



## ***Healthy Lives, Health People: Update and Way Forward – Next steps for FPH***

### **Background**

Since publication of the Government's public health white paper, *Healthy Lives, Health People*, FPH has been engaged in an extensive advocacy programme – including work with the other main professional public health organisations – to campaign for changes to the proposals in order to ensure that:

- the health and wellbeing of the public is protected at all times;
- the capacity of the public health workforce to deliver good public health is maintained and strengthened;
- a robust, fit-for-purpose public health system is created;
- responsibilities are clear – especially for managing public health emergencies;
- all three domains of public health – health improvement, health protection and health services – are embedded in the new system;
- the public, professionals and government have trust and confidence in the new system.

Action by FPH – and its partners – includes:

- responding to all five public health consultation documents, including the review of the regulation of health professionals;
- writing to the Prime Minister, the Secretary of State for Health, the Public Health Minister and Chief Medical Officer to highlight the risks posed by implementing the reforms as proposed, and to put forward constructive proposals to mitigate those risks;
- working with Lords and MPs on our proposed amendments to the reforms;
- submitting and giving evidence to parliamentary committees on public health, commissioning, the *Health and Social Care Bill*, and behaviour change;
- engaging actively with Department of Health officials to discuss emerging policy;
- lobbying to attain public health representation on the NHS Future Forum, submitting evidence to its 'listening exercise' and responding to its findings;
- working with FPH members to advocate our position;
- supporting all of our advocacy work with media activity to maximise our position.

All the latest FPH activity on the public health and NHS reforms can be accessed at [www.fph.org.uk](http://www.fph.org.uk)

## Continuing challenges for FPH, public health and the new system

There are still major issues which remain unresolved and which FPH will continue to advocate on and lobby for. These are, in the main:

- the creation of Public Health England as an NHS organisation, such as a special health authority;
- statutory registration of all public health specialists – irrespective of professional background;
- the positioning and responsibilities of the director of public health;
- all public health specialists working in the public sector to be appointed via a statutory advisory appointments committee, as they are now;
- the preservation (and strengthening) of public health capacity – now and in the future, particularly with regards to the future of specialty registrars about to/completing training;
- what the ring-fence budget will be expected to cover and the size of budget to be allocated;
- clarification of roles and responsibilities during public health emergencies.

FPH will put forward proposals for amendments to the *Health and Social Care Bill* on the outstanding points highlighted in this document.

NB: All comments in quotes are from *Healthy Lives, Healthy People: Update and Way Forward*.

## The public health reforms – next steps for FPH

The Government has now published its response to the white paper consultation.<sup>1</sup> It has also published its response to the NHS Future Forum report.<sup>2</sup> This paper sets out what has been achieved thus far, and those areas where further advocacy and campaigning are still required.

## Protecting the public through statutory regulation of the public health workforce

What FPH called for:

- In order to ensure people's health and wellbeing are protected, a robust system of statutory registration for all public health specialists (whether qualified in medicine or dentistry or from other backgrounds) must be in place, to provide continuing professional scrutiny and monitoring of those who make decisions which have a profound effect on the health and wellbeing of large numbers of people.
- Public health professionals from backgrounds other than medicine or dentistry should also be subject to revalidation – as for those registered with the GMC and GDC. The current statutory proposals for revalidation for all medically qualified doctors, including

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<sup>1</sup> Available to download at: <http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm>

<sup>2</sup> The NHS Future Forum report is available at: <http://healthandcare.dh.gov.uk/future-forum-report/>

The Government's response to it is available at:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_127444](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127444)

public health specialists, were introduced post-Shipman to protect the public and provide robust scrutiny of continuing professional expertise and qualification.

Government response:

- In its response, the Government recognises the NHS Future Forum’s recommendation that “registration by an appropriate national body should be compulsory for non-medically qualified public health staff” [FPH interprets “staff” as including all public health professionals working at specialist level]. The Government states it recognises the need for “an appropriate system to ensure the highest quality of decision-making”. However, it then defers the issue by calling for further evidence from the public health profession on “significant risks to the public which would necessitate a statutory regime”. It refers to the work being currently undertaken on the workforce strategy, deferring decision-making until its publication. This raises the question: if the Government recognises the need for an “appropriate system”, then why wouldn’t they extend the tried and tested system currently in place to make certain the public’s safety wasn’t at risk?

Next steps:

- FPH, in its response to the review of the public health workforce, provided extensive evidence on why the profession must have statutory regulation (available at [www.fph.org.uk](http://www.fph.org.uk)).
- It also highlighted its concern over the Government’s side-stepping of this issue in a letter to Secretary of State, Andrew Lansley and in a media statement – both available at [www.fph.org.uk](http://www.fph.org.uk)
- FPH will seek to gather further evidence and continue to make strong representation for the protection of the public through statutory regulation of the specialist public health workforce.

## **Responsibility for protecting and improving the health of the local population**

What FPH called for:

- Clarification that local authorities are responsible for protecting and improving the health and wellbeing of their local population, at all times, including planning for and managing emergency situations and outbreaks, supported by Public Health England (PHE).
- directors of public health (DPHs) to lead the local planning and response to emergency/outbreak situations, supported by PHE.

Government’s response:

- Local authorities will be prescribed new responsibilities including through regulation for protecting and improving the health and wellbeing of their communities. They will have responsibility for all three domains of public health, and will be required to provide public health advice to NHS commissioning groups. Local authorities will be responsible for delivering a range of public health services including access to sexual health services, the national child measurement programme, NHS health check assessment and elements of the healthy child programme.
- Local authorities will be required, through regulation, to ensure that plans are in place to protect the health of their local communities. DPHs will be responsible for working with PHE and the NHS, to “ensure appropriate public health responses to the whole spectrum of potential problems, from local incidents and outbreaks to emergencies”.

- Public Health England will provide public health leadership for emergency preparedness and response “providing independent scientific and technical advice at all levels”.

Next steps:

- The full list of public health responsibilities of local authorities (which will also be linked to what will be covered by the ring-fenced public health budget) is still not clear. The Government is undertaking further work with ‘stakeholders’ on the “precise detail of services to be prescribed”. FPH will ensure that it is involved in these discussions and makes representation on what services local authorities should provide, linked to the public health budget and what it should cover.
- It is still not clear who, at the local level, will lead on responding to emergency and/or outbreak situations. FPH will push for an explicit requirement that the local authority, through its DPH, should also lead local action on outbreaks/emergencies, advised and supported by PHE.

## Public Health England

What FPH called for:

- Public Health England (PHE) to be established as an NHS organisation such as a special health authority (or failing this, as an executive agency) to ensure that the new organisation is viewed as an independent, authoritative and trusted source of evidence-based public health support and advice, and has the confidence of the public, professionals and government.
- PHE to be the employer for public health consultants and specialists working in PHE, local authorities and NHS commissioning bodies, on NHS terms and conditions, to allow for the efficient allocation of resources by providing expert, effective and adequately resourced local teams, working closely with local services. It would also support the redeployment of resources, for example, where extra public health capacity is needed in an area. Maintaining NHS terms and conditions for public health specialists means that they would continue on a par with their colleagues in other healthcare professions, ensuring professional recognition and influence. It would also ensure that the public health specialty continues to attract individuals of the very highest calibre, from all disciplines, including medicine.

Government’s response:

- PHE will be established as an executive agency, bringing together regional directors of public health (RDPHs) and their teams currently in the Department of Health and strategic health authorities, and other public health organisations including the Health Protection Agency, public health observatories, cancer registries and others.
- PHE would support local authorities in the delivery of local public health action including through: gathering, analysing and disseminating national information and intelligence, and evidence to support development of local plans; advocating on public health nationally; providing national leadership on emergency preparedness and response, working through the local DPH and local resilience hubs.
- With an emphasis on acting openly and transparently, it will provide “impartial and scientifically rigorous advice to the Government, the public and partners on public health issues”.

Next steps:

- Establishing PHE as an executive agency is an important first step towards achieving an authoritative, independent, trusted public health organisation. However, FPH will continue to push for it to be established as an NHS organisation such as a special health authority as this would enable the new organisation to be seen as completely independent of the Government.
- If established as an executive agency or an NHS body, we will also continue to push for PHE to employ public health consultants and specialists working in PHE, local authorities and NHS commissioning bodies, on their current NHS terms and conditions, preventing potential fragmentation and loss of skills and expertise.
- Greater detail is required on the structures that will be established to support the interface between the national (PHE), sub-national and local public health system (particularly with regard to emergency planning) – for example, clarity is required on the role of the health protection unit director in an emergency situation.
- The Government will be producing an ‘operating model’ for PHE. FPH has been invited to provide advice on the development of this and will continue to engage actively with DH.

## The director of public health

What FPH called for:

- A local, strategic leader for health and wellbeing, trained and registered to specialist level. The DPH should produce an independent annual report on the current health and future health needs of their population (and how well they are being met), be a statutory member of the health and wellbeing board, be directly accountable to the local authority CEO, responsible for managing the ring-fenced public health budget, have direct access to the local authority’s cabinet and councillors, be jointly appointed by the local authority and PHE through a statutory appointments process, and not be sacked without the approval of both the local authority and the Secretary of State. As previously highlighted, they should also be responsible for not only planning but also leading the local response to outbreak/emergency situations.

Government’s response:

- There’s much of what we asked for in the response. Their vision is for the DPH to be the principal health adviser to local authority elected members and officials, responsible for delivering the local authority’s public health functions, and producing an annual report on their local population. They will be responsible for all three domains of public health across their area, including ensuring the *planning* of appropriate public health responses to emergency situations – though no explicit statement that they will lead the local response.

Next steps:

- The Government has a strong vision for the DPH – but there are areas where their proposals still fall short of what is required to secure a safe and effective public health system. The major issue of regulation is dealt with in the previous section but other key areas FPH will continue to push for in relation to the appointment and positioning of the DPH in the local authority include:
  - that all public health specialists – DPHs and all public health consultants – should be appointed through a statutory appointments process (such as already exists) to

ensure that only the most appropriately trained and qualified people are employed in order to protect the public. [The Government states that the joint appointment process proposed between local authorities and PHE will be robust enough to ensure this and to support continuing professional development – FPH disagrees.]

- the status of the DPH should be at board level, and at the least equivalent to the director of children’s services and the director of adult social services. [The Government has stated it will work with stakeholders on ways of achieving this, which is welcome, and “would expect the DPH to be of Chief Officer status”. FPH believes that ‘require’ would be more appropriate than “expect”. There is no amendment in the Bill to reflect this however, which FPH will seek to rectify – if the Government expects it, why not state it so everyone is clear about the position of the DPH?]<sup>3</sup>
- the need for the DPH annual report to be independent, and to provide a robust assessment not only of the health and wellbeing needs of their local population, but also challenge on how well these are being addressed.
- an explicit statement (as highlighted above) that the DPH should lead the local response to outbreak and emergency situations – on behalf of the local authority, supported by PHE.
- a clear statement in the Bill that the DPH should **not** be sacked without the explicit approval of the Secretary of State for Health.
- FPH will continue to lobby hard for those outstanding issues above to be made explicit in the re-committed Bill in order to ensure that those individuals making critical decisions about people’s health are skilled and expert to do so.

## Maintaining and strengthening public health workforce capacity

What FPH called for:

- Public health capacity to be maintained and strengthened in the new system – particularly in response to information gained that public health posts were being cut as part of NHS management costs, and in view of the sector-wide recruitment freeze. Public health training to be organised and provided alongside that of other medical specialties, and an extension of the grace period, post-training, for public health specialty registrars to support them through the transition to the new system. Clarity was also sought on the employment and appointment process for public health specialists as outlined above.

Government response:

- Little detail other than acknowledgement of the concerns around future arrangements, terms and conditions of employment, and a deferral to the forthcoming workforce strategy which will:
  - scope current public health workforce situation;
  - consider its role and purpose, and how it can be transformed to meet future challenges and opportunities, as well as offer a career pathway;
  - set out plans for a high quality, sustainable specialist workforce;
  - look at training and education opportunities for the wider public health workforces eg. health visitors;
  - consider how best to use workforce data.

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<sup>3</sup> Legal prescription of chief officer statutory roles in councils is not without precedent – the Section 151 finance role and a council’s equalities and legal monitoring officer are prescribed. There is therefore no reason why the *Health and Social Care Bill* should not so specify the DPH as a statutory role for councils.

Next steps:

- FPH is represented at the highest level on the workforce strategy development group and will continue to push not only for a clear strategy on how workforce capacity will be strengthened in the future, but also how it will be maintained throughout the transition period – with particular reference to what will happen to the c.4,500 staff currently employed in organisations and agencies (such as the HPA and public health observatories) that will be moved to PHE.
- FPH will press for **early** clarity on employment and appointment processes as uncertainty is becoming dispiriting and poses the real risk of losing expert staff from the profession.
- FPH will continue to lobby – including through its Specialty Registrar Committee – for concrete action to ensure that those leaving public health training during the transition period are retained by the system, thus capturing their skills and expertise, and realising the investment in their training.

## Public health and commissioning

What FPH called for:

- That the third pillar of public health – health service public health<sup>4</sup> – is embedded throughout the new system, particularly in the commissioning structures including clinical commissioning consortia and the new NHS Commissioning Board.

Government response:

- Although it refers to health service public health as “population health” – a label which has many different interpretations in the UK and which is therefore confusing in this context – there is some recognition by the Government of the need for public health expertise in this field to be embedded within commissioning structures. It has recommended that public health expertise should input into the newly proposed clinical senates and local clinical networks – though there is nothing in the Bill amendments to make this a statutory obligation.
- The Government will make it a requirement for clinical commissioning consortia (previously GP Commissioning Consortia) to have multi-professional input. The Government is making it an explicit requirement to have a nurse and doctor on the board of the consortia. There will be no such requirement for a public health specialist.
- In its proposals for the structure and function of the NHS Commissioning Board<sup>5</sup> there was practically no mention of the importance of public health input into the new board.

Next steps:

- FPH has highlighted these issues in its letter to Secretary of State, Andrew Lansley, and in its submission to the Health and Social Care Committee (available at [www.fph.org.uk](http://www.fph.org.uk)).
- FPH has made strong representation at the highest level in the Department of Health and NHS on the vital importance of having a specialist public health appointment on the NHS Commissioning Board itself, and public health specialist expertise embedded at all levels of the Boards structures. It has written, jointly with the Association of Directors of Public

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<sup>4</sup> Health service public health is the area of public health which specifically relates to the planning, efficiency, audit and evaluation of health services. Public health specialists working in this field provide critical expertise, skills and knowledge on the effective commissioning and delivery of health services for their local population. Their understanding of the geography of health needs can be utilised to direct the planning and commissioning/decommissioning of services to meet those needs.

<sup>5</sup> *Developing the NHS Commissioning Board* – available from [www.dh.gov.uk](http://www.dh.gov.uk)

Health, to the NHS Chief Executive outlining our concerns and seeking an early meeting to discuss them.

## **Public health funding including the health premium**

What FPH called for:

- A ring-fenced public health budget, nationally and locally, which is managed (at the local level) by the DPH, and which should be sufficient to meet the needs for which that budget is intended – including covering resource costs for local public health teams such as administration support. It should also cover all three domains of public health – health improvement, health protection and health service public health.
- Careful consideration to be given to the introduction of the health premium, particularly to avoid increasing inequalities; if the premium was paid retrospectively this could increase inequalities in less affluent areas as these areas have less resource with which to make progress.

Government's response:

- There is a commitment from the Government to a ring-fenced public health budget – though the exact size of that budget is still to be agreed. The Government is working with the NHS and local authorities to “refine assessments of current baseline spending on NHS activity which, in future, will be funded from the public health budget”. Public health money will be split between local authorities, the NHS Commissioning Board and PHE. Shadow allocations to local authorities for 2012/13 will be made by end 2011.
- The Government states it will work with local authorities and a “group of key partners” on taking forward the development of the health premium.

Next steps:

- FPH will seek representation on any established working group to take this work forward.
- FPH will await the publication of the Public Health Funding Regime and continue to provide challenge on this issue to ensure the budget is sufficient for what is expected of it.