must be designed to address the needs of the most challenged communities in a holistic manner and with a preventative focus.

35. There must be a greater understanding of the social determinants of mental and physical health and of the very high lifetime cost that result from exposure to deprivation, abuse and poverty. Emotional, psychological, and mental health need to be given equal weight to physical health and medical interventions. Medical interventions are likely to be less needed and more effective if the social, emotional and mental aspects are addressed together.

36. Health and social care systems must account for the UK's increasingly ageing population, and must respond with policies designed to encourage and facilitate healthy ageing. A Compassionate Communities approach ensuring that as far as possible people are prepared for and experience 'good death' will have positive mental and physical health benefits for families and communities in the short and longer term.[51]

37. Economically, health and social care systems need to better consider environmental and social sustainability as a highly supporting, not competing, mechanism. The most successful and ethical businesses discovered this years ago and have acted accordingly. Health and social care systems like the NHS have even more to gain from systems such as the Triple Bottom Line Approach.

38. Health and social care services must decarbonise as soon as possible for financial and legal reasons, to be an example of good practice and for social reasons. The NHS and health and social care providers must reduce their carbon footprint and service costs. The Environmental efficiency of the NHS is a critical area that requires attention and focus. Action is required to address wastage through overprescribing, excess transport and buildings/energy costs. FPH acknowledges

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[51] http://www.compassionatecommunities.org.uk/

the role of fora such as the Academy of Medical Royal Colleges' 'Choosing Wisely' programme and also 'Realistic Medicine.'

Resource issues, including funding, productivity, demand management and resource use

Question 2: To what extent is the current funding envelope for the NHS realistic?

39. Please refer to the introduction.

Does the wider societal value of the healthcare system exceed its monetary cost?

What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?

40. FPH recommends capitated place-based budgets for health and care, with mechanisms placed to incentivise local authorities to investment in prevention.

What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?

41. FPH supports use of funds raised from sources such as Sugar Levy to be reinvested in public health and social care services.

Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?

42. The NHS has its place in the UK psyche as one of the major pillars of our society. Founded to help address some of the nation's biggest inequalities, the NHS has become a national treasure. As society has changed, so too have the diseases that challenge us, both individually and collectively. Major killers like obesity, diabetes, and heart disease are influenced by our lifestyles and our environment. Inequalities persist and, in these austere times, are widening. It is still true today that where you live is a major factor in how long, and how healthily, you will live.

43. The NHS has also changed; evolving, innovating to meet those challenges – struggling at times, but in the main available to those who need it, irrespective of wealth or status. However much it has changed, however much it needs to continue to change, fundamental to the NHS's ethos should be that it delivers the maximum public health benefit from every pound invested, that it ensures the highest possible standard of care, and that it remains a universal healthcare system; open to all, free to all, and funded by all through general taxation.

44. We underline the importance of social efficiency. It is more efficient to fund health through general taxation, and inefficient not to address poverty as source of inequality in health and in health service usage.

Workforce

Question 3: What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

45. Since the introduction of the Health and Social Care Act 2012, the public health profession has seen different employers trying to coordinate terms and conditions to cover seniority, pension arrangements, leave entitlement as well as salaries and incremental scales. It is important that

public health leaders have experience of working across local government, the NHS and PHE. We need a single public health system with easy movement between employers.

46. The biggest risk faced is not being able to attract medically qualified specialists to work in local authorities. Public health support to the NHS is provided by local authorities and doctors are needed in multidisciplinary teams to support acute service re-configuration, development of integrated primary care, and health and social care coordination. FPH is concerned by general reductions in public health consultant posts within some local authorities, movement of medically qualified consultants to PHE, and restructuring of smaller teams. Budget cuts place teams at greater risk.[52]

47. FPH is concerned by the contraction of local and national PHE services generally, and, in particular, frontline health protection services. The Acheson report was clear on the need to ensure presence of one Consultant in Communicable Disease Control per 400,000 of the population. Yet, by 2012 this dropped to one in 500,000 and, unless arrested, could drop to 1 in 700,000. The capacity and capability to deliver, with depleted and disconnected public health workforce, for example, a level of response to pandemic influenza, as was the case in 2009, is at serious risk.[53]

What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?

- The creation of opportunities for entry level health and social care training in the UK;
- The development and or clarification of progression ladders from entry level to Post Graduate level in health and social care;
- The increased focus on making a career in health and social care attractive – in terms of workload, culture, values and work satisfaction;
- Appropriate remuneration and status for health and social care practitioners and professionals.

What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?

48. FPH, in its recent report, "*The Health Related Consequences of the European Union Referendum*", made clear the significant benefit to healthcare provision in the UK that free movements of health professionals around the EU, with mutual recognition of professional qualifications, is a significant benefit to healthcare provision in the UK. Up to 10% of the health and social workforce in the UK is of European Economic Area (EEA) origin, addressing existing shortages of skilled staff and able to work in the UK because of EU Treaty provisions.

49. At EU level there is an awareness of the shortages of health workers that exist in a number of countries. It is estimated that the EU will need one million additional healthcare workers by 2020, an increasing urgent issue. Since 2008, the European Commission has funded studies looking at health workforce planning issues such as skills gaps, staff retention strategies and ethical recruitment practices as well as joint actions which bring together member states to explore these issues in detail.

50. At present, there is easy access to skilled labour, and this free movement of health professionals benefits health professionals individually, and the UK generally as a net importer of health and social care professionals. This ensures that skills gaps in the UK workforce are filled quickly, and is particularly important in the NHS and for medical specialties, as well as e.g. home and institutional care for the elderly, as part of UK current efforts to increase domestic medical workforce supply.

51. The UK life sciences sector also benefits from free movement of skilled people within the EU. The UK currently acts as a hub for global researchers, attracting more university-educated EU citizens

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[52] FPH is feeding into the long term review of the workforce commissioned by the DH, PHE and Health Education England, http://bit.ly/1leyAje.

[53] UK Faculty of Public Health, Staffing guidelines: Standards for Effective Pubic Health Teams, http://www.fph.org.uk/staffing_guidelines. FPH is happy to provide further evidence to substantiate on this point

than any other member state, and resulting in 20% of the UK academic community being made up of EU nationals. The UK benefits from access to the Erasmus and Marie Curie schemes that provide mobility of early career researchers, as well as the EPIET programme, providing training in communicable disease control. The quality of UK science is strengthened and acts as a vital magnet for life sciences investment.

52. FPH notes with concern the recent findings of the Royal College of Physicians' report, "*Underfunded. Underdoctored. Overstretched. The NHS in 2016*", which concludes that hospitals could not cope with a fall in the numbers of doctors from outside the UK. The report outlines that:

    - To cope with the shortage of doctors-in-training, the NHS has become increasingly reliant on doctors who qualified outside the UK;
    - Doctors from outside the UK account for two in every five hospital doctors, with nearly one in five qualifying elsewhere in the European Economic Area;
    - This is one of the highest levels of any OECD country, and higher than any other key EU country. It leaves the NHS vulnerable to the impact of changes to immigration rules;
    - Increased reliance on older doctors, with increasing early retirement is a problem;
    - This is a major issue for the GP workforce, which has lost large numbers of experienced and skilled staff. We must take action to avoid this pattern repeating in hospital medicine;
    - Flexible models of working, including in acute and general medicine, are crucial if the system is to respond effectively to growing numbers of doctors who work less than full time;
    - 40% of female consultants work less than full time compared with 4% of male counterparts;
    - As the proportion of women in the medical workforce increases, training numbers must be sufficient to support the growing number of less than-full-time posts.

53. We support the RCPs' conclusion that we need joined-up action across government if we are to address the workforce challenges facing the NHS. The Department of Health, Treasury, Home Office, Department for Exiting the European Union, and Department for Work and Pensions need to work together with the health and social care professions and NHS organisations to find immediate and long-term solutions.

54. Migration rules and plans for exiting the EU must enable staff from outside the UK to work in the NHS; pension rules should not disadvantage doctors for staying longer in the NHS; and medical school and medical careers should be accessible across society

What are the retention issues for key groups of healthcare workers and how should these be addressed?

55. Stress, work overload and lack of control are frequently quoted issues. Addressing this means caring for the carers, ensuring that staff are supported in their wellbeing and work life balance and that they feel valued.

56. Flexible working options and flexible career options which recognise the stressful nature of some roles and enable staff to take breaks, move sideways or across the system.

Question 4: How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

57. High quality initial training supported by an ongoing culture of CPD.

58. Ensure all staff receive training in the emotional, psychological and mental health elements of their role – and that this is applied in practice. Greater focus should be placed on addressing the 'work-life balance' issues faced by staff.

59. The establishment of clear standards in training and practice, for example, ensuring that all health and social care workers are able to effectively treat and or refer people who are tobacco

dependent (as yet there is no such requirement despite tobacco being the largest preventable cause of morbidity and mortality in the UK). Such a standard could be established and regulated by current authorities such as the GMC and NMC.

60. The adoption of a whole system approach, to ensure that where possible, staff are able to work across healthcare, social care and public health disciplines.

61. The establishment of a Royal College, or Chartered Institute of Social Work, in order to do for the social care profession what the Royal Colleges and Chartered institutes have done for other such as General Practitioners and Surgeons.

What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?

62. New drugs and technologies have the potential to reduce the burden on the health and social care workforce, promoting a low-cost/ high population impact model.

What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?

63. Costs should not be the driving factor in relation to the development of a skilled, adaptable health and social care workforce. FPH would recommend funding be directed towards:

    a) Targeted efforts to recruit and build on the current workforce, to counter rates of attrition and account for demographic changes within the current workforce;
    b) Funded education and training for health and social care from entry to post graduate level;
    c) Incentivising staff to remain in the sector by making long-term career and professional development opportunities attractive;
    d) Identifying and providing specific training in areas where there is a skill deficit.

What investment model would most speedily enhance and stabilise the workforce?

Models of service delivery and integration

Question 5: What are the practical changes required to provide the population with an integrated National Health and Care Service?

How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?

64. FPH recommends:

- Establishment of a single capitated budget mediated through a place based approach;
- Integration of primary care, including GPs, into the public health and care system;
- Establishment of parity between emotional, social and mental health needs with medical/physical health needs;
- Establishment of Health Alliances – which include local communities.

How can local organisations be incentivised to work together?

65. Incentives and rewards for cooperation, not competition, can be put in place. A performance based incentive system could be applied in a whole system manner.

How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?

66. The removal of the false distinctions between hospital and community services, and mental and physical health and care services. Such demarcation only places highly skilled and adaptable professionals in rigid silos, reducing their ability to work holistically with individuals.

67. Integration of primary care, including GPs, into the public health and care system.

68. The effective establishment of parity between emotional, social and mental health needs with physical or medical health needs across the whole system. This needs to include the emotional, social and mental health needs of staff.

69. Development of means to enable staff to move with patients across the system, rather than patients moving between, blocks within the system, creating a more holistic relationship between patient and health/social care provider.

70. The establishment of a Royal College, or Chartered Institute of Social Work, in order to give social work the professional status needed to effectively integrate with other healthcare disciplines.

71. Efforts should be taken to remove the blocks to better integration by improving the alignment of whole system objective and measurements (ideally linked to resourcing).

Prevention and public engagement

Question 6: What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

72. The whole system needs to be incentivised to invest in and deliver prevention. Prevention activity needs to be sophisticated and systematic. FPH recommends:

    - Emphasis should be paid to promotion of healthy local, regional and national economies. For example, growth should be inclusive, with support being given to social enterprises, sustainable enterprises and local producers so that they, and the communities they operate in, benefit from national growth;
    - Cuts to local authority public health budgets to reduce the deficit should be recognised as the 'falsest of false economies', as described by the Kings Fund, and reversed;
    - Emotional, social and mental health should be addressed equally alongside physical health;
    - A practical manifestation of this would be the continuity of health and social care provision so that clients receive the personalised care from professionals needed to build and maintain relationships. The present commoditisation of health and social care undermines this
    - Thought should also be given to the short and long-term value of the provision of social prescriptions and welfare/debt advice in primary care settings;
    - Plans should be made to improve the provision, and availability of quality, healthy hospital food – the NHS still has a long way to go before this fundamental provision in optimised (see Soil Association's Food for Life Catering Mark for examples of health and sustainable catering);[54]
    - The NHS should use its estate to promote active travel through provision of adequate cycle storage/showering facilities, and advocate closer public transport links;
    - The NHS should use its estate to incorporate restorative green and blue spaces to promote physical activity, recovery and wellbeing (see NHS forests);[55]

[54] https://www.soilassociation.org/certification/the-food-for-life-catering-mark/
[55] http://nhsforest.org/

- The NHS should invest in, and support Healthy Homes initiatives. For example, the Healthy Housing Hub in Derby is highly effective in reducing demand on health, social care and emergency services, maintaining independent living within vulnerable people's own homes and facilitating timely hospital discharge.[56] This is a good example where existing good practice in housing provision is not incorporated into health and social care systems planning strategies because there are only weak arrangements for this type of planning and the way that resources are distributed locally undermines 'joined up' policy. There may opportunities with the Devolution agenda to address these issues;

- The NHS should mandate and enforce smoke-free hospitals (encompassing all heated tobacco and nicotine products);

- The NHS should properly use daylight/natural light to promote wellbeing and good sleep patterns in hospital settings;

- The NHS should promote widespread adoption of WHO health promotion hospitals approach;[57]

- Making Every Contact Count must be embedded across NHS and social care organisations;[58]

- Alcohol brief intervention/motivational interviewing should be offered in all hospitals.[59] [60]

What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?

A strong specialist workforce

73. A strong public health specialist workforce provides leadership, capability and capacity that can:

    - Ensure the delivery of public health functions;
    - Provide a source of expert advice to political leaders and other policy makers;
    - Provide high quality decision-making: the ability to bring in research and intelligence and integrate with community and other views;
    - Improve health and social outcomes, ensuring the best use of scarce resources;
    - Provide resilience: to lead in major events such as outbreaks and flooding;
    - Anticipate changing environments and new hazards and threats;
    - Reduce the burden of non-communicable diseases on health and social care;
    - Ensure succession planning, including future DPHs and other key roles.

74. FPH feel very strongly that the future of high quality needs-based commissioning in the NHS will be compromised by a lack of specialist public health staff experienced and available to support GPs and other clinical leaders in that function in CCGs. In addition, as Integration and closer Health and Social Care commissioning models develop in a climate of increasing resource pressures, local health communities will require more rather than less support of this sort to maintain improving health outcomes.

75. FPH also emphasises the substantial and core role consultants in HCPH play in maintaining Joint Strategic Needs Assessment (JSNA) chapters – particularly those that relate to individual diseases and/or associated healthcare services – which are supposed to be a central support for health and wellbeing work. Many JSNAs are getting increasingly out of date – possibly due to lack of public health, and HCPH capacity within local authorities.

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[56] http://www.derby.gov.uk/housing/improvements-and-repairs/healthy-housing-service/
[57] http://www.hphnet.org/index.php?option=com_content&view=category&id=10&Itemid=374&limitstart=20
[58] https://www.gov.uk/government/publications/making-every-contact-count-mecc-practical-resources
[59] http://www.who.int/substance_abuse/activities/sbi/en/
[60] http://www.bmj.com/content/340/bmj.c1900

76. Whilst we recognise there are still public health teams that provide a superb and high quality service in the way envisaged in the Act, many are experiencing capacity or capability challenges as resource pressures and skill-mix change affects English public health departments. FPH recommends that an urgent review is undertaken on the current capacity for HCPH and whether Public Health England or NHS England need to take action to maintain a sufficient core of skilled practitioners to cover all healthcare commissioning organisations.

77. FPH further recommends, as it has done since the passage of the Health and Social Care Bill, that a public health presence should be embedded on a statutory basis on the Board of NHS England. FPH is committed to supporting this function and we are looking at ways of ensuring the best possible training experiences for future specialists but feel strongly that Public Health England and NHS England's oversight, influence and support is vital in safeguarding this role for the future.

78. FPH attaches with this response some case studies of the value that Healthcare Public Health brings to the sustainability of the NHS.

Upstream legislative policy interventions

79. The Faculty of Public Health (FPH) draws attention to our 12-point action plan for public health. Start Well, Live Better is the culmination of an extensive consultation with our members about the top public health priorities for this government and the next.

80. From children's health to climate change, Start Well, Live Better sets out 12 important and practical actions for anyone serious about giving our children the best possible chance of a healthy and happy life – and each intervention will make an important contribution to addressing the sustainability of, and reducing pressure on, the NHS.

Give children the best start in life
- Implement the recommendations of the 1001 Critical Days cross-party report
- Make personal, social, health and economic, and sex and relationship education a statutory duty in all schools
- Reinstate at least two hours per week of physical activity in schools

Introduce good laws to prevent bad health and save lives
- Stop the marketing of foods high in sugar, fat and salt before the 9pm watershed on TV, and tighten online marketing restrictions
- Introduce a 20% duty (per litre) on sugar sweetened beverages
- Introduce a minimum unit price for alcohol of at least 50p per unit of alcohol sold
- Implement standardised tobacco packaging
- Set 20mph as the maximum speed limit in built up areas

Help people live healthier lives
- Give everyone in paid employment and training a living wage
- Reaffirm commitment to a universal healthcare system, free at the point of use, funded through general taxation

Take national action to tackle a global problem
- Invest in public transport and active transport
- Implement a cross-national approach to meet climate change targets including a rapid move to 100% renewables and a zero-carbon energy system.

81. **Childhood obesity**: In August the Government published its childhood obesity plan. FPH welcomes the fact that the government has produced this plan to tackle childhood obesity, which includes measures for reformulation, the introduction of a sugar tax, an exercise plan for schools, a standard for public sector food procurement and the reinstatement of a healthy schools standard.

82. However, this plan lets down a generation of children by not going far enough to tackle childhood obesity. We are at a crisis point: if we are successful in tackling childhood obesity, we will give all children, particularly those from the most deprived backgrounds, the best start in life so they can grow up to be healthy adults.

83. If we fail, it is children and their families who will pay the price, as well as the tax payer, because of the estimated £4.2 billion costs to the NHS of treating obesity in everyone. We must not become blasé about the risks that obesity poses to the one in five children who are obese by the time they are 10. An obese child's weight can cause them significant health problems and make it more likely they will develop life-limiting diseases like Type 2 diabetes.

84. FPH remains fully supportive of a duty on sugary drinks a part of a wider strategy to tackle childhood obesity, and is very disappointed that the necessary, evidence based measures to make the duty a success are not included in the plan. These include tougher regulations of junk food marketing to children, particularly online, where there are far fewer restrictions.

85. No single measure will not combat childhood obesity. We are very disappointed that the sugar duty is the only one of 11 evidence-based measures that are included in this report, and that the government has failed to adopt the comprehensive evidence compiled by Public Health England.

86. We are disappointed that some in the food industry have been claiming that a sugar duty would lead to job losses: in fact, it would be good news for the wider economy as well as our health, because of the money saved from treating obesity-related health conditions. People living in the most deprived circumstances have the most to gain from the duty, because they are more likely to experience health problems caused by a poor diet that is high in sugar.

87. We know from independent analysis of the responsibility deal that five years of voluntary agreement with industry has largely failed to address this crisis. There is no evidence that voluntary approaches are effective. The previous Chancellor told parliament he did not want to duck the difficult decisions and tell his children's generation that we did nothing to tackle childhood obesity. We and the wider public health community want to see the new government show the same commitment to child health by taking bold action.

88. FPH is a member of the Obesity Health Alliance and we support its policy positions, which the Committee can read here http://obesityhealthalliance.org.uk/wp-content/uploads/2016/08/OHA-Joint-Policy-Position-Statement-Aug-2016.pdf.

Trade and Health

89. FPH has previously raised our strong concerns that the Transatlantic Trade and Investment Partnership currently under negotiation between the EU and United States risks increasing levels of competition in the NHS, fragment services and make it harder to give patients high quality, integrated care. It also risks increasing the cost of vital medicines, including cancer drugs, for patients across Europe.

90. As the Government consider their potential negotiations on bilateral trade agreements post the European Union Referendum, it is important that public health concerns override economic or trade concerns in any area where these priorities may conflict. This means:

    - Including clear and strong public health exceptions, and;
    - Defining public health as broadly as possible (e.g. not restricting the definition, explicitly or implicitly, to emergencies or to particular diseases).

91. We draw the Committee's attention to our detailed report on this issue:

    - FPH, Trading Health? Executive Summary http://www.fph.org.uk/uploads/TTIP%20executive%20summary.pdf

- FPH Trading Health? Full Report
http://www.fph.org.uk/uploads/FPH%20Policy%20report%20on%20the%20Transatlantic%20Trade%20and%20Investment%20Report%20-%20FINAL.pdf

92. We also note the recommendations of the Health Impact Assessment undertaken by the University of New South Wales on the regional equivalent Trans-Pacific Partnership Agreement https://www.phaa.net.au/documents/item/494

Mental Health and Wellbeing

93. Poor mental health brings with it costs to individuals and their families as well as to society as a whole through costs to public services: health, social care, housing, education criminal justice, social security and the wider economy. People with mental health problems are more likely to experience physical health problems, smoke, be overweight, use drugs and drink alcohol to excess, have a disrupted education, be unemployed, take time off work, fall into poverty, and be overrepresented in the criminal justice system.

94. Productivity losses, benefit payments and cost to the NHS associated with mental health problems cost the English economy £70bn a year 59.

95. It is vital that public health (and other health and social care) practitioners become advocates for public mental health providing strong leadership and prioritising mental health within current public health practices. Here is a list of key actions that all professionals working in public health and beyond can take to promote mental wellbeing and prevent mental health problems:

- Whether you work in a specialised public health role or generalist/general work force, consider what you can do within your sphere of influence to advance the public's mental health as a leader, partner and advocate;
- Move, wherever possible, from deficit to strengths-based approaches and ensure you promote good mental wellbeing, address the factors that create mental wellbeing and tackle mental health problems;
- Adopt a proportionate universalism approach, including universal interventions to promote mental wellbeing across whole populations, with more progressively targeted interventions to address specific needs among more vulnerable and at risk groups;
- As part of the universal approach, ensure that you are working towards your own mental wellbeing and that of your colleagues;
- Move towards ensuring mental health receives the same billing and priority as physical health in your work;
- Adopt a life course approach. The foundations of mental health are laid down in infancy in the context of family relationships. Place-based intervention in settings such as schools, workplaces and communities complements the life course approach and makes the most of existing opportunities;
- Reduce stigma and discrimination by increasing mental health and wellbeing literacy across the whole population. Include interventions to improve understanding of the impact stigma and discrimination have on the lives of people with mental health problems;
- Contribute to the expansion of the public mental health evidence base and focus on the interventions and activities that make the biggest impact;
- Ensure that you build evaluation into everyday practice and monitor the effects of practice on mental health.

96. FPH draws attention to FPH's recent report, *Better Mental Health for All: A public health approach to mental health improvement* and is keen to discuss the recommendations and findings in further detail with the Committee. http://bit.ly/28LW9U9

Welfare Reform, life chances and child poverty

97. Poverty is the major cause of inequality in health and in service usage. FPH provides the secretariat for the APPG on Health in All Policies. In February 2016, the APPG published its report into the impact of the Welfare Reform and Work Bill 2016-17 on child poverty.[61] The report outlines that a generation of children who grow up in poverty and have worse health as a result.

98. We must have a successful and prosperous economy, but this APPG report clearly illustrates that the Government's attempts at an economic recovery may risk increasing the health inequalities faced by poor and vulnerable families and children.

99. There are 3.7m children in the UK living in poverty, the majority [60%] of whom have parents in low-paid work, and that the Welfare Reform Bill introduces measures that have the potential to increase the number of children growing up in poverty by 1.5 million by 2020. This is unacceptable especially when there is strong evidence that shows that eliminating child poverty in the UK would save the lives of 1,400 children under 15 every year.

100. Of the measures the Bill proposed six were found to directly and detrimentally affect child poverty. The seventh measure which looked at the impacts of the 1% reduction in social housing rent, appeared to have a short-term, positive impact on household incomes but in the longer term would reduce the availability of affordable housing, driving up rents and housing costs.

101. The APPG has made more than 30 recommendations to address the negative effects of the Welfare Reform and Work Bill, which we attach as an appendix below. We need a comprehensive, cross-government strategy to tackle child poverty, otherwise we are in danger of failing our children and creating a lost generation. The cumulative effects of this bill will in turn increase pressure on the NHS, and further compromise its sustainability.

102. In this context, FPH emphasises that it is disease free live expectancy which poor people lose more of so they may be living with long term conditions for more than 30 years. This is major cost to health service and why resource allocation should be redirected to areas with lowest disease free life expectancy. We also emphasise the use of disability free life expectancy as a means to more fairly reflect burden of inequality and long term conditions on health service demand.

103. It also means that 'preventive services' such as stop smoking need to be rigorously offered through clinical care for those already having long term conditions to prevent deterioration and aid recovery.

104. Related to this, FPH draws attention to the growing acknowledgement that those first early years of a child's life are absolutely crucial. Getting it right as parents with professional help and public resource to support where needed has the potential to make a huge difference to how that child will grow into an adult contributing to society.

105. FPH supports the recommendations of the 1,001 Critical Days Cross Party manifesto. It is a vision for the provision of services in the UK for the early years period, which puts forward the moral, scientific and economic case for the importance of the conception to age 2 period. This period of life is crucial to increase children's life chances. Society is missing an opportunity if we do not prevent problems before they arise and that it is vital that a focus on the early years is placed at the heart of the policy making process.

106. The Manifesto highlights the importance of acting early to enhance outcomes for children. Too many children and young people do not have the start in life they need, leading to high costs for society – for the NHS – and too many affected lives. Every child deserves an equal opportunity to lead a healthy and fulfilling life, and the 1001 Critical Days Manifesto supports this.

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[61] http://www.fph.org.uk/uploads/APPG_on_Health_in_All_Policies_inquiry_into_child_poverty_and_health_2.pdf

A Health in All Policies Approach

107. FPH supports the findings of the recent Health Select Committee report in public health post 2013:

"*National system leadership is important to signal clarity of purpose and commitment to the local system when it comes to improving health and wellbeing. In order to demonstrate where national leadership for public health lies, and to avoid confusion and the risk of giving conflicting advice to the local system, the Government should produce a clear statement of who does what in respect of the main system leaders, namely, the Department of Health, Public Health England and NHS England.*"

108. *Embedding health in all policies is important at both national and local level. But while there is evidence of progress locally, there is less evidence of such an approach becoming embedded across Government departments. We urge the Government to take bold and brave action through its life chances and childhood obesity strategies in order to improve public health and reduce health inequalities.*

109. *How most effectively to secure joined-up working across Government is a complex challenge to which there is no single or simple solution. The issue is not amenable to a simple structural fix—building sound relationships is a key step in the process.*

110. *A Cabinet Sub-Committee on Public Health is unlikely in itself to be the answer to securing more effective joined-up policy to improve health and wellbeing. We consider instead that the strengthened cross-departmental working which is required is more likely to be achieved by vesting responsibility for providing political leadership for public health at a national level in a Minister in the department responsible for coordinating cross-departmental work, the Cabinet Office. We recommend that a Minister in the Cabinet Office be given specific responsibility for embedding health in all policies across Government, working closely with the Minister for Public Health in the Department of Health.*

111. *Since Public Health England was established, the interface between it and the DH has lacked clarity. We therefore urge the Government to review the relationship between the DH's Public Health Group and PHE. The 'tailored review' of PHE which DH is currently carrying out offers a good opportunity to do so.*

112. *Likewise we urge NHS England and PHE to clarify how the two organisations are seeking to pool their expertise and resources around public health in order to ensure that the local health system feels adequately supported and not conflicted by confusing messages or requirements.*

Air Pollution

113. FPH fed into and endorses the Royal College of Physicians' and Royal College of Paediatric and Child Health's report, *Every Breath we Take* (http://bit.ly/1PUBD09), which examines the impact of exposure to air pollution across the course of a lifetime.

114. The report sets out the dangerous impact air pollution is currently having on our nation's health. Each year in the UK, around 40,000 deaths are attributable to exposure to outdoor air pollution which plays a role in many of the major health challenges of our day. It has been linked to cancer, asthma, stroke and heart disease, diabetes, obesity, and changes linked to dementia. The health problems resulting from exposure to air pollution have a high cost to people who suffer from illness and premature death, to our health services and to business. In the UK, these costs add up to more than £20 billion every year.

115. FPH has also draws the Committee's attention to our recent report, *Local action to mitigate the health impacts of cars* which adds to the knowledge of the dangers from air pollution, and the urgency with which we must improve our air quality. http://bit.ly/2aoKT2m

Public Health expertise embedded in commissioning

116. FPH expresses deep and ongoing concerns about the future of public health specialist input into healthcare planning and commissioning as a result of the Health and Social Care Act 2012 (the Act). Effective healthcare commissioning and meeting the challenges of NHS England's Five Year Forward View requires CCGs to deliver highly competent local commissioning of effective and efficient healthcare services based on need.

117. The value that public health specialists have traditionally brought to that CCG role was recognised in the Act, which made this service to CCGs a statutory part of the new public health role of local authorities in England.

118. Healthcare public health is one of the three core domains of specialist public health practice, alongside health improvement and health protection. Healthcare public health (HCPH) is concerned with maximising the population benefits of healthcare while meeting the needs of individuals and groups, by prioritizing available resources, by preventing diseases and by improving health-related outcomes through design, access, utilisation and evaluation of effective and efficient healthcare interventions and pathways of care.

119. FPH draw the Committee's attention to our recent definition of Healthcare public health[62] (http://bit.ly/1IvNRqu), which is also attached with this submission.

120. Since the Act, and subsequent severe resource reductions of approximately 20% for English councils, there has naturally been pressure on the public health functions that transferred to local authorities in that reorganisation. One consequence of this in many places has been a gradual reduction in the specialist workforce that is dedicated to working on HCPH with CCG NHS commissioners.

121. Whilst this is not universal, there are many examples we have come across where that function is substantially limited or even absent. This is a matter of ensuring that the right people, with the right skills – experts in population health – are in the right place and able to provide the population with assurance that their local (and national) services will be commissioned to the highest quality and represent the best value for money, and improving the efficiency of the NHS.

122. Naturally many English council public health departments focus on their direct health improvement roles, wider strategic public health upstream work and the commissioning of those limited health services for which the councils are now responsible. We have many examples where private consultancy has been used by CCGs or DPHs because of a lack of those necessary skills or limited capacity within their existing teams working on mainstream health services commissioning, suggesting there is unmet need developing.

123. Spending valuable funding on costly management consultancies, which may not be of the highest quality, to fill gaps left by public health does not represent the value for money the public would expect in addressing their population health.

124. There has also been a loss of more experienced specialist staff familiar with health services commissioning in many public health departments and although public health training is carefully overseen and comprehensive, many trainees and newly qualified Consultants now have limited experience of direct NHS work and familiarity with NHS datasets required in such work.

[62] UK Faculty of Public Health, Definition of Healthcare Public Health, November 2015, http://bit.ly/1IvNRqu

What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?

125. Personal responsibility and self-management are important principals to be promoted through advocating improved health literacy, it is equally important to recognise that the state and its institutions have a responsibility toward the health and wellbeing of the populace. The most effective interventions are upstream legislative and regulatory interventions.

126. The State needs make decisions based on the best available and most up to date scientific evidence base in legislating for health. It needs to ensure local areas are properly and fairly funded. The current cuts to local authority budgets is, and will continue to be, very damaging to the prevention agenda unless this changes.

127. Local and / or regional bodies need to gather and analyse local data and evidence. They need to understand their people and their needs with a view to understand current and future prevention needs.

128. The establishment of a specific civil service position, responsible for monitoring trends in public health, noting when both self-reporting, and national statistics begin to highlight worsening morbidity and mortality. At present, no official, or body has commented on the rise in poor self-reported health in the UJ, and there have only been cursory investigations into the falling life expectancy of elderly people in 2012 and 29013, and the very large rise in deaths in 2015.[63] [64] FPH supports the Health Select Committee's recent proposal for cross department.

129. The state needs to actively monitor and regulate industries related to unhealthy lifestyles. For example, the state needs to:

    e) Address the marketing of unhealthy foods high in fast sugar and salt, particularly to children;[65]
    f) Effectively monitor and regulate industries developing heated nicotine/tobacco products in line with other European nations
    g) Reduce the threat of climate change to human and planetary health.

Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?

130. Yes there is a mismatch, both in funding between treatment and prevention, and between different local areas due to different approaches of local authorities.

131. There is gross lack of investment in emotional and mental health, both in terms of treatment and prevention. For children, the Future in Mind programme has gone some way to address this, and facilitated investment in universal interventions and early intervention, as well as treatment, enhancing personal and community resilience.[66]

132. The public health ring fence has been extremely helpful to date, where it has been honoured. The challenge has been managing a ring fence within a local authority system which is diminishing, resulting in cuts to provision which is essential to prevention.

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[63] http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationsummarytables/2014-07-16
[64] http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationsummarytables/2015
[65] https://www.sustainweb.org/publications/who_sets_the_agenda/
[66] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

133. Decarbonisation of NHS services can release economic savings, and help achieve shifts towards self-care, out of hospital care, and improved public health and wellbeing (see Sustainable Development Unit's research 'Securing Healthy Returns').[67]

Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?

134. Yes. "Upstream" interventions categorised as "Price" are most likely to decrease health inequalities, while "downstream" "Person" interventions appear most likely to increase inequalities. Please see section on childhood obesity.

By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?

135. The most effective means would be the effective use of good quality evidence to build the, solid, business case for prevention.

What are the barriers to taking on received knowledge about healthy places to live and work?

136. Individual behaviours take place within a culture. For example, Smoke Free Legislation in the Health Act 2006 changed social norms and influenced individual behaviours.

137. Therefore the focus needs to be on shifting social norms and building healthy places, which enable and support healthy choices and behaviours.

138. Currently the implementation of measures to enhance positive health impacts of built environment / infrastructure developments are hindered by developers' viability concerns (e.g. unwillingness to include high proportion of affordable housing, or build to high sustainable homes standards).

How could technology play a greater role in enhancing prevention and public health?

139. Technology needs to be easily and effectively integrated into people's everyday lives. In terms of primary prevention, there are already a number of mobile apps that are in use for supporting healthy behaviours, e.g. PHE's Sugar Smart app, and exercise/fitness apps. On a secondary prevention level, using effective technologies to support monitoring of health conditions can aid self-management and reduce burden on services.

Question7: What are the best ways to engage the public in talking about what they want from a health service?

140. Technology needs to be easily and effectively integrated into people's everyday lives. In terms of primary prevention, there are already a number of mobile apps that are in use for supporting healthy behaviours, e.g. PHE's Sugar Smart app, and exercise/fitness apps. On a secondary prevention level, using effective technologies to support monitoring of health conditions can aid self-management and reduce burden on services.

141. It is important to acknowledge that what patients and the public consider to be priorities within health services is not necessarily what professionals and providers consider as priority.

142. The patients that engage most with decision makers are not necessarily representative of service users as a whole. Those most in need of services are often the least able to engage. Care needs to be taken to ensure equitable representation of patients in consultations and the co-production of services. Communication should be both ways, with clear rationale for healthcare decisions and transparency of processes.

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[67] http://www.sduhealth.org.uk/policy-strategy/engagement-resources/fnancial-value-of-sustainable-development.aspx

143. It is better to talk about how people want to live healthy fulfilling lives (reduce reliance on service provision / passive client model). An excellent model that engages with people to 'get a life not a service' is the Local Area Coordination (LAC) approach adopted in Derby.[68] LAC empowers people to improve their health and wellbeing through community solutions. It supports the wider transformational change for the NHS to ensure a sustainable health service by focusing on prevention, person centred and flexible care through local, joined up support.[69]

144. The promotion of individual behaviour change need to be reinforced by the promotion of a healthy culture; with key health messages from birth, through school and on through employment through employers. Direct means such as action to restrict the promotion and sale of unhealthy foods and drinks; investment in healthy towns and communities; and incentivising people to engage in all forms of active travel.

Digitisation of services, Big Data and informatics

145. Data linkage is life-saving. The public needs to be properly engaged in a discussion of how population health data enables better services and the connection of services throughout health and social care and enables us to understand more about the causes and solutions to health problems.

Question 8: How can new technologies be used to ensure the sustainability of the NHS?

What is the role of technology such as tele-care and tele-health, wearable technologies and genetic and genome medicine in reducing costs and managing demand?

146. Technology has an enormous role in reducing costs and managing demand in the health and social care system, and will increasingly do so with a digital generation. If used appropriately, technology can be harnessed to improve diagnostic accuracy, support self-care and facilitate healthy behaviours and therefore reduce demands and costs for services. However, use of technologies in this context needs to be monitored and evaluated for cost-effectiveness, patient safety and unintended consequences.

What is the role of 'Big Data' in reducing costs and managing demand?

147. Big data needs to be produced in a timely manner. Facilitating data sharing within and between organisations can help to improve service planning and delivery; maximise outcomes for individuals with complex needs; and improve efficiency by reducing duplication of data recording and improving communication between health and related professionals. However, effective data sharing needs to be balanced with safeguards for patient confidentiality and appropriate usage. Local organisations should develop clear data sharing protocols, supported by national guidance.

What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?

148. Apart from the application of the technologies – there will be 'people dynamics' to manage for staff, patients and public. There is a culture of caution when it comes to data sharing, due to concerns around confidentiality and appropriate usage on both sides (professionals and public). Systems for recording data are not always compatible within or between organisations.

[68] http://www.derby.gov.uk/health-and-social-care/your-life-your-choice/active-in-community/local-area-coordination/
[69] Ibid

How can healthcare providers be incentivised to take up new technologies?

149. Evidence gathered through robust evaluations of new technologies can and likely will be used to demonstrate their value for money

Where is investment in technology and informatics most needed?

150. Investment in technology and informatics would have the most impact in evaluative processes, to ensure the ability to build the evidence bases for effectiveness of new treatments and technologies, the review and development of clear systems, and the development of guidance and protocols for effective and safe data sharing

If you require any further information, please contact:

Femi Biyibi
Policy Officer
Faculty of Public Health
Femibiyibi@fph.org.uk
0203 696 1476

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