



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 response to *Healthy lives, healthy people: our strategy for public health in England*

Introduction

About the UK Faculty of Public Health

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 and wellbeing of the population through three key areas of work: health improvement, health protection and health services. In addition to maintaining professional and educational standards for specialists in public health and providing practical information and guidance for public health professionals, FPH advocates on key public health issues, influencing policy change at the highest level, and working closely with policymakers, professionals and the public to make a positive difference to people's health and wellbeing.

In addition to this overall response, FPH has responded separately to each of the individual consultations relating to the public health white paper, *Healthy Lives, Healthy People – our strategy for public health in England*. These are available at: www.fph.org.uk

What is public health?

Public health is the science and art of promoting and protecting health and wellbeing, preventing ill health and prolonging life through the organised efforts of society.¹ There are three domains of public health: **health improvement** (including people's lifestyles as well as inequalities in health and the wider social influences of health), **health protection** (including infectious diseases, environmental hazards and emergency preparedness) and **health services** (including service planning, efficiency, audit and evaluation). All three domains need to be addressed actively by the public health system if the public's health and wellbeing are to be protected and improved.

¹ http://www.fph.org.uk/what_is_public_health

FPH response to *Healthy Lives, Healthy People*

On 30 November 2010 the Coalition Government published its vision for public health in *Healthy Lives, Healthy People*. This white paper sets out a radical new approach to public health which aims to: “empower local communities, enable professional freedoms and unleash new ideas based on the evidence of what works, while ensuring that the country remains resilient to and mitigates against current and future health threats”.

Healthy Lives, Healthy People represents a welcome increase in focus on population health and offers great potential for health improvement through embedding public health expertise in local authorities.

However, some aspects of the proposed changes pose potential risks to the safe and effective delivery of public health in England. These include:

1. **Lack of clear lines of accountability** and communication for protecting and improving the health of the local population.
2. **Loss of independence for the public health workforce** to challenge powerful interests whose actions risk the health of the population.
3. **Lack of clarity as to how professional standards will be maintained** for staff who will undertake the public health functions that are moving out of the NHS system.
4. **Failure to recognise the health service domain of public health** and create explicit mechanisms for public health input and advice to the commissioning and provision of healthcare services.
5. **Fragmentation of the public health workforce**, limiting opportunities to share scarce skills, maintain and develop capacity and assure competence
6. **Creation of practical difficulties for the Health Protection Agency** that will inhibit its trading activities and result in a loss of funding for key members of staff, ultimately affecting its ability to deliver high quality services.
7. **Ring-fencing of the public health budget in the manner proposed may result in its redistribution** for activities other than originally intended.
8. The particular challenges of reorganising public health and **ensuring safe, equitable and appropriate health and health services** at a time when the traditional levers for strategic oversight are being removed.
9. **Loss of public health staff** during the transition period.

These risks have been identified by FPH members in a consultation process which has included surveys of the membership, e-group discussions, national and local consultation events, and Board and committee debates. During this process, we have developed proposals which capitalise on the advantages of the new system and mitigate the risks. These are included in our response below.

Key messages

- **Local authorities** should be clearly accountable for protecting and improving the health of their resident population at all times, supported by Public Health England.

- **Public Health England (PHE)** should be established either within the NHS as a special health authority or, if that is not accepted, as an executive agency of the Department of Health, employing the existing public health specialist workforce currently working in primary care trusts (PCTs) and strategic health authorities (SHAs). It should be organised primarily through local and national hubs, with sub-national support where necessary to secure coordination and the efficient use of resources. Directors of public health, jointly appointed with local authorities, would be supported by PHE teams seconded to work with local authorities and NHS commissioning through local agreements, using honorary appointments where appropriate to secure the necessary accountabilities. This would enable PHE to support national and local policy development and implementation in all three public health domains, seconding consultants and specialists to local authorities, GP consortia and other organisations requiring public health input and advice. Developing PHE along these lines offers a number of advantages. It would:
 - secure the independence needed for the public health workforce to challenge powerful others whose actions could pose a risk to population health.
 - provide effective, expert and adequately resourced local teams, supporting and working closely with local services, across all three domains of public health.
 - allow teams to be deployed at a local level to provide strategic leadership for public health.
 - enable flexible deployment of staff and secure a critical mass of public health expertise to work with local authorities.

- ensure that in emergency situations, such as the recent flu pandemic, or when there are unexpected gaps in staffing, employees could be redeployed in an appropriate and timely manner.
 - provide clearer accountability.
 - enable the Health Protection Agency to continue its trading and research activities that would be compromised by the present proposals so threatening key elements of its work.
 - enable PHE to hold a truly secured ring-fenced budget.
 - ensure that scarce, expert resources are used efficiently for the benefit of the whole population
 - ensure that public health commissioning expertise is available to every organisation making commissioning decisions, including the NHS Commissioning Board and local commissioning consortia.
 - Ensure the maintenance and development of a robust, authoritative and trusted public health intelligence function.
 - provide expert national support for cross-governmental working to tackle the wider determinants of health.
 - maintain protection of public health by the continuation of existing mechanisms to ensure professional competence.
 - ensure that staff needed for the effective operation of the future system are not unintentionally lost in the transition process.
- **An expert and influential director of public health (DPH)** is key to the success of the new local public health system. The jointly-appointed DPH must be trained and registered to specialist level in public health, and should not be sacked for any reason without the approval of both the local authority and the Secretary of State for Health
 - To ensure that expert support is available now and in the future for all those concerned with protecting and improving the public's health, public health should be maintained and developed as an **authoritative, influential, resilient, multidisciplinary profession working across the three domains** of health protection, health improvement and health services.

Accountability for protecting and improving the health of the local population

The lack of clarity in *Healthy Lives, Healthy People* with regard to the accountability of PHE and local authorities for health protection and health improvement is a matter of grave concern. It puts the health of the public at serious risk, particularly in emergency or epidemic situations.

Local authorities already have some responsibilities for protecting and improving the health and wellbeing of their populations including, for some, environmental health and 'proper officer' functions. The new responsibilities for health go much further than this for upper-tier authorities – but there is a real risk of duplication and confusion if, as is implied by the white paper, PHE is accountable for health protection in some circumstances and local authorities in others.

A safer and more straightforward approach would be for the Government to confirm, as a matter of urgency, that local authorities will be accountable for protecting and improving the health of their populations at all times, including during outbreak and emergency situations. PHE should support local authorities in these roles and duties. In practical terms, this support should include making specialist public health resource (and other expertise, such as occupational health and behavioural science) available through secondments or similar arrangements where necessary. Local authorities should be required to use specialist public health expertise to deliver health and wellbeing for their local population.

Public health experts based in PHE, commissioning consortia or local authorities must be able to retain their health protection competence and knowledge so that they have the up-to-date skills required to support an emergency response.

Recommendations:

- Local authorities should be accountable for protecting and improving the health of their populations at all times, including outbreak and emergency situations. PHE should support local authorities in doing this and ensure that dedicated specialist public health and other expertise are available to them.
- Local authorities should be required to use the skills and expertise of public health specialists to deliver health and wellbeing for their local population.
- Public health specialists working in PHE, local authorities and consortia must be able to maintain their health protection skills and knowledge.

Public Health England – delivering a robust public health service

The new, integrated, national public health service, Public Health England (PHE), will be vital in protecting the health of the public, and will need to work closely with local public health teams, the NHS, local authorities, the NHS Commissioning Board and national governments to improve and plan for the public's health. We propose that PHE should be established either within the NHS as a special health authority or, if that is not accepted, as an executive agency of the Department of Health, employing the existing public health specialist workforce currently working in PCTs and SHAs and seconding them to local authorities, GP commissioning consortia and other organisations requiring public health input and advice. It should be organised primarily through local and national hubs, providing sub-national support where necessary. This proposal has emerged from a number of listening events and discussions and has strong support from FPH members of all levels of seniority and experience. It is similar to that articulated recently in some detail by McKee *et al.*² PHE created along these lines would support national and local policy development and implementation on all three domains, employing consultants and specialists who would be seconded to local authorities, consortia and other organisations requiring public health input and advice.

PHE as a source of independent advice

The new service should be able to offer independent advice on all matters relating to the maintenance, improvement and protection of health. Independence for the voice of public health is critical. It must not be unduly influenced by politics, but should advocate freely on behalf of its population on the basis of an unbiased and expert assessment of health needs, and a detailed understanding of the context. This is as relevant to national policy and delivery as it is more locally.

PHE and local service provision

This new public health service must also provide effective, expert and adequately resourced local teams, working closely with local services on all three domains of public health. PHE should ensure dedicated public health resources are available to:

- local authorities to inform and support delivery of health improvements in their local population, such as through the seconding of public health specialists (as well as those

² McKee M, Hurst L, Aldridge RW, Raine R, Mindell JS, Wolfe I, Holland WW. Public health in England: an option for the way forward? *Lancet*. 2011 Feb 25

with other specialist functions such as experts in occupational health or behavioural science for example) to the local authority.

- The NHS Commissioning Board and GP commissioning consortia to inform and support the effective commissioning of health services. We offer more detail on the role of public health expertise in health service commissioning in 'Public health and health services', p12.

Maintaining a robust public health workforce

Public health often works through influence and negotiation with a broad range of networks. It will only be able to do this if sufficient capacity is retained within skilled, locally based teams. We urge the Government to ensure that the move to implement the establishment of PHE, local authority public health departments and GP commissioning consortia is undertaken in such a way as to preserve the existing public health workforce and to avoid both the loss of experience and expertise and its erosion over time. Employing all public health specialists within PHE would mitigate this to some extent. This risk is being exacerbated currently by the public health redundancies being planned and implemented as a consequence of substantial management cost reductions in the Department of Health, SHAs, PCTs and local authorities.

Securing the health protection function of PHE

The health protection function of PHE is crucially important. Experience of health protection in the UK over many years has demonstrated consistently that the successful management of complex incidents and epidemics depends heavily upon sound national, sub-national and local coordination, communication, command and control. A clear and confident line-of-sight from the Secretary of State to the local responder requires all three tiers of organisation to be in place and the absence of a sub-national public health tier, for example, would put the health of the population at significant risk during an emergency response. Establishing PHE as a special health authority or executive agency need not interfere with this clear sight-line. Provided that appropriate contractual arrangements, enshrining clear accountabilities, were in place it would provide the Secretary of State with the ability to mandate action where appropriate and necessary whilst maintaining public confidence in the independence of the advice available to him.

Currently, the Health Protection Agency (HPA) is a Category 1 responder under the *Civil Contingencies Act*, bringing benefits for emergency planning and response by specifying a duty of cooperation with and from partner responder organisations. This important lever must be replicated in the new system at each relevant response level.

Healthy Lives, Healthy People does not acknowledge explicitly the considerable resource in specialist health protection now held locally by many PCTs including infection control nursing, emergency planning, sexual health, TB contact tracing and bloodborne virus control. Some of this may now be held within community health services under the Transforming Community Services (TCS) arrangements, but still needs to be commissioned locally. This local resource was vital in delivering a command and control response to the flu pandemic in 2010. The new system must enable local authorities to manage these resources and/or to command them through the surge capacity and mutual aid requirements of the new shared agreements as set out in the NHS white paper, *Equity and excellence: liberating the NHS*.

Co-ordination of public health functions across local authority areas

For the purposes of effectiveness and efficiency, some public health functions will need to be organised or coordinated by PHE across local authority boundaries. For example, a population base of 1.5-2.5 million would support a robust initial emergency and 24/7 incident response, based around the current 26 Health Protection Units areas. A population of this size would also, in many areas, facilitate links with existing, highly relevant, specialist clinical networks across NHS Trusts. A larger population base of 3-8 million would be required for some public health intelligence functions such as those currently provided by public health observatories, cancer registries and regional epidemiology units. Specialist public health training would be most effectively provided in training programmes with the capacity of the current deaneries, complemented by a national recruitment system. Wherever possible, these larger areas should be coterminous for the domains of public health practice and with other relevant service or response 'footprints'.

Similarly, the new system must encourage and enable joint working between the county, unitary, district and borough councils covering a given geographical area.

The role of environmental health practitioners in the new system

Environmental health practitioners play a crucial role in the current public health delivery system. It is important, as the new system is developed, that their skills and expertise are retained and capitalised on and their roles developed and strengthened over time, supporting local authorities not only in their health protection work but also in the wider aspects of health improvement.

Currently, environmental health practitioners are based in district/borough, unitary or metropolitan councils. They are not normally employed in the county councils where many public health teams, including the DPH, will be based. It is important that strong relationships are established (and where they currently exist, further developed) to enable environmental health practitioners to contribute to every level of public health delivery.

PHE and the devolved nations

PHE must be able to provide advice and guidance to the devolved nations where they are unable to access this locally. It will be critical to the success of these plans that the division of functions and the interplay between PHE, government departments, local authorities and NHS partners in all four UK countries is explicit and well understood on all sides.

Recommendations:

- Establishing PHE as a special health authority or as a distinct executive agency of the Department of Health would offer a practical way forward, ensuring PHE is free to give independent, unbiased advice and to provide appropriate local and national support.
- PHE should provide effective, expert and adequately resourced local teams, supporting and working closely with local services, including local authorities, GP commissioning consortia, the NHS, and commercial and third sector organisations on all three domains of public health.
- PHE should have local, sub-national and national levels of organisation.
- PHE must be able to provide advice and guidance to the devolved nations where they are unable to access this locally.
- PHE should be classified as a Category 1 Responder or have similar, equally powerful levers to ensure that it supports and is able to secure support from other responders at every level during emergency situations.
- PHE should provide devolved nations with specialist public health advice where this is not available within those administrations.
- Environmental health practitioners should be viewed as an important part of the public health workforce, and their skills and expertise capitalised upon.
- The new system should encourage and enable joint working between local authorities, within and across upper tier boundaries.

The role of the director of public health

The annex to *Healthy Lives, Healthy People* provides a useful description of the role of the DPH, emphasising its central importance to the effective operation of the public health system. This emphasis is welcomed, as is the increased opportunity to influence local services through the work of local authorities and the requirement to publish an independent annual report on the population's health. There are, however, some inconsistencies and omissions which must be addressed if the DPH is to deliver real improvements in health and wellbeing.

Strategic influence and independence of the DPH

In order to provide effective strategic leadership for public health, the DPH must be able to influence all aspects of the work of the local authority and the local health economy. The public must also be confident that the DPH is able to provide informed, independent professional advice. Public confidence built during non-emergency situations will greatly strengthen the ability of the DPH to provide the necessary authoritative leadership and advice when disaster strikes. The advice given, and the decisions taken by, the DPH will have far-reaching implications, potentially affecting the health and wellbeing of many thousands of people over many years. Ill-informed advice and action, however well-intentioned, will present a significant risk not only to the local population but also to those organisations which have relied upon the DPH's apparent expertise.

The ability of the DPH to influence health of the local public will be enhanced significantly if the DPH is required to include in their annual report comment on the extent to which local services are meeting local need.

Specialist training and expertise

It follows that the DPH must have the skills and experience needed for this expert, and highly specialised job. The need for training and registration at specialist level in public health must be made explicit and a requirement by primary or secondary legislation. We expand on this point in our separate response to the consultation on regulation in public health. To complement this, and to provide additional protection to the public and employing organisations, a statutory appointments process, along similar lines to the Advisory Appointments Committee process currently used for all DPH and other consultant/specialist appointments in the NHS, must be implemented by all organisations employing public health specialists at this level.

Strategic positioning of the DPH within the local authority

In order to influence effectively throughout the local authority, the DPH must be appointed at corporate or strategic director level (accountable directly to the local authority chief executive) and have direct access to the authority's cabinet, councillors, CEO and executive directors. Similarly, the DPH must be able to influence the commissioning decisions made by local GPs. To facilitate this, GP commissioning consortia should be required to work in partnership with the DPH and to take account of the DPH's annual report in developing their commissioning plans. The DPH should also have a responsibility to make their expertise available to their GP commissioning consortia, local PCT cluster and other appropriate local organisations involved in the planning, commissioning and delivery of health and wellbeing for their local population. The DPH must be a statutory member of the Health and Wellbeing Board. To ensure that they are able to discharge all their responsibilities effectively, the DPH will also need to manage the local ring-fenced public health budget.

Accountability of the DPH

If jointly appointed by PHE and the local authority, as proposed in *Healthy Lives, Health People*, the DPH will be accountable to the Secretary of State for Health (managerially, via PHE), to the Chief Medical Officer (professionally), to the local authority (managerially via the CEO and professionally directly to members) and to the local population. They may also be accountable to the NHS Commissioning Board. These arrangements have the potential at best for confusion and at worst for irresolvable conflicts of interest. Clarity with regard to the DPH's accountability for each of their functions is essential, but requires decisions on the wider issue of the respective accountabilities of PHE and local authorities before it can be resolved. Formalised, contractual relationships between the DPH and both organisations will be essential.

To protect the DPH's ability to provide independent advice and to speak publicly, when necessary, on the health and wellbeing of their population they need to be confident that they cannot be sacked without the agreement of both of the organisations to whom they are accountable ie. the Secretary of State for Health and the local authority.

Specialist public health support for the DPH

Given the strategic importance of the role of the DPH and the huge range of functions and responsibilities they must cover, it is vital that the DPH has appropriate support from public health specialists and practitioners with skills and expertise in a wide range of areas including public health expertise in epidemiology, service commissioning and decommissioning, service provision and effectiveness, medicine, dentistry, health protection,

health promotion and behaviour change, sexual health, child health, mental health and workplace health. Clarification is required on the nature of the team that will support the DPH. Robust mechanisms must be in place for ensuring that competence has been obtained and is maintained by staff in all these areas. Accountability issues for consultants and specialists are similar to those for the DPH and may at times be even more complex if, for example, they are for part of their time supporting local GP commissioners or service providers.

Commissioning of complex, multiagency services

Commissioning services such as immunisation, sexual health, mental health, safeguarding and public health services for children (including school nursing and health visiting), is often a complex, interdisciplinary and interagency process. Under the current proposals, services in each of these areas will be commissioned by multiple bodies. This raises the real danger, for example, that in the case of safeguarding, vulnerable children and adults could fall through the gaps in the system between commissioners. To minimise this risk, careful consideration should be given to how the different elements of the system will work together and where specific responsibilities should sit to ensure the efficacy of the system as a whole – particularly where, for example, GP commissioning consortia boundaries are not coterminous with local authority boundaries. Each of these services should be commissioned as a package – and where processes are working effectively these should be retained. This must be supported by sufficient funding to cover services, commissioning and transaction costs. DPHs should have an active role in safeguarding children and vulnerable adults, including involvement in safeguarding committees, particularly with regards to developing policy, prevention strategies for the whole population and monitoring the effectiveness of service intervention. DPHs should also ensure effective partnerships with community safety agencies, drug, alcohol and domestic violence services.

Recommendations: The annex of *Healthy Lives, Healthy People* sets out a vision for the role of the DPH. In addition to the vision specified in this white paper, a DPH must:

- Provide strategic leadership for all three domains of public health at local level.
- Be trained and registered to specialist level in public health.
- Be required to produce an independent, public annual report on the health and health needs of their population.
- Be a statutory member of the Health and Wellbeing Board.
- Be directly accountable to the local authority CEO and have direct access to the authority's cabinet and councillors.

- Have responsibility for managing the ring-fenced public health budget and public health staff, which should be appropriate and adequate to support them in delivering the health and wellbeing of their population.
- Not be sacked for any reason without the approval of both the local authority and the Secretary of State for Health.
- Have appropriate contractual relationships with PHE and the local authority.
- Be appointed jointly by the local authority and PHE, through a statutory appointments process, accredited by the FPH, which mirrors the existing process for DPHs and consultants/specialists in public health.
- Have an active role in safeguarding children and vulnerable adults, and in commissioning complex, multiagency services.

Public health and health services

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. They have the specialist training required to interpret the huge amounts of information and data received on their local population, their health needs and the various services provided for them. Their understanding of the geography of health needs can be utilised to direct the planning and commissioning (and, where appropriate, decommissioning) of services to meet those needs. Their management training and experience enables them to inspire, lead and deliver change in systems and organisations.

However, *Healthy Lives, Healthy People* makes little reference to this critical aspect of public health. With the commissioning of health services for the local population residing with GP commissioning consortia, under the new proposals, and recognition by GPs that they need the expert input of their public health colleagues, it is vital that specialist public health expertise is utilised to inform and support the delivery of effective and cost-effective health services. Public health expertise in this area is also used to audit and evaluate these services to understand their effectiveness and efficiency – and to inform improvements, decommission services where necessary and re-evaluate where resources should be best directed in order to meet health service needs.

Recommendation:

- That greater recognition and emphasis be given to the health service domain of public health through making it a duty of local authorities and NHS organisations to ensure public health specialist input to all planning, commissioning and decommissioning decisions which could have an impact on the health or wellbeing of their population.

Public health in GP commissioning consortia

The full engagement of GPs can do much to address health inequalities, improve quality of care and protect the health of the population. However, there are significant challenges to overcome in achieving this. GPs are culturally focused on the patients that they see, rather than the populations that they serve. Proposed changes to allow choice of registration with GPs may make this phenomenon even more pronounced, as GPs will have a broader population coming from outside their usual 'catchment' area. They will have to address the needs not only of those presenting to them, but also of disadvantaged groups and others who do not present to primary care. GPs recognise that they need the expert input of their public health colleagues in ensuring that services are appropriate, accessible and equitable and, in particular, that hard-to-reach groups are considered in service planning and commissioning.

To mitigate against these factors and ensure that services are commissioned to meet the needs of the whole population, the strategic input of public health specialists is essential. Just as the DPH has responsibility to make available public health expertise to their local GP commissioning consortia, so too do GP commissioning consortia have a duty to ensure they have public health input into the commissioning of health services for the local population.

Public health input will also be important to the planning and commissioning of primary care services such as dentistry, pharmacy, and optometry to ensure that appropriate and sufficient services are in place for the local population.

During the consultation process, our members have consistently raised serious concerns about the potential lack of public health commissioning and decommissioning expertise in GP commissioning consortia. It is essential that public health involvement in the new commissioning arrangements is formalised. The population perspective brought by public health experts and the patient-focused perspective of GPs are complementary, and the expertise that public health consultants have in commissioning and evaluating services must not be overlooked.

Exceptional funding decisions

Public health professionals working within health services take a lead role in facilitating exceptional funding decisions for treatment recommendations outside NHS guidelines. This role requires a population perspective on budgets and evaluating evidence, vital to support GP commissioning consortia. GP commissioning consortia should be required to work in partnership with the local DPH and their team to ensure that commissioning decisions are underpinned by expert public health advice, informed by a detailed understanding of their local communities and context.

Erosion of GP involvement in public health interventions

There is also a risk that the valuable roles currently played by many GPs in delivering public health interventions could become less of a priority for individual practitioners who take on new commissioning roles in addition to their existing clinical commitments. We would thus endorse the recent recommendation by the Public Accounts Committee that accountability frameworks should be strengthened to encourage GPs to contribute towards health and wellbeing priorities.³ We would also support the active participation of GPs in Health and Wellbeing Boards and the production of – and delivery of services in the context of – joint strategic needs assessments.

Primary care information

New tools available in primary care information systems are, for the first time, enabling systematic application of population health measurement and risk stratification to support consistent care across populations and identify people with unmet health needs which will lead to early death if there is no intervention.

The work of the National Support Teams, for example, in devising models of avoidable mortality through better primary care intervention and through lifestyle service availability has made an important contribution to the achievement of saving lives and reducing inequalities, which will leave a major gap in support when it ceases to operate on 31 March 2011. With existing data from QOF and new primary care based information systems, more lives could be saved by applying similar population health approaches – this process as been driven by public health professional expertise and has been taken up by primary care to a varying extent in different parts of the country.

³ House of Commons Committee of Public Accounts. *Tackling inequalities in life expectancy in areas with the worst health and deprivation*. London: Stationery Office, 2010

Work to reduce health inequalities requires full cooperation between public health specialists and GPs. It also requires national agreement to necessary and appropriate information sharing between the new public health teams in local authorities, observatories and registeries, PHE, GPs and the NHS. Accurate and effective joint strategic needs assessment will be impossible without this.

Recommendations:

- Public health involvement in the new commissioning arrangements should be formalised.
- GP commissioning consortia should be required to work in partnership with DPHs and their teams to ensure that commissioning decisions are underpinned by expert public health advice, and should consider including public health expertise on their boards.
- We endorse the recent recommendation by the Public Accounts Committee that accountability frameworks should be strengthened to encourage GPs to contribute towards health and wellbeing priorities.

Academic public health, research and evidence

High quality public health teaching and research, addressing all three public health domains, are crucial to the success of public health.

Public health professionals must engage closely with all levels of teaching, including undergraduate, postgraduate and continuing professional development, in relevant disciplines. Although academic enquiry and rigour are essential components of good public health practice, links between service and academic staff have often been weak in the past. Local authorities do not generally have the strong research and evidential tradition of the NHS, and public health research and evaluation may be difficult to initiate and maintain in that environment, particularly in the current economic climate.

The new arrangements should not miss the opportunity to strengthen working relationships, enabling the public health research and practice communities to engage more effectively with each other. The formation of the new National Institute for Health Research school of public health is, potentially, an excellent vehicle for bridging the divide. Research funders and academic health science centres could also do much to facilitate this by making engagement a key requirement, but the process will require active support from universities and clarity on the relevant contractual frameworks.

Recommendations:

- The opportunities presented by the new system to build and strengthen relationships between teaching, research and service public health must be grasped as an incentive by funders, academics, universities and service providers.
- There should be a duty on researchers in receipt of public funds to ensure that their evidential outputs are more widely disseminated than the scientific literature, and this should be supported via PHE.
- Support from the academic community will be necessary to create an appropriate culture and environment of public health research which has historically not been present in local authorities.
- Appropriate funding will be required to ensure that evaluation of evidence and research in public health is not sidelined during the current difficult financial climate.

Developing and enhancing the availability, accessibility and utility of public health information

The new system must ensure that decision-makers and all those working in public health and the new public health system have access to timely, comprehensive and appropriate intelligence to inform their decisions and advice. Intelligence is more than just the provision of data – it requires analysis and interpretation to make it accessible. Scientifically credible intelligence and information is essential to the understanding of health needs, modelling of future scenarios and assessment of impact and effectiveness. This is relevant both for service commissioning, outcomes assessment, planning and redesign, and for the recognition of and response to hazards and outbreaks. Public health professionals need a comprehensive and detailed understanding of their local population if they are to identify the need for – and to effect – change in the three public health domains.

Maintaining confidence and trust in public health information and intelligence

To ensure information is trusted by both the public and other users such as local authorities and GP commissioners it is important that users are assured that the intelligence produced has academic rigour and is seen as independent from government. This is vital for the retention of public and professional confidence in the outputs produced. The manner in which the health intelligence service is integrated with the Department of Health is crucial. If PHE is established as a special health authority or as an executive agency, there would be greater confidence that the intelligence functions will be perceived by the public and other

users as having the necessary independence. It will also enable the new body to generate and use future income that is so vital to the generation of new evidence.

Loss of health intelligence skills and service

Whatever organisational model is adopted for PHE, there is a real risk of loss of key, scarce skills. Health intelligence will be compromised greatly if the current resources for health intelligence cut back further than the 30% currently proposed for the public health observatories and the Health Protection Agency; the 30% reduction in itself will result in a significant reduction in service. The future organisational model for the health intelligence function must provide opportunities, as it does now, for innovation and ability to generate vital income to improve the evidence base.

PHE and health intelligence

PHE must take a determined lead in ensuring that the collection, analysis and dissemination of population level data is developed and enhanced, building on the existing work of the Health Protection Agency, PHOs and cancer registries. This information must remain easily and rapidly accessible to individuals in PHE working in local authorities, GP commissioning consortia and other new locations. *Healthy Lives, Healthy People* contains no incentives to encourage the dissemination of data or best practice horizontally at the local or sub-national level, risking duplication of effort and creation of inefficiencies.

Given the skills and expertise of the bodies to be integrated into PHE, it will be important – and more efficient – to ensure that the NHS Commissioning Board also benefits from the intelligence capacity and skills to be created within PHE. This could be achieved through joint funding and delivery of the outcomes frameworks. An arrangement such as this could save resources and duplication of effort and secure the future provision of reliable evidential support to commissioning consortia.

Public health observatories have been instrumental in building skill and capacity among local health intelligence staff, and in implementing the first common, professional competency framework for public health analysts. This function is highly valued by health intelligence colleagues. Skill and capacity building should be retained or commissioned by PHE and built into its sub-national deliverables.

The role of NICE

Nationally, NICE provides first-class support for commissioners, service providers and public health. The welcome emphasis on evidence in the new public health system will increase

demands for the authoritative analysis and guidance that NICE provides. There is real concern at the recent review of its work programme, deleting some important public health reviews and delaying others. An effective public health system and service requires NICE to be expanded rather than eroded.

Local public health intelligence

Locally scarce public health intelligence skills, currently within PCTs, need to be protected. The role of public health intelligence is changing, with less focus on analysis as more is done at national level on behalf of all local organisations, more time on interpretation and repackaging in a local context, and, importantly, linking and connecting information from primary care, NHS providers, local authority services, and supporting data sharing and data linkages. New models of delivery will need to be explored, through shared services across several local areas or through an outsourced service.

Disruption to data flows

The implementation of *Healthy People, Healthy Lives*, could result in disruption of existing data flows and the loss of analytical expertise. In the short term, there is also a genuine risk to the existing availability of information and analytical expertise, for example if funding for regional PHOs is not guaranteed.⁴ This may lead to gaps in surveillance and monitoring, directly affecting the ability of public health specialists to produce trend data in population health and, in particular, health inequalities.

The Public Health Library for England is an important vehicle for ensuring knowledge translation, and dissemination in a joined up manner. PHE should review the role of the library and build on it in future.

Recommendations:

- Sources of public health evidence and data, for example PHOs, must be independent if the public and other users in local authorities and GP commissioners are to be able to use this information with confidence and the public are to have trust in its validity.
- Arrangements for maintaining currently robust systems of surveillance and monitoring, including the PHO function, need to be protected and secured for the future.
- PHE should lead on commissioning collection, analysis and dissemination of population level data from the NHS Information Centre, building on the existing work of the HPA, cancer registries and PHOs, and linking closely with local services.

⁴ Wilkinson A. Funding threat to public health training. *BMA News*, 3 March 2011

- The future organisational models for PHE should also allow innovation and the ability to generate vital income to improve the evidence base.
- Mechanisms should be put in place to incentivise sharing of data and best practice horizontally to avoid duplication of effort at the local and sub-national levels.
- The role of the National Institute for Health and Clinical Excellence in producing independent evidence-based public health guidance be strengthened, rather than eroded.⁵
- The National Public Health Library must be maintained and developed as an important resources to inform public health action.

The consultation also asks the question regarding public health evidence and what wider partners nationally and locally contribute to improving the use of evidence in public health, and we would refer you to our comments above on academic public health and NICE.

Funding public health in England

It is right that the public health budget at local and national level is ring-fenced, and that it should not be subject to “other pressures”. The ring-fenced budget must not be used to alleviate the financial pressures that local authorities may be under. The current proposals make this a real possibility. If the ring-fenced budget is transferred from PHE to local authorities, authorities must be required to account for spend against each budget line and the DPH must manage the ring-fenced public health budget. There is an additional danger that public health priorities will be downgraded or lost in the current financial climate, restricting the ability of public health specialists to deliver on the wider determinants of health and reduce health inequalities. The public health outcomes framework could mitigate this to some extent, but its scope may be limited. DPH responsibility for the budget at a local level is therefore essential to ensure that it is spent in response to health needs rather than short-term local political – or other – demands. There is a further risk that, particularly in a difficult financial climate, local commissioners and service providers, including local authorities, GP commissioning consortia and the NHS, will make the assumption that the ring-fenced budget should be able to cover all public health activity, rather than the defined, focused inputs for which it is intended.

It is vital that the funds allocated to the budget are sufficient for their defined purposes now and remain so in the future.

⁵ Kmietowicz Z. NICE is told to halt work on 19 public health topics. *BMJ* 2010; 341: c7306.

Recommendations:

- The uses to which the ring-fenced budget is to be put must be identified clearly, and the size of the budget calculated from a realistic baseline.
- The funds available must be sufficient to meet the needs for which that budget is intended, and should continue to be so in the future.
- DPH responsibility for managing the budget at a local level is essential.

Training the future public health workforce

Current public health training works well and attracts high calibre recruits from a wide range of backgrounds. Dislocation from the 'mainstream' would present significant risks for recruitment, retention and quality control, as happened historically when Medical Officers of Health and their staff were employed by local authorities. This was one of the major drivers for the establishment of the speciality of community medicine (now public health) and the transfer of staff to the NHS.

Public health must remain an attractive prospect to recruits from medicine, dentistry and other backgrounds. This requires equity of pay with comparable career options. To ensure public and professional confidence, and to maintain its attraction for recruits from all backgrounds, public health training should be organised and provided alongside training in other medical specialties with similar routes of access, standard setting and quality assurance. It is currently organised and funded in this way and works well. The range of training placements will, however, need to be increased to ensure trainees gain experience in all relevant settings.

PHE should play a leading role in planning the future workforce and ensuring that funding is available to meet academic and service training needs.

Training placements need to reflect the broad skills and knowledge requirements for this speciality workforce, linked to the existing FPH curriculum for training⁶. Supervision for training requires that placements be linked to consultants/specialists in public health with the appropriate experience and qualifications and it is important that these opportunities are maintained during the transition period and into the future.

FPH has responded in full to the *Liberating the NHS: developing the healthcare workforce*.

⁶ http://www.fph.org.uk/training_e-portfolio#post2007

Recommendations:

- Public health training in England should be organised and provided alongside training in other medical specialties with similar routes of access, standard setting and quality assurance.
- PHE should have a key role in workforce planning by feeding into the Skills Network via the DPH.
- The new roles of future employers of public health specialists need to be identified, with appropriate funding to accompany any transferred workforce, along with clarification that education and training is included within the remit of the ring-fenced budget.

Safeguarding the public through the statutory regulation of public health specialists

Consultants and specialists in public health, including DPHs, give important advice and take decisions, which have a profound impact on the lives of many thousands of people. Although doctors and dentists working at this level must have statutory registration to demonstrate achievement and maintenance of satisfactory standards of competence and ethical behaviour – to safeguard the public and minimise the risk to them and to their employers – this is not currently required for those from backgrounds other than medicine, although their responsibilities are often identical. It is therefore a logical and necessary progression to make both subject to statutory regulation, underpinned by one set of FPH specialist standards. Public health specialists from backgrounds other than medicine and dentistry should be registered by the Health Professions Council (HPC).

FPH has responded in full to the *Review of the regulation of public health professionals*.

Recommendations:

- Statutory regulation is the most effective regulation for public health specialists from a background other than medicine in order to reduce risk to both the public and employers;
- There should be statutory recognition to use an agreed protected title such as ‘public health specialist’;
- The Advisory Appointments Committee process must be preserved and extended into new employment settings for public health specialists in order to quality assure the workforce;
- Defined specialists should be regulated;

- Specialists from a background other than medicine should be revalidated;
- The Health Professions Council should become the statutory professional regulator for public health professionals who are not regulated. Consistency across registers is vital.

***Healthy Lives, Healthy People* – the government’s approach to improving health and wellbeing**

The white paper sets out government’s “radical” approach to improving people’s health and wellbeing. It supports the lifecourse approach advocated by Sir Michael Marmot in his review of health inequalities⁷ which examined the wider determinants that impact on health including material circumstance, psychosocial factors, the social environment. This has the potential to influence the wider determinants as offered by embedding DPHs and their teams in local authorities. The establishment of PHE as an organisation addressing all three domains of public health could also bring exciting new synergies. For example, there is an advantage in bringing together the health improvement expertise currently in PCTs with the epidemiological and field services aspects of health protection, currently in the HPA, to improve proactive preventive work in health protection (including, for example, control of STIs, bloodborne viruses and TB), which often involves complex behaviours and/or socially marginalised groups.

There are, however, two areas of major concern. Firstly, the approach puts insufficient emphasis on the role of regulation in health improvement and protection, and a significant emphasis on the responsibility of individuals to look after their own health and wellbeing. This is reasonable, but its success requires the Government to do what only it can do; enabling and supporting the efforts of society to make healthier choices the easier choices, and to address those barriers – such as poor housing, unemployment and poorly-designed environments – that prevent people from making the healthier choice.

In *Healthy Lives, Healthy People*, the Government states that it wants to take the “least intrusive” approach necessary and refers to the Nuffield Council of Bioethics’ “ladder of interventions”, focusing on voluntary agreements rather than regulation or legislation. However, insights from behavioural science and from history demonstrate clearly that behaviour change campaigns only modestly increase knowledge and modify attitudes and have minimal effects on long-term behaviour.⁸ Moreover, there is comprehensive

⁷ *Fair society, healthy lives*. Accessible from: <http://www.marmotreview.org/>

⁸ Marteau T, Ogilvie D, Roland M, Suhrcke M, Kelly M. Judging nudging: can nudging improve population health? *BMJ* 2011; 2011; 342:d228

longstanding evidence demonstrating that individual level factors influencing behaviour change do not act in isolation from the social, environmental, structural and regulatory context within which people live and by which they are constrained.

Strategies which rely on individual behaviour change can widen health inequalities because the most socially advantaged are more likely to have the material or psychological resources to allow them to take action to minimise their exposure to risk and to adopt health promoting behaviours, as well as access those services and resources which support them to do this.

Regulation and legislation have a complementary role to play as part of a comprehensive approach to improving public health. The Government must use them where appropriate, rather than waiting for alternative approaches to fail. Where voluntary agreements are used, it is essential that timely monitoring and evaluation is in place, with agreed criteria and 'trigger points' for initiating more robust action.

Secondly, effective public health practice can take some years to achieve tangible results. It depends fundamentally upon good working relationships between individuals and organisations, rooted in trust and mutual respect. These take time to develop and are easily fractured. Frequent service and system reorganisation disrupts programmes and relationships and limits the potential for positive health impact. A period of system stability is now essential if *Healthy Lives, Healthy People* is to have the impact on health the UK public needs – and deserves.

Recommendations:

- That government sets out clear 'trigger points' for intervention – including implementing regulation – when voluntary agreements to improve health (particularly with industry) fail.
- That the new system is permitted a lengthy period of consolidation and delivery before further reform is contemplated.
- That government commits to evidence-based policy-making that takes into account the full range of interventions for which there is evidence, including regulation, legislation, taxation and subsidy.
- That government commits to the implementation of regulation if voluntary measures fail within a reasonable and agreed timescale.
- Appropriate funding should be made available to establish further evidence of how to influence the wider determinants of health.