



Faculty of Public Health

of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

FPH response to *Equity and excellence: Liberating the NHS*

The UK Faculty of Public Health (FPH) is the leading professional body for public health specialists in the UK. It aims to advance the health of the population through three key areas of work: health improvement, health protection and health care. 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. We welcome the opportunity to respond to the NHS White Paper and contribute to the government's plans for the development of a Public Health Service.

We surveyed our 3,300 strong membership about the proposals contained in *Liberating the NHS* during August 2010. The 1,160 replies that we received to our questionnaire form the basis of the response outlined in this paper. The views expressed represent those of people working to inspire and lead service development, prioritise interventions and protect and improve the health of the population in a range of different settings, from local government to PCTs, large hospital trusts and academia. The strong response from the public health workforce represents a desire to engage with the government's proposals and help shape an NHS and a Public Health Service that truly support, protect and improve the health of the population.

Our membership, whilst appreciative of the increased focus on public health, expressed concerns or were unsure whether the reforms outlined in the White Paper would increase efficiency, or help to improve the health of the population. This reflects in part the fact that the impact over time will depend heavily upon the details of the local and national arrangements which will be put in place, and these are not yet clear. It is also an expression of a genuine concern that increased transaction costs, as a result of many new commissioners, and the costs of potential redundancies, are likely to have significant financial implications. We look forward to further clarification from the Department of Health on the wider health impacts and financial implications of these reforms.

Our top line comments are outlined below, followed by further analysis and response.

General comments

- FPH welcomes the emphasis in *Liberating the NHS* on improving and protecting the public's health and on outcomes and equity.
- The proposed reforms have the potential to make a significant, positive and enduring impact on the health of the population. For them to succeed in this, responsibilities in the new system must be defined and

resourced appropriately and every opportunity taken to build in synergy, collaboration and efficiency.

- Public health specialists are trained in and work in three domains:
 - improving health;
 - protecting the public from disease and disaster; and
 - health care quality, safety and appropriateness, identifying how the population's need for care can be best met.
- It follows that public health expertise should be embedded in all aspects of health care:
 - in regulatory bodies, to make sure the right questions are asked and answers understood;
 - in commissioning groups and the National Commissioning Board to help them work out the right balance of services, inspire new models and evaluate cost-effectiveness; and
 - in providers to help them with all three aspects of public health
- A strong director of public health with wide responsibilities for health protection, health improvement and oversight of services for a *geographically defined* population is pivotal to the success of the new system. They should be required to report in public on the health of their population and the extent to which health needs are being met by local services. They must be an executive director of the Local Authority and accountable directly to the chief executive.
- All specialists in public health employed in the public sector, including Directors of Public Health and their local teams, should have a contractual relationship with the Public Health Service. This will ensure that the highest professional standards are maintained and will facilitate cost-effective and equitable access to specialised skills.
- FPH welcomes in principle the proposed ring-fenced budget for public health. Its purpose should be clearly defined, it must be large enough to meet the purpose it serves, and it must be managed by the Director of Public Health, with advice and support from Health and Wellbeing boards.
- The establishment of Health and Wellbeing boards represents an excellent opportunity to influence and energise change; to ensure health and care needs are met comprehensively and efficiently; and to embed public health principles in local authorities. This will require that they are given the necessary powers and have a credible and influential membership, with reach across sectors.

Turning now to the detail of the proposals:

The Public Health Service

FPH welcomes the creation of the Public Health Service. We look forward to more detail on the structure of this organisation in the forthcoming Public Health White Paper, but in the meantime we suggest some principles that it should be based upon. The Public Health Service offers an opportunity to create and maintain a workforce that serves the population's health effectively and efficiently, but it must have sufficient independence, resource and stability.

Independence

Independence is the first of these principles. Like any clinical advice, the advice given by public health specialists needs to be credible, authoritative and responsive to the needs of the patient. Public health specialists are health professionals whose 'patient' is the population they serve. This means that they have a professional duty to the health of that population, and ethical, and in many cases contractual, obligations which bind them to that duty. This translates into duties to make professional opinions publicly known, to advocate for necessary changes, to be an authoritative source of advice and to take and support appropriate action to improve the population's health. This may place them, individually or collectively, in a position where their professional opinion and advice is at odds with the views of local and national elected officials. Public health specialists and directors of public health need to operate within a contractual framework that protects this professional freedom but also balances this with accountability and responsibility in relation to delivery of specific delegated tasks. The relationship between the Public Health Service (and in particular the Directors of Public Health) and the Department of Health must be framed in such a way as to achieve this balance. We would welcome the opportunity to help define how this independence may be maintained.

Resources

The second principle is that the Public Health Service needs to be adequately resourced. This requires not only adequate finances but also the right number and type of staff. We welcome the ring-fencing of the public health budget, as long as it is clearly defined, and that excluded activities that have a bearing on public health will continue to be funded from other budgets. Public health at local level achieves the best outcomes when strong local teams of properly trained and regulated specialists with remits across health protection, health improvement and health care commissioning and provision are brought together under an effective Director of Public Health, with access to high quality local and national data and the best available scientific evidence base. The Public Health Service will also need sufficient flexibility to deploy staff to best effect, moving quickly to address situations of acute or pressing need. Given the limited size of the public health specialist workforce, this flexibility in response would necessitate that the public health specialist workforce remains a single entity. A Public Health Service that has a

contractual relationship with all public health specialists would do much to facilitate this.

Workforce

This relationship will help to ensure that the Public Health Service is served by a stable and motivated workforce. Previous reorganisations have resulted in 10-15 per cent of the specialist workforce leaving, and our survey indicates a similar risk this time (17 per cent said they would either retire or move out of public health practice, or consider doing so, as a result of the proposals outlined in the White Paper). This risk is heightened by the current financial climate. All public sector organisations, including the NHS, are being asked to reduce their costs significantly and there is a substantial risk that the resources available to public health will have been eroded substantially before the proposed new arrangements are in place.

The creation of the Public Health Service presents an opportunity to provide a highly visible and secure home for the entire public health specialist workforce, one which would also facilitate the training of future specialists. However, it will only be perceived as doing so where it contains public health specialists working across the full range of public health practice, including those involved in commissioning and planning of services. Concerns over the fragmentation of the public health specialist workforce arise from the uncertainty over the remit of the proposed public health service and current indications that it will limit its scope to health protection and some elements of the health improvement agenda.

Commissioning

FPH welcomes the principle of empowering those closest to patients to advocate and make decisions around the healthcare that they receive. However, whilst GPs, nurse practitioners and other frontline health professionals are well aware of the health needs of the individual patients who come to them for help and care, they are not necessarily best placed to make strategic decisions around service planning, health protection, or health improvement for their local population. This daily patient perspective may indeed inadvertently bring them into direct conflict with an evidence based population perspective that they will need to draw on when making commissioning decisions. This underlines the importance of having public health support and advice firmly embedded in the system to help with these decisions.

To help them to address these three 'domains' of public health, GP commissioners will need the support, skills and expertise of public health colleagues. This is a message strongly backed by our membership, of whom 97 per cent either agreed or strongly agreed that such support was "vital", while 93 per cent agreed that without this input, population-based health initiatives might carry a low priority. GP-led primary care is by its very nature reactive; with public health input it can be much more proactive in planning appropriate care services, making arrangements for possible infectious outbreaks, and encouraging the local population to take

responsibility for improving its own health. Prioritisation can also be challenging for GPs who, with a typical list size of 1500 patients, may see relatively few patients each year with less common health problems – they may for example, care for only one or two people with a new stroke each year and perhaps one or even zero patients with colorectal cancer.

Public health expertise in service development and prioritisation can offer a vital, evidence-based overview that will allow GP consortia to plan services that intervene before more expensive, treatment-based healthcare may be needed. In short, whilst welcoming the emergence and creation of GP consortia, we also argue that it is essential that public health expertise is firmly embedded in these new arrangements.

NHS Commissioning Board

We welcome the creation of the NHS Commissioning Board. Here, too, the involvement of public health expertise at the highest level will be necessary to assure its success in improving the population's health and commissioning specialised services. Presumably the Public Health Service will operate alongside the Board, and we welcome further clarity from the forthcoming Public Health White Paper in outlining this relationship. The implied function of the Board as a means of monitoring and addressing unacceptable variations in healthcare provision that could widen health inequalities is also welcome. The relationship between the Board and local Health and Wellbeing Boards is also crucial, to ensure continuity of service provision and ensure that some low-volume (but not defined as specialised) services are not neglected.

NHS Outcomes Framework

FPH endorses strongly the focus on outcomes and equity throughout the White Paper and its accompanying papers, and the proposal that health and social services should be assessed on their ability to achieve them. However, we feel that the outcome framework for the NHS requires a clear focus on prevention as well as on treatment and care. We acknowledge the value of the five 'domains' upon which the outcomes framework will be developed, but we would also suggest an additional, sixth domain, around preventing ill health. Prevention of disease and improving the population's health is not only a clinical objective, it is also fiscally prudent.

We also welcome the involvement of NICE in developing quality standards.

The role of the Director of Public Health

FPH welcomes the joint appointment of Directors of Public Health (DsPH) with local authorities. If managed correctly, these new arrangements have the potential to promote closer working between all the partnerships locally that will have an impact on health, from environmental officers to the local fire service to town planning. However, the success of these arrangements hinges on the role of the DPH. It is essential that their position is one of relative independence, free from direct political

intervention. It is vital that they have responsibility for a defined geographical area (to ensure clarity of purpose, and so that they are accountable to their local population), and that they are required to report annually in public on the health of their population and to assess whether local services are meeting local health needs. They should be accountable directly to the chief executive of the local authority, and work closely with colleagues across all sectors in the local area. The role of the Health and Wellbeing Boards (see below) will be instrumental in advising and collaborating with the DPH to achieve a coherent and effective system for improving, protecting and planning services for the health of the local population.

Democratic legitimacy and Health and Wellbeing boards

FPH is supportive of the establishment of Health and Wellbeing boards. However, it is vital that their powers are statutory, and that they develop quickly into organisations that take a pragmatic and proactive approach to local health issues, rather than well-meaning but ineffectual talking shops. To this end, tangible powers and a credible, influential membership is essential. The inclusion of the DPH and the Mayor outlined in the *Increasing democratic legitimacy in health* paper goes some way towards this, although the inclusion of the latter may provoke questions about the political independence of the Health and Wellbeing Board. Health and Wellbeing Boards will also need to establish strong working relationships early on with GP consortia to agree commissioning priorities and assessment of local health needs. We suggest that public health colleagues would be well placed to broker this interaction.

Education and training

To support all these changes and developments it is essential that appropriately trained staff are available. These will assist local communities in improving their own health, ensure that specialist advice is available to protect the public, and enable commissioning consortia to function effectively.

A specialist training programme is available to support all these objectives. This provides a workforce that is able to assist with implementing the proposed reforms and adaptable to the changing context. To make sure that staff are developed to meet these and future needs it is important that training opportunities and arrangements are built in to the new structures, across all three public health domains. In particular, public health specialists will benefit from updating with regard to the current Local Authority environment; and many General Practitioners will need immediate support to develop their skills in the local commissioning of healthcare services. The Faculty of Public Health has for many years provided specialist training for GPs and others who wish to pursue a career in public health.

Professional regulation

It is vital for the protection of the public that all public health consultants and specialists have statutory regulation and are appointed by advisory appointments committees - even if they work in a local authority.

Directors of Public Health and their consultant and specialist public health colleagues will have wide-ranging responsibilities for the health of the populations they serve. Their decisions and advice will have implications for the life and death of many thousands of individuals. Statutory regulation is currently only in place for those who are doctors or dentists. To ensure public confidence and protection, it must be extended to all public health specialists, including all Directors of Public Health, as a matter of urgency.

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