



House of Commons
Health Committee

Public Health

Twelfth Report of Session 2010–12

Volume III

Additional written evidence

*Ordered by the House of Commons
to be published 19 October 2011*

The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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¹ Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

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Written evidence

Written evidence from Professor Hilary Pickles (PH 07)

SUMMARY

- Public Health is important and we need to get it right.
- The organisational changes currently proposed have major dis-benefits, costs and risks.
- It would be better to stop and start again than attempt to modify the current proposals.

INTRODUCTION AND ASSUMPTIONS

1. There are many actions by the new coalition government which could impact on the health of the public in the short or longer term, not always by design. The actions of the Chancellor may have the greatest impact on poverty and inequalities, and those by the Secretary of State (SofS) for Energy and Climate Change the greatest on the longer-term health of the world populations. The focus here on the changes introduced by the SofS for Health, which enormous as they are, may not be the most important overall to the long term population's health.

2. This inquiry is looking at plans for public health systems in England as outlined in various recent white papers and the Health and Social Care Bill 2011. At present there is a "pause" in the implementation process and changes are promised. However, this note is only able to comment on the original plans for organisational change and not on any yet-to-be-disclosed amended version. The rhetoric is ignored when appeared not to be delivered by the written proposals. Health protection, health improvement and health services, the three domains of public health, would all be affected.

3. Space does not allow comment on all aspects of the proposed changes, so I will rely on the work of others. I did not contribute directly to the response from the Faculty of Public Health but endorse the written responses to the consultations and the evidence given by the President at the session on the 17 May. Comments I make here are to complement what has already been said.

ESSENTIALS FOR A GOOD PUBLIC HEALTH FUNCTION

4. The essence of public health practice is to use evidence-based interventions to better people's health and well-being. Wherever it is located, the following are necessary for an effective specialist public health function:

- Data and other information, on which to evidence decisions and monitor impacts.
- The ability to formulate and implement programs to better public health, through direct control or influence.
- The independence to act as advocate for public health, carrying credibility with wide audiences.

5. The current system has been through very many upheavals over the years, with all senior service public health specialists having been through at least one previous organisational change if not several. In spite of that, the system worked more or less up to a few months ago, with any defects in the formal structures compensated for by personal links. The Flu Pandemic in 2009, although not of the severity many feared, showed the resilience of the SHA-PCT-NHS-HPA system and its ability to rise to a challenge.

CONCERNS ABOUT THE PROPOSED CHANGES

6. Each of the three aspects given above in para 4 faces major disruption.

- Depositories of reliable data and those best able to do high-level analyses risk being affected, eg through the funding cuts to the Public Health Observatories and to the Health Protection Agency (HPA). Other sources of intelligence are being affected too, eg from the added secrecy created by Foundation Trusts.
- Teams and relationships are being disrupted, with concerns about the security of the budgets for essential public health programs.
- The essential local advocate, the Director of Public Health (DPH), risks being downgraded in the Local Authority (LA), voices from the HPA risk being muzzled within DH, and the influential regional public health teams are being lost.

LOCAL AUTHORITIES AND PUBLIC HEALTH

7. Local authorities already have responsibilities for the well-being of their populations and in theory it should be possible to make the taking in of the DsPH and their teams work well. LA information staff already work with public health colleagues on local population data. EHOs have long worked with consultants in

communicable disease control (CsCDC) on outbreaks. The current proposals may appear a logical extension of the recent joint DPH appointments. However, the devil is in the detail and here things may not pan out so well:

- The DPH needs direct reporting to the CEO, with direct access to lead councillors.
- Public Health (PH) budgets have to be enough for the task, with an acceptance that others' budgets help deliver PH too.
- Independence of the DPH is essential as is appointment by a committee similar to the current appointment advisory committee (AAC), but risk the DPH being excluded from the inner LA circle.
- The role of Public Health England (PHE) in staff based in LAs needs careful thought, maybe with the piloting of different models.
- Confirming formal accountability for health protection lies with LAs leaves PHE only with a local advisory role, and potential complications when events cross LA boundaries.
- Advocacy by the DPH for excluded and disadvantaged populations may sit uneasily with the views of some local political leaders.
- The increased separation from the NHS will make some functions more challenging, eg coordinating the NHS contribution to emergency responses, understanding NHS imperatives, delivering high immunisation rates through NHS staff.
- The Health and Well-Being Board risks being a time-consuming talking shop with the real action taking place elsewhere.
- There could be tensions in differing terms and conditions of service for those working together but employed by the local authority, DH (PHE) or the NHS. Current NHS employees are likely to want to stay as such.
- There may well be lessons from before 1974 and why many Medical Officers of Health were judged unsatisfactory at that time.

PUBLIC HEALTH ADVICE AND NHS SERVICES

8. Public health engages with the NHS commissioning agenda at present at a variety of levels. Formal set-piece needs assessments in the annual Joint Strategic Needs Assessment could continue in the new world unchanged. The Health and Well-being Board could “sign off” annual commissioning plans, as advised by the DPH, though the mechanism for and implications of challenging these in any event are obscure.

9. However, much of the nitty-gritty of commissioning seems far removed from this. Increasingly, it is suspected the NHS will be looking at cost-improvement programs, or recovery plans, often in-year and urgent. There will be investigations into unexpected activity in providers, or adverse events for investigation jointly with providers. The thresholds for un-affordably low priorities may need flexing, or clinical pathways redesigned with PH brokering a deal between primary and secondary care. Public health may need to be at the NHS commissioning table as a trusted member much of the time.

10. This sits uneasily with a DPH and team based in another organisation, perhaps with theoretical responsibility for advice to several GP commissioning consortia but without the formal NHS executive director responsibility held by current DsPH. The work program of the public health team will be determined by the LA and be subject to local political influence, potentially inhibiting the giving of frank PH advice, for example on any service refiguring which could be interpreted as downgrading of local facilities.

11. The working of the MOU between PCT and the new HPA when the CsCDC were transferred over showed that “free good” arrangements can be unsatisfactory, as the priorities of different organisations drift apart. Public health advice to commissioning may well be available from elsewhere, eg independent agencies or practitioners, or from GP interpretation of nationally-analysed data. Quality and relevance may be of concern. I have yet to see workable plans for the provision of top-notch PH advice which can be “owned” by GP commissioners.

12. Public health will also be needed in the Commissioning Board and its outposts, not least to assist with the oversight of primary care, and wherever specialised services are commissioned.

13. As the over-hasty dismembering of PCTs and SHAs takes place, and various functions have no natural home, DsPH risk having “responsibility” added to their personal brief, but without the staff or resources to manage them. A glaring defect of the proposals is the added difficulties created by a competitive NHS market for the close working between health and social care, without which we will not be able to manage the growing burden from long-term conditions. When formal accountability lines are lacking in statutes, there has been a recent tendency to make an individual personally accountable, easily interpreted as enabling the centre to dump its responsibilities. The DPH looks like a sitting duck for acquiring various joining—up functions, bridging the LA and the NHS.

THE NEED FOR AN INTERMEDIATE TIER

14. The Regional Directors of Public Health (RDsPH) have been invaluable in bridging LAs and NHS, with the added advantage of close involvement with DH. From my experience in London, any hiatus from an absent RDPH and team would be scary. The mayor and GLA in London will continue some cross-London functions, like emergency planning, but there is much of the NHS agenda outside their brief. The RsDPH have helped with the coordination of many issues affecting the public health, eased tensions between individual DsPH and ensured the right people are in post as DsPH and performing well. Major service reorganisation often requires cross-district action, and without the SHA team may prove impossible to progress. As civil servants the RDsPH are currently constrained in speaking out against the proposals, and in-post DsPH may think it wise not to. Whatever the supposed imperatives of “localism”, my own perspective is that a regional tier of public health is so important it would have to be reinvented—presumably within PHE—if the proposals go through.

INEQUALITIES AND THE UNREGISTERED AND GP BOUNDARIES

15. The population responsibilities of LAs are well-established and there is much case history for dealing with those that are not registered as resident. Pragmatic arrangements have developed with the current NHS where PCT boundaries and registered populations do not marry exactly with those of their LAs. If GP commissioning consortia are smaller units, and patients can register outside a defined practice catchment area, these mal-alignments would become more common, so the essential joint-working between LA and NHS would become even more problematic. A requirement for co-terminosity would be much more sensible.

16. Where boundaries do not match some people and issues risk falling through the gaps. People who are not captured by various head-counts risk added discrimination, so widening inequalities further, with this affecting some areas disproportionately. At present PCTs risk-share over a wide population and ensure all the population gets health services. It is unclear what is being proposed for those that have failed to register with a GP. As budgets become tighter, the natural tendency will be for GP practices to concentrate on the needs of the core registered population. The task for PH as advocate for the disadvantaged looks like becoming more difficult.

INDEPENDENCE OF THE PARTY LINE FROM DH

17. Many public health issues are problematic and have no easy solution. Whereas it may be right for public funds to be focussed on the approved mainstream, it can be dangerous to disregard other scenarios. Once a Ministerial decision has been made, civil servants may find it impossible to continue to consider alternatives, and hence prove inflexible to changing circumstances. Health protection may be where this matters most, hence the comfort gained from the independence of the Public Health Laboratory Service, the National Radiation Protection Board and their successor, the Health Protection Agency (HPA). The proposed Public Health England (PHE) would be part of a government department, and risks joining the enforced central group-think. An emerging public health hazard could end up being disregarded or misinterpreted.

18. Some policies of the current government have been criticised, eg the failure to deal adequately with the food and drink industries in tackling obesity and excess alcohol. The public health community needs to be free to add to the evidence base and advocate policies more closely based on that evidence than is the case with the current government line. There are concerns that those employed or appointed by PHE may feel themselves muzzled, even if not formally constrained.

19. The Chief medical officer (CMO) should be the key person in promoting and protecting public health. The holder of this post has a public persona and works across government. Dilemmas from tensions between emerging government policy on public health and the factual evidence should be passable up to the CMO who is in a unique position to influence events. But she may not be able to win the day. She needs to maintain a significant and skilled team reporting to her who are free to give unfettered advice on matters affecting public health. Cut-backs in DH may risk important public health issues not being progressed.

MAKING THE SYSTEM WORK

20. Many of the previous reorganisations to the NHS have not been driven by considerations of public health, with subsequent changes to the deployment of public health resources feeling like afterthoughts. As the architecture changes, new people get appointed in newly-described posts and new relationships are forged. Gaps in the formal arrangements are identified and pragmatic solutions found. The reality of the disruption has not in the past been as bad as many feared, with existing players reappearing in new local organisations and able to continue essential work. The longer there is between organisational changes, the more likely that defects in the design get overcome by practical local arrangements.

21. It feels different this time. Firstly the pace and scale of changes are unprecedented. Secondly there will be no surviving intermediate tier to manage the process and ensure continuity of those cross-cutting functions so important in PH. Thirdly there is a massive budget squeeze at the same time, so no resources for double-running or to pick up functions inadvertently left out. Fourthly there is proposed a major shift of many public health players out of the NHS, to local or national government, and many with other options may choose not to go. Finally, the overall consensus is these changes are ill-thought out and simply will not work. As the acute

sector and new GP commissioners run out of funds and LAs are unable to keep up their existing provision let alone increase it to deal with the increasing demand, financial chaos is predicted, and public health and its budgets will be raided, yet again.

22. While the public health fraternity are adaptable and flexible, some challenges may be simply too much. There are many risks from these changes, with important projects having to be disbanded, colleagues in the voluntary sector let down, and needed NHS service changes so much more problematic to deliver. Greatest of all may well be the “unknown unknowns”. When the next pandemic strikes, for example, expect public health systems to be in disarray and unable to deliver what the public expects.

RECRUITMENT AND RETENTION IN PUBLIC HEALTH

23. It is a time of much uncertainty. The Faculty president told the committee of the very real difficulty affecting those completing training. Going forward, it is unclear what posts will be retained for public health specialists and more junior colleagues. Working within local or central government has restraints which may be unwelcome to those used to the freedom that NHS consultant status brings. I am unclear what the terms and conditions of employment will be, but those within the NHS and its pension scheme may be reluctant to see them go. The net effect is that there could well be many existing or potential future public health specialists who prefer to find other careers than move to PHE or a LA. This may apply especially those who have medical qualifications and options to return to general practice or another clinical speciality.

24. Had I not already retired, I would have left the NHS at this time, unable to bring myself to spout the party line and help staff through changes I feel are so unnecessary and counter-productive. There is still an important public health job that has to be done, and I trust others feel able to continue.

THE ALTERNATIVE FUTURE

25. The proposed changes feel like an unnecessary self-inflicted wound when there is so much real work to be done. Cancel the proposed Health and Social Care Bill and see what can be delivered, more slowly, under the existing primary legislation. Some aspects of the proposed changes have much support, like increasing involvement of GPs in commissioning decisions, and greater involvement of LAs in public health matters. PCTs may need to be recognised in the new clusters, since that clock may not be possible to turn back. If various bodies are to be brought together as PHE, this can be done as a SHA or executive agency or through a more informal collaboration.

26. The real prize in this is not a satisfying career for public health specialists and practitioners, but the health of the public.

ABOUT THE AUTHOR

27. Trained as a physician and clinical pharmacologist, I spent 14 years in DH, then 12 years as a district DPH, interspersed with a year as Director of PH policy at the PHLS as it turned into the HPA. Since retirement from the NHS in 2008 I have worked as an occasional independent PH consultant for the SHA and London PCTs on projects such as service reorganisations, pandemic flu, emergency short-stay admissions, detainee healthcare, and (ongoing) the vetting of low priority treatments and consultant referrals. I am an honorary professor associate at Brunel University.

May 2011

Written evidence from Sustrans (PH 08)

ABOUT SUSTRANS

Sustrans makes smarter travel choices possible, desirable and inevitable. We're a leading UK charity enabling people to travel by foot, bike or public transport for more of the journeys we make every day. We work with families, communities, policy-makers and partner organisations so that people are able to choose healthier, cleaner and cheaper journeys, with better places and spaces to move through and live in.

It's time we all began making smarter travel choices. Make your move and support Sustrans today. www.sustrans.org.uk

KEY POINTS

- Sustrans is a major player in improving public health, through programmes which bring a shift to walking and cycling for local trips;
- we welcome the Government's recognition, in the Healthy Lives, Healthy People white paper, that *“it is not better treatment but prevention [...] which is likely to deliver greater increases in healthy life expectancy”*, and hope one day to see a Secretary of State for public health, with influence across all relevant Departments. Public Health England also needs the power to influence those sectors responsible for major health determinants;

- we would like to see a commitment to grow the percentage of health budgets committed to public health, year on year;
- we welcome the relocation of public health functions into local government, but are particularly concerned that the issues of transport, planning and public health may be marginalised in Health and Wellbeing Boards, and in the JSNA process;
- there is a significant potential for shift to active, health-enhancing travel choices for local trips, benefiting health, sustainability and the climate agenda, and health equality. We hope to see DH, DfT and CLG working together to ensure planning and transport policies and investments are focused on all these objectives;
- and so, it is important that the Public Health Outcomes Framework should reach into the planning and transport sectors; and
- in particular, we would like to see DH and DfT jointly committing to:
 - incorporate public health criteria more fully into transport investment planning, including the Local Sustainable Transport Fund and Local Transport Plan processes;
 - publish an updated and reinforced Active Travel Strategy;
 - and oversee the implementation of NICE guidance, such as Physical Activity and the Environment and Prevention of Cardiovascular Disease (and the forthcoming walking and cycling guidance, of course); and
- we are surprised that the white paper did not mention the National Cycle Network, a world-class, voluntary-sector-led, public health programme which deserves endorsement from the DH.

1. Sustrans BACKGROUND

1.1 Sustrans is the UK's leading sustainable transport charity. We deliver national programmes of practical intervention which promote regular walking and cycling. These programmes raise physical activity levels and improve public health, reduce climate change emissions, improve road safety and enhance wider quality of life.

1.2 Our comments therefore address public health and the Committee inquiry only from the point of view of physically active living and active travel. We have in general taken the Healthy Lives, Healthy People white paper as our starting point for comment.

1.3 The significance of active travel—walking and cycling for daily travel purposes—is clearly evidenced in the mainstream of public health policy and evidence review. We base our strategies and project design particularly on “*At Least Five a Week*”,¹ the “*Foresight Tackling Obesities*”,² report, guidance from the National Institute for Health and Clinical Excellence (NICE) such as “*Physical activity and the environment*”³ and “*Prevention of cardiovascular disease*”⁴ and our own, published, evidence review.⁵

1.4 Work that we have done for DfT and the Passenger Transport Executive Group (pteg), as well as work by others, makes clear that there is a significant potential for growth in walking and cycling for local trips (see para 5.5, 5.6).

1.5 Sustrans' programmes have a significant impact on public health.⁶

- the National Cycle Network carried 407 million walking and cycling trips, by 3.1 million individuals in 2009, with over two thirds of users reporting increased activity levels thanks to their local routes;
- our Bike It programme doubled regular cycling to school, and has now worked with over 400,000 children;
- our Personalised Travel Planning team has worked with over 250,000 households, providing travel information and support and consistently achieving shifts of between 10% and 15% of car trips to walking, cycling and public transport; and
- we lead the Travel Actively consortium—all of the national walking and cycling groups, jointly delivering 50 projects across England, with a target to get 1.8 million people more active through walking and cycling.

1.6 A number of Sustrans' local projects are delivered in partnership with NHS bodies, particularly Primary Care Trusts (PCTs), commissioned as part of the PCT public health function; we are working with these public health teams and others, to seek the best possible results from the move of public health into local government.

1.7 We also contribute to the development of policy (for example, working with DH on the Responsibility Deal for Public Health), guidance (eg work on NICE guidance development groups) and capacity (founder member and board of the Physical Activity Alliance; co-founder of the Take action on active travel alliance). In this we collaborate with most of the national public health organisations.

2. GENERAL COMMENTS ON PUBLIC HEALTH RESTRUCTURING

2.1 Sustrans wholeheartedly supports the Government's recognition, in the Healthy Lives, Healthy People white paper, that “... it is not better treatment but prevention [...] which is likely to deliver greater overall

increases in healthy life expectancy”. This recognition should drive future health investment planning, in order to get on top of the growth in healthcare demand and to achieve the best possible quality of life for individuals.

2.2 We support the government’s decision to make public health a true cross-government priority and create a Cabinet sub-committee.

2.3 We support the relocation of public health functions into local government. This restructuring is likely in our view to make health promotion more effective.

2.4 In our opinion, the Government should commit to an ongoing increase in the percentage of the total health budget focused on health promotion and the prevention of non-communicable diseases. Otherwise, the demand for healthcare must become unaffordable, while collateral issues, such as the declining health of the national workforce, will also create ever greater economic strain.

2.5 The white paper also recognised—and we welcome this clarity very much—that active travel can contribute to better health, sustainability and the climate agenda, and health equality. This is a strong argument in favour of cross-government and inter-sectoral collaboration, and joint investment strategies.

3. ISSUES CONSIDERED BY THE INQUIRY

3.1 We consider that public health should be a prime concern of the Department of Health—that the provision of many aspects of healthcare should come to be regarded as the regrettable but necessary intervention of society when health promotion has been unsuccessful. In an ideal world, we would like to see a Secretary of State for Public Health, whose role and influence would cut across the whole of government.

3.2 Regarding the creation of Public Health England (PHE), from our perspective the most important issue is that PHE should have influence much more widely than just through the public health system as historically understood. Many of the determinants of individual lifestyle choices fall within the remit of other government departments and their sectors, and for PHE to be able to affect these determinants in a positive way it needs to be able to steer, directly or indirectly, factors such as planning policy and practice, and transport investment planning.

3.3 We are pleased to see that the inquiry raises the issues of the Health and Wellbeing Boards (HWBs) and of Joint Strategic Needs Assessment (JSNA). Over April and May this year, Sustrans has surveyed Directors of Public Health (DsPH) to investigate their views on the importance of active travel as health promotion, the extent of their engagement with their transport peers, and their future plans in this area. The results (interim) are worrying:

- 85% of DsPH regard physical activity as important or very important;
- 45% feel they have a strong or very strong relationship with their transport colleagues;
- and 76% collaborate to at least some extent with transport in active travel promotion;
- but only in 23% of cases will transport feature more than generically in the next round of JSNA;
- and 66% expect transport to be unrepresented on the HWB;
- only 48% of respondents had contributed more than a stakeholder consultation response to their local authority’s Local Transport Plan 3 (the current round);
- and only 44% were involved to this level in their council’s bid to the DfT Local Sustainable Transport Fund—which is ideally suited to behavioural interventions promoting a shift to active travel; and
- this implies that, although many individuals “get” the shared public health and transport agenda, the system is obstructing good collaboration and, above all, that the opportunities for public health to help steer transport policy and investment planning are being missed.

3.4 We would like to see concerted action by the three Government departments involved in this area—DH, DfT and CLG—to ensure collaborative work, at the highest level of local government, between public health, planning and transport. This should include a specific focus on HWBs and JSNA. No doubt you will have heard from the expert public health bodies of a concern that when DsPH move into local government, they must be located in roles of sufficient seniority to ensure their voice is heard across the other, relevant areas of local decision making: this is a concern we share.

3.5 The inquiry mentions public health involvement in the commissioning of NHS services. We would draw your attention to the reverse of this question—GP commissioning of health promotion, including commissioning from providers outside the traditional health sector, such as Sustrans. Under the current proposals, GPs will continue to have an important role in referring individuals whose lifestyles are insufficiently physically active to programmes which promote physical activity, such as through walking and cycling. There may be an issue as to how such physical activity promotion is paid for, if GP commissioning budgets do not include a public health element. We hope that the development of Public Health England, the establishment of public health budgets within local authorities and the relationships of these with GP consortia will take such issues into account.

3.6 And there may be a training issue: GPs and the commissioning specialists in consortia may not be as expert in health promotion—and specifically in areas such as active travel—as they will be in the commissioning of medical and clinical services.

3.7 Regarding the Public Health Outcomes Framework, our view is that the breadth of public health activity and the wide range of bodies and sectors involved in delivery of health promotion mean that Public Health England will need to work in wide cross-sector partnership so as to collate all the available evidence. Some effective actors in health promotion are a long way outside the health world, and may not even be aware of the Outcomes Framework. They may use different measures, and often may only determine intermediate outcomes (such as more children walking and cycling to school). And of course in the transport field the standard approach to economic assessment is Cost Benefit Analysis, which doesn't fit with the approach in health.

3.8 In the field of active travel, Sustrans has a Research and Monitoring Unit (RMU) producing high quality evidence based on our own practical programmes and those of others, including the Travel Actively consortium, the Cycling Demonstration Towns (CDT) and Sustainable Transport Demonstration Towns (STDT) in England. The RMU works with DfT, as well as with WHO, National Obesity Observatory and others.

3.9 We recommend that the research, monitoring and evidence strategies of PHE should explicitly set out to create cross-governmental and inter-sectoral evidence partnerships, with DfT, with Sustrans and with other transport specialists.

3.10 We also recommend that PHE should be explicit about the need for evidence on the environmental determinants of individual behaviour, and on the impact of environmental intervention. Some evidence and policy specialists seem to assume that public health programmes are exclusively about individual focused motivational and marketing approaches: the behavioural impact of the National Cycle Network (see para 4.3) illustrates just how significant an environmental improvement can be.

4. THE ENVIRONMENT CONDITIONS BEHAVIOUR

4.1 Healthy Lives, Healthy People notes that “improving the environment in which people live can make healthy lifestyles easier. When the immediate environment is unattractive it is difficult to make physical activity [...] part of everyday life. Unsafe or hostile urban areas that lack green spaces and are dominated by traffic can discourage activity.”

4.2 We consider the environment as a central determinant of people's lifestyle choices. Until the environment itself “nudges” individuals towards, rather than away from active lifestyles, we cannot expect significant and lasting behaviour change. In the Netherlands, 25% of trips by the over-60s are made by bicycle⁷—that is the type of environment we should be creating here.

4.3 So we draw your attention to the National Cycle Network, which in 2009 carried 407 million trips by 3.1 million individuals—50:50 on foot and by bike (303 million in England). Over two million of these users say the existence of the Network has led them to increase their levels of physical activity, and more than half were below the recommended 5X30 minutes of physical activity per week. This is a world-class, voluntary-sector-led, public health programme, perhaps the largest public health intervention currently underway, and deserves explicit Government endorsement as such.

4.4 Again, Healthy Lives, Healthy People says that “the DH will support local areas ... for example by sharing learning from the experiences of the nine healthy towns as well as sustainable travel towns and cycle towns”, and that “local sustainable transport, including active travel, will be supported through the DfT £560 million Local Sustainable Transport Fund”.

4.5 In Sustrans' view the commitment to cross government policy-making and delivery needs to be much greater. Public health needs to be centre stage in transport, and indeed in planning policy. We would have liked the white paper to explain **how** these other policy fields will ensure growth in walking and cycling, and how the growth will be resourced.

4.6 It will be of critical importance that the local Director of Public Health and colleagues are able to influence and steer local transport strategies and investment. Sustrans and others have urged DfT to make public health objectives central to planning and transport policies and strategies, and above all to investment planning objectives.

4.7 DH and DfT collaborated effectively on the Active Travel Strategy, published in early 2010. The loss of this strategy with the change of government is unfortunate. We hope for a commitment to publish an updated, improved and more delivery-focused version.

4.8 The Cycling Demonstration Towns programme, whose success the White Paper acknowledges, has been halted by DfT. It should be reinstated—quickly enough for the existing momentum to be maintained—on public health grounds alone, although of course it also addresses government objectives on climate, congestion, quality of life etc.

4.9 And we recommend cross-governmental work to ensure that existing public health guidance from NICE, such as PH08 Physical Activity and the Environment and PH25 Prevention of Cardiovascular Disease, is

implemented by local authorities and the other groups named by NICE. We would like to see DfT put its own logo onto guidance like this—whether jointly with NICE or by republishing under the DfT brand. NICE has just begun the development of guidance on the promotion of walking and cycling (due October 2012)—this would be an ideal place for DfT to start co-branding.

5. THE POTENTIAL OF ACTIVE TRAVEL TO BENEFIT HEALTH

5.1 Many authoritative voices have made clear the importance of active travel in healthy lifestyles. Back in 2004, this committee considered evidence on the obesity epidemic. It reported: “*If the Government were to achieve its target of trebling cycling in the period 2000–2010 (and there are very few signs that it will) that might achieve more in the fight against obesity than any individual measure we recommend within this report*”.⁸

5.2 Foresight, in 2007, said “*the top five policy responses assessed as having the greatest average impact on levels of obesity [include] increasing walkability/cyclability of the built environment*”.⁹ the Chief Medical Officer called for “*national targets ... to double travel on foot in England’s towns and cities, and to increase travel by bicycle eightfold*”.¹⁰

5.3 The Cabinet Office calculated the costs associated with our current approach to transport, including cost of congestion, physical inactivity, CO₂ emissions, other pollutants, noise and accidents, to £38–48 billion in England.¹¹ Physical inactivity contributed £9.8 billion to this, and other areas directly related to public health included air quality (£4.5–10.6 billion), road casualties (£8.7 billion) and noise (£3–5 billion).

5.4 The same Cabinet Office research project showed that people could replace 78% of their local car trips under five miles with walking, cycling or public transport.¹²

5.5 Studies by Sustrans for the Department for Transport (DfT) on the STDT programme correlate well with this. In the three demonstration towns (Darlington, Peterborough and Worcester) almost 50% of local car trips could have been made by at least one other, more active and sustainable, mode of transport.¹³

5.6 More recently, we worked with pteg to model the potential for increasing cycling in the six city regions (population 11 million). We found that an area-wide approach similar to that piloted in the CDT programme could generate 96 million additional cycle trips per annum from an investment of £337 million spread over three years. The best estimate benefit value of this travel behaviour change would be over £700 million (good value for money in transport terms). Annual health benefits are modelled at £62 million, and the savings to the NHS alone, over ten years, at £196 million.¹⁴

May 2011

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Written evidence from the Chartered Institute of Environmental Health (PH 09)

ABOUT THE CIEH

As a **Chartered professional body**, we set standards and accredit courses and qualifications for the education of our professional members and other environmental health practitioners.

As a **knowledge centre**, we provide information, evidence and policy advice to local and national government, environmental and public health practitioners, industry and other stakeholders. We publish books and magazines, run educational events and commission research.

As an **awarding body**, we provide qualifications, events, and trainer and candidate support materials on topics relevant to health, wellbeing and safety to develop workplace skills and best practice in volunteers, employees, business managers and business owners.

As a **campaigning organisation**, we work to push environmental health further up the public agenda and to promote improvements in environmental and public health policy.

We are a **registered charity** with over 10,500 members across the UK and, increasingly attracting members in many other countries around the world.

1. INTRODUCTION

1.1 The CIEH welcomes the intention of the Health Committee to scrutinise the plans for the Government's proposals for major changes to the organisation of the public health services.

1.2 We also welcomed the announcement of the Government's "pause and listening" process which has included seeking further views from interested parties and the public and commissioning Professor Steve Field to head the NHS Futures Forum and to report on possible improvements to the Health Department's proposed NHS reforms in England.

1.3 It was our understanding that our contributions to the pause and listening process, and the work of the NHS Futures Forum would be limited to the proposals in respect of reforms to the public health arrangements for England. However, we have been concerned to note that none of the four work streams within the NHS Futures Forum includes any explicit reference to public health, and the Forum includes only one representative from the public health professions.

1.4 There is therefore a risk that, with the debate concentrating on other changes to the NHS, the effects of the proposed changes to the public health system are being overlooked. This could put the health of the public at risk, and lose the opportunity to improve on the current arrangements.

1.5 We hope that the report of the Health Committee may go some way to address these concerns which we believe are widely held amongst the professional bodies representing the public health workforce.

2. SUMMARY

2.1 The CIEH supports the proposal to transfer the public health lead from the NHS to local government. Local authorities have democratic legitimacy for their role as community leaders and they are effective at engaging with communities and enabling individuals and communities to have more power over their own lives, a key theme of the Marmot review.¹ Local authority environmental health departments already provide the bulk of the public health workforce and they are best placed to deliver the effective public health interventions which serve to protect and improve the health and wellbeing of individuals and whole populations as well as prolong healthy lives.

2.2 A consistent and joined-up approach by all the public health partners across the three pillars of public health (health improvement, health protection and healthcare) will reduce health inequalities. The fairness of acting on the physical and social determinants of health is highlighted by Sir Michael Marmot's Review, and the opportunity to make significant savings to the NHS in the process was stressed in the work carried out by Sir Derek Wanless and others previously and reaffirmed in the Health Committee's most recent report.²

2.3 Since their inception, environmental health practitioners (formerly called public health inspectors) have worked with the Government and other partners to deliver such interventions, and that commitment will continue.

2.4 In this submission to the Health Committee we have identified four key areas where we believe that there are outstanding issues which we hope that the Health Committee will be able to consider and address in its recommendations.

2.4.1 Accountability must be clear within the public health system.

2.4.2 Local authorities must be seen as public health leaders in their localities.

2.4.3 Directors of Public Health must be competent and powerful.

¹ Fair Society, Health Lives February 2010

² 5th Report—Commissioning: further issues HC 796 I and II 5 April 2011

- 2.4.4 The funding for the new public health services, nationally and locally needs to be adequate, stable, transparently distributed and predictable.

3. ACCOUNTABILITY MUST BE CLEAR WITHIN THE PUBLIC HEALTH SYSTEM

3.1 The individual and collective roles and responsibilities of the Department of Health, Public Health England (PHE), the NHS Commissioning Board, local authorities, Directors of Public Health, GP commissioning consortia and Health and Wellbeing Boards must be made clear and coordinated in the new system.

3.2 The CIEH is particularly concerned that the independent voices of bodies like the Health Protection Agency and the National Treatment Agency will be lost, with no proposal to introduce any substitute sources of independent advice and advocacy and no proposals to otherwise counteract this loss.

3.3 The CIEH has three specific propositions to make to help remedy the loss of independence and bolster the ability of PHE to speak out on public health issues, matters in which the public has a legitimate interest.

They are:

- 3.3.1 PHE must be established with a degree of independence, including in overseeing the arrangements for collecting, analysing and disseminating the data valuable for public health purposes. PHE should be assisted in its work by an advisory panel (or forum) comprising representatives of the public and of relevant public health interests, including environmental health. This approach enables Public Health England to stay in touch with public health practice and the public's priorities as well as test out its thinking on a knowledgeable yet independent body of people.
- 3.3.2 There should be a post of Chief Environmental Health Officer, answerable to the Chief Medical Officer and able to advise Public Health England, Parliament and the public on environmental health aspects of public health. There has been such a position at times in England's history and there is such a post today in other parts of the UK.
- 3.3.3 PHE can only effectively operate as a truly national public health service if it has a genuinely comprehensive and strategic remit for all relevant functions including national commissioning, not just those elements now covered by the Health Protection Agency.

4. LOCAL AUTHORITIES MUST BE SEEN AS PUBLIC HEALTH LEADERS IN THEIR LOCALITIES

4.1 For localism to be meaningful, it must be for local authorities themselves to determine the public health needs and arrangements in their locality, in consultation and collaboration with the other public health partners, including the local NHS.

- 4.1.4 Public Health England should support local authorities in their extensive public health facing work protecting and improving the health of their local populations through all the services they control.
- 4.1.2 Health and Well-being Boards must have the power to sign-off local commissioning plans, ensuring that they are aligned with the Joint Strategic Needs Assessment and the Health and Wellbeing Board's local public health strategy so as to address the identified needs of the population and that strategies as far as they are able are "joined up" to aid efficiency.
- 4.1.3 Under the new arrangements there will be a continuing need for co-operation between different agencies and providers, including PHE, Councils at both County and District level, the NHS, all commissioning bodies and all other public health partners. A statutory duty of cooperation is an essential tool to ensure adequate partnership engagement and should be placed upon all these, comparable to the statutory framework that exists for dealing with civil contingencies.

5. DIRECTORS OF PUBLIC HEALTH MUST BE COMPETENT AND POWERFUL

5.1 In the multi-disciplinary public health workforce, the leadership and support given by the Directors of Public Health will be crucial to success. The new arrangements clearly acknowledge the multi-disciplinary approaches to public health and it would be anachronistic if the qualifications for Directors of Public Health were not to reflect this.

- 5.1.1 Directors of Public Health should have adequate legal duties and powers to enable them to do their job effectively.
- 5.1.2 They should have a right to direct access to both the local authority's Chief Executive and all its Councillors, as well as to the relevant commissioning bodies operating in their area.

6. *The funding for the new public health services, nationally and locally needs to be adequate, stable, transparently distributed and predictable*

6.1 Vital capacity, especially in terms of skilled personnel, is already being lost from the Health Protection Agency, local authorities and the NHS due to current public spending cuts and uncertainty as to future structural needs and funding levels. In order to avoid further loss of skilled support to the implementation of the new arrangements we urge speed of decision making at least in the final shape of the proposals.

6.1.1 The public health partners will benefit in making their plans for future public health services from the earliest possible disclosure of the likely ring-fenced funding for the early years of the new services.

6.2 We have particular concerns regarding the ring-fenced funding to local authorities. It is clearly vital that the new services are launched successfully and there is a great deal of work to be done in a short space of time to ensure this success. It is right therefore that at the outset of these new services the grant funding should be ring-fenced. The grant-funding should be appropriately weighted to reflect levels of deprivation and health inequality and the formula used for assessing and distributing the grants to local authorities should reflect this.

6.2.1 The total amount of funding available for the new services must be sufficient for all the public health functions expected to be delivered.

6.3 We also have concerns regarding the health premium, intended by the Department to incentivise a successful public health performance by local authorities, but which runs counter to the Government's ambitions for a successful launch and for enhanced localism. There is a danger that a plethora of confusing outcomes and indicators, linked to short-term performance of long-term public health objectives will make the overall distribution of funding for the new services obtuse, perverse and unfair.

6.3.1 The proposed health premium must be applied simply and fairly and recognise that some public health gains are won over the longer term.

7. CONCLUSION

7.1 The CIEH would be happy to clarify and discuss these matters further to ensure that public health is protected and improved by the new arrangements that will be put in place for England.

May 2011

Written evidence from the Sport and Recreation Alliance (PH 10)

The Sport and Recreation Alliance is the national independent voice for sport and recreation, representing over 320 member organisations including the national governing bodies. Our members account for 151,000 sports clubs catering for some 13 million participants, and the Alliance exists to protect and promote the role of sport and recreation in society. The Alliance welcomes the opportunity presented by this inquiry to highlight the importance of physical activity for public health and consider the likely impact of the proposals contained within the Health and Social Care Bill.

SUMMARY

- Physical activity brings significant benefits in tackling a wide range of preventable diseases, for people of all ages.
- Sport and physical recreation have a broad appeal, are inexpensive to deliver and are an essential part of an effective strategy for public health.
- The Government's proposal to radically shift power to local communities should not come at the expense of much needed coordination at the national level.
- The Department of Health, the Department for Culture, Media and Sport and the Department for Education all have a common goal in promoting and delivering sport and physical recreation. This shared interest should be reflected in close cooperation between departments and between Cabinet colleagues.
- Health and Wellbeing Boards must include representatives from sport and recreation. Such boards could potentially serve as a valuable coordination mechanism for local sport provision and physical inactivity initiatives, but to do so effectively they require strong leadership.
- It is vital that the creation of a separate public health body does not lead to a fragmented health system; physical activity has a role to play both in terms of preventing and treating disease.
- "Medic-to-sport" initiatives such as the Amateur Swimming Association's "Swim4Life" GP Referring Programme which form a connection between patient advice and local sport and recreation opportunities should be a key feature of public health framework.

THE VALUE OF SPORT AND RECREATION

1. The myriad benefits of physical activity for health are well documented. There is a comprehensive evidence base to support the promotion of sport and physical recreation as a cost effective, inclusive and sustainable route to tackling a range of public health challenges. Physical activity brings significant benefits in tackling a wide range of common diseases, for people of all ages, and inactivity is as important as smoking and an unhealthy diet as a major factor of chronic disease; achieving the recommended levels of moderate intensity physical activity can reduce premature mortality by between 20–30%.¹

2. Research has shown physical activity to be protective against obesity, type II diabetes, osteoporosis, haemorrhagic strokes,² arthritic problems,³ cardiovascular disease and certain cancers. An active lifestyle can

also improve psychological wellbeing, proving effective in tackling clinical depression, stress, anxiety and low self-esteem.⁴ Increased sporting activity is linked to the development of the type of personality resistant to drug and alcohol addiction,⁵ while girls participating in sport are less likely to be sexually active at a young age and have teenage pregnancies.⁶

3. Despite the benefits on offer, levels of physical activity in England remain low. The Department of Health's most recent survey revealed that only a quarter of adults reported that they regularly took part in sport, and less than half of respondents said they made walks of 20 minutes or more at least three times a week.⁷ The UK is the most obese nation in Europe, and the Government's proposals for public health must therefore address a significant challenge. The promotion of active lifestyles—of which sport and physical recreation are a key part—would both improve health outcomes and represent a significant saving for the NHS. The direct costs associated with physical inactivity have been estimated to be between £1 billion and £1.8 billion,⁸ excluding the far greater indirect financial costs to society as a whole which are estimated to exceed a further £5 billion. Without decisive action the costs of tackling obesity could reach £50 billion by the year 2050.⁹

4. It is vitally important to reverse the current situation whereby a majority of adults are either overweight or obese while a minority meet guidelines for regular physical activity.¹⁰ Sport and physical recreation have a broad appeal and are inexpensive to deliver, and can bring about lasting improvement for individuals of every age and background. It is clear that there can be no effective strategy for public health which does not promote and facilitate sport and physical recreation.

THE ROLE OF NATIONAL AND LOCAL GOVERNMENT

5. Given the long-term public health benefits of regular physical activity, the Department of Health, the Department for Culture, Media and Sport and the Department for Education all have a common goal in promoting and delivering sport and physical recreation. This shared interest should be reflected in close cooperation between departments and between Cabinet colleagues, and it would therefore be extremely disappointing if the Secretary of State for Health did not take an active role in this regard. At the very least, Public Health England must engage fully with national governing bodies, Sport England and DCMS. The Government's proposal to radically shift power to local communities should not come at the expense of much needed coordination at the national level.

6. The success of the shift of power to local communities will depend on the effectiveness of Health and Wellbeing Boards as mechanisms for fostering collaboration between local networks. While they are potentially very valuable as a mechanism for coordination between local authorities and commissioning consortia, they will fail without strong leadership and solid support from all sides. If physical activity is to form a part of the public health agenda it is clear that sport and recreation must be represented, given that local authorities already carry out a range of relevant functions, including provision of leisure services. The Sport and Recreation Alliance has therefore recommended that County Sport Partnerships be included on the boards, as each has full view of local initiatives and is able coordinate and facilitate the sharing of information locally (and nationally through the County Sport Partnership Network).

PHYSICAL ACTIVITY AS PREVENTION AND CURE

7. While the intention to ring-fence funds for the purpose of delivering public health outcomes is welcomed, it is extremely important that this separation does not lead to a fragmented health system; physical activity has a role to play both in terms of preventing *and* tackling disease. While exercise in early life is protective against a wide range of conditions, physical activity in later life can help the management of painful conditions, and should not be confined to a "public health" function. There is a risk that, under the proposed arrangement, sport and physical recreation could in fact become more alienated from areas of the health service in which they have much to offer.

8. The Sport and Recreation Alliance believes that GPs should be fully equipped to promote and facilitate sport and physical recreation, and as such proposals to strengthen the focus on public health issues in education and training are welcome. GPs can be stronger advocates for participation in sport and physical recreation and should not only understand and communicate the full range of benefits of regular physical activity (both as a preventative measure and as a form of treatment) but also be aware of local opportunities and have access to resources which can be easily disseminated to patients. Sport and recreation organisations are well placed to work alongside GPs to develop pathways to physical activity, as demonstrated by the example of the Amateur Swimming Association's "Swim4Life" GP Referring Programme. The programme is an initiative to establish swimming as a tool for GPs across the UK, seeking to transform the way swimming is delivered to individuals.

9. The trial run of "Swim4Life" was successfully delivered in the East Midlands through the effective coordination of ASA regional staff, a GP Practice and the manager and staff of a local swimming pool. Patients were contacted by the GP—utilising the ASA's template correspondence—and were encouraged to visit their local pool, where participating staff greeted patients and guided them through the visit. The results of the trial programme were encouraging; of the 1,500 patients who were contacted by their GP, 60 participated in the programme and a quarter of those who completed the programme went on to become members of the facility. The ASA's initiative therefore goes beyond a GP recommendation to undertake more exercise by providing a

comprehensive system of referral, starting with active engagement by the GP. By linking the advice individuals receive in the doctor's surgery with the service provided at local facilities, swimming becomes more accessible and more attractive to those who would otherwise remain insufficiently active.

10. The "Swim4Life" example demonstrates the potential benefits of utilising sport and recreation networks at the local level. A second example is the Get Walking Keep Walking (GWKW) programme, which is a four year project developed by the Ramblers. GWKW aims to increase regular independent walking amongst previously inactive and insufficiently active people. The scheme comprises of six projects designed to exploit the ease and accessibility of walking in an imaginative way, drawing together a unique combination of outreach, led walks, resources and online tools. The basic principle of GWKW is for people to gradually increase their level of walking using structured plans, and there are a number of ways in which participants can engage with the programme; at the end of February 2011 GWKW had engaged 71,635 people from across the UK. An independent evaluation of GWKW¹¹ revealed that participation in the programme led to an increase in the number of days on which people are active for more than thirty minutes. There were clear benefits for individuals, who were more likely to be happy, motivated, energised and engaged, with nearly 40% saying they had taken up another form of exercise following their involvement in the programme.

THE PUBLIC HEALTH OUTCOMES FRAMEWORK

11. Sport and recreation clearly have a significant role to play across the five domains identified in the Government's White Paper, and the list of proposed indicators of health improvement rightly includes the percentage of adults meeting recommended guidelines on physical activity. However, the Sport and Recreation Alliance believes that the Framework should take into account the wide range of activities that may be included here, ranging from shorter duration, more intensive activities (such as squash or running) to less intensive, longer duration activities such as cricket or golf. The indicator must reflect that each of these activities leads to a positive outcome for health, but that patterns of participation differ greatly.

12. It is important that the Government recognises that there is to some extent a hierarchy in terms of importance within the set of recommended indicators, and the Sport and Recreation Alliance has sought to bring attention to the importance of the physical activity indicator. Physical activity is in effect a "super-indicator", given the evidence linking it to positive outcomes across a range of other indicators including: reduction in crime (domain 2); truancy rate (domain 2); prevalence of healthy weight (domain 3); self-reported wellbeing (domain 3); prevalence of recorded diabetes (domain 4) and mortality rate from all cardiovascular disease (domain 5). The relationships between these various measures of health highlight the fact that indicators should not be taken in isolation.

13. The framework should do more than track what is happening (eg measuring mortality rates) but should indicate progress in prevention. In this context, physical activity indicators are more revealing as a measure of an effective public health strategy, and should be prioritised when it comes to the payment of a health premium. The Outcomes Framework must also take into account the pattern of participation in physical activity across different age ranges. It is vital that public health strategies address the problem of declining physical activity levels over the life-course; last year a quarter (26.2%) of 16 to 34 year olds met activity guidelines in 2009–10, as opposed to 7.7% of those aged over 55.¹²

14. The Sport and Recreation Alliance believes that the formula driving the health premium should be able to accurately reflect achievements relating to physical activity, taking account of the varied nature and time span of the associated health outcomes. Many of the benefits derived from physical activity are not seen for many years; for example, exercise in early life will lead to healthy outcomes in later life (for example, by preventing cardiovascular disease). Given that physical activity is important for health outcomes across the life-course, the health premium should be designed so as to reward long-term thinking as well as short-term results.

June 2011

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Written evidence from the NHS Alliance (PH 11)

EXECUTIVE SUMMARY

- The Alliance welcomes the creation of Public Health England and the transfer of Directors of Public Health (DsPH) and health improvement functions to local authorities but we have a number of concerns about the overall coordination and delivery of public health functions at both national and local level.
- We believe DsPH need to put more focus on the skills of persuasion, public engagement, facilitation and leadership and less on the analysis of problems. The responsibility for providing information and benchmarking data to inform local commissioning should remain with sub-national Public Health Observatories that should be co-located with outposts of the National Commissioning Board.
- DsPH need to have a continuing role in commissioning NHS services and they should sit on GP Consortium Boards. In time all GP Consortia should have a GP with a specialist interest in public health who works closely with the DsPH.
- There are too many outcome measures and too much focus on separate outcomes for public health, social care and the NHS. There should be more work on developing shared outcomes for older people, long term conditions and mental health. This would help to drive effective partnership working and pooling of budgets to address local priorities. Health and Wellbeing Boards should rank outcomes in priority order depending on local needs identified in the Joint Strategic Needs Assessment (JSNA) and the local strategy should focus on addressing the highest priorities.
- There should be more focus on public health as everyone's responsibility and less on public health as the responsibility of a professional workforce. This will require new ways of working if the wider health and social care workforce is to see every contact as a public health opportunity.
- Rather than look for new resources public health needs to get better at identifying and developing local assets to support the delivery of public health outcomes. This should include a systematic approach to providing support for voluntary and community organisations that promote participation in leisure and voluntary activities and that develop and maintain supportive social networks and nurturing relationships for vulnerable individuals (NICE Guidance on Behaviour Change).
- There should be more investment in recruiting, training and supporting local people to take on the role of motivating and championing change within their communities. It is not clear from the current proposals how the training and support of such individuals is going to be funded or who will provide it. We believe this needs a systematic approach with Health and Wellbeing Boards working closely with their local voluntary and community sector who have the reach into and trust of marginalised groups that is not always the case with the statutory sector. Investing in this approach is an important way of addressing inequalities.

1. We welcome the creation of Public Health England within the Department of Health and more importantly welcome the formation of a cross government cabinet sub-committee on public health that hopefully will ensure an integrated approach across all government departments.

2. There is merit in the abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse and of making the functions of these organisations part of the remit of Public Health England. These functions require national leadership and expertise, and they also require local delivery and engagement. We also believe however that there is a case to be made for a sub-national framework for some of these functions. This need not necessarily be around geographical regions but could be around groupings of common interest. There is for instance an effective core cities network for the eight largest cities outside London and similarly there could be a rural areas network and a network for smaller towns. These areas have different needs and issues and this sort of approach could lead to better benchmarking of like with like.

3. The Secretary of State has too often functioned as the Chair of an organisation responsible for health care delivery rather than the Chair of an organisation responsible for the nation's health. Given the challenges of demographic change, long term conditions and behaviourally determined problems such as obesity and alcohol, we welcome the shift to a much greater focus on public health. There is a lot of exhortation to partnership working and shared budgets at local level, the Secretary of State needs to take a leadership role in driving partnership working and shared budgets for public health, both across government departments through the cross government cabinet sub-committee, and across the silos within the Department of Health.

4. The future role of local government is crucial for the success of the proposed new arrangements. We broadly welcome the location of Directors of Public Health (DsPH) in local authorities but we have some concern about the breadth of the role and about DsPH being servants of two masters—Public Health England and their local authority. We believe that the balance of this relationship needs to be in favour of the local authority and that this needs to be made clear in any job description.

5. Getting the right person in post will be critical and as well as recommending that a representative of local GP Consortia should sit on the interview panel for these posts, we also hope that there will be an emphasis on the soft skills of persuasion, public engagement, facilitation and leadership as well as the more technical skills of health protection, data analysis, evidence and evaluation. We would also hope that the Public Health England representative on these panels will be there to ensure that candidates meet the appropriate professional standards, leaving the final choice of candidates to local panel members.

6. Statutory Health and Wellbeing Boards are an essential component of the proposed changes. Their role should be to develop the overall strategy for the local health and social care economy through the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategies. The Board will need to build relationships with local providers and local commissioners and will need to have excellent communication systems across the local health and social care economy and with patients and the wider public.

7. The Board with the Director of Public Health will need to produce a local action plan with clear priorities that outlines how the joint strategy is going to be delivered and how it will be monitored against agreed outcomes.

8. One way of ensuring that local providers sign up to the local Health and Wellbeing Strategy and the action plan would be for Health and Wellbeing Boards to establish an arms length local Provider Forum that would provide a vehicle to ensure that local providers are engaged in the cost effective re-design of a locally integrated and collaborative approach to service delivery that meets local strategic objectives and the needs of the local community. DsPH would then have a key role in providing data, information and evidence to bridge between the Health and Wellbeing Board and the Provider Forum. Membership of the Provider Forum should include the voluntary and community sector as well as statutory providers, private sector and not-for-profit social enterprises.

9. The role of HealthWatch on Boards is problematic. The Alliance believes there are three separate elements of public and patient involvement: wider engagement and participation of the public in how NHS money is spent and what NHS services cost; scrutiny and quality assessment of existing services; and advocacy for marginalised and disadvantaged groups. We are not convinced that all of these can be done by a single body and we are also not convinced that HealthWatch should be a core member of the health and wellbeing board. We believe that the core function of HealthWatch should be local overview and scrutiny and this is reinforced by the proposal that Health Watch should be led by a statutory committee within the Care Quality Commission. This will place Health Watch in the position of having to scrutinise itself for decisions made collectively by the Health and Wellbeing board.

10. The proposed arrangements for public health involvement in commissioning NHS services are very weak and there is no direct responsibility other than the statement that DsPH *will work in partnership with other local government colleagues, and partners such as GP consortia, the wider NHS, early years services, schools, business, voluntary organisations and the police, to achieve better public health outcomes for the whole of their local population.* The Alliance believes that DsPH should be represented on GP Consortia and that they should be using data to work with GP Consortia in order to develop transparent and accessible ways of demonstrating how NHS funds are spent, about how savings can be made and about how local communities can be supported in taking more responsibility for their own health.

11. An additional way of strengthening the link between public health and consortia would be for the Royal College of GPs to work with the Faculty of Public Health to produce a training programme for GPs with a specialist interest in public health. Over time it would then be possible to require that all GP consortia have a GP with a specialist interest in public health who works directly with the DPH.

12. A further concern about the proposed new arrangements and in particular the proposals for the public health outcomes framework is that; firstly there are a very large number of outcomes and; secondly DsPH and their local authorities will inevitably focus on health improvement outcomes and primary prevention. We are in favour of outcome measures but we believe that the local strategy will need to set priorities in response to local needs and we would also prefer a model in which there is a small number of required outcomes that are shared across the local health and social care economy. These outcomes should focus on older people, long term conditions and mental health. These are the issues that make the greatest demands on health and social

care and we believe that shared outcomes in these areas will encourage local partnership working between public health, adult social care and GP Consortia so that they learn how to work together effectively.

13. There should still be separate outcome measures for Public Health, Adult Social Care and the NHS but these should also be prioritised in response to local needs. During the set-up and development phase Health and Wellbeing Boards should be encouraged to focus on shared outcomes in order to encourage the development of effective partnership working.

14. The proposed arrangements for commissioning public health services follow a number of different strands with commissioning routes through Public Health England, local authorities and the national commissioning board and GP consortia. While the Alliance accepts that national screening and immunisation programmes will need to be commissioned at national level, we would prefer to see a more joined up approach to commissioning public health at local level. At the end of the day poor uptake of national programmes is usually do to local circumstances and can only be addressed at local level.

15. Similarly when Public Health England decides to fund national campaigns, the evidence suggests that these will have more impact if they are done in tandem with local campaigns which highlight where further local information and services which support the campaign can be accessed.

16. If public health commissioning is going to translate into effective local public health delivery there needs to be a much more systematic approach to public health delivery through the development of existing local assets that include all primary care providers and the local voluntary and community sector.

17. GPs, dentists, pharmacists, community nurses, health visitors, optometrists, and allied health professionals will need to ensure that every contact is a potential public health opportunity. In addition opportunities need to be created for primary care professionals to take on additional public health roles. These should include “healthy living pharmacies”, health checks, early intervention for alcohol problems, smoking cessation, falls prevention and opportunities for GPs to acquire expertise in public health as GPs with a specialist interest.

18. NICE Guidance on Behaviour Change recommends among other things that support should be provided to local organisations that promote participation in leisure and voluntary activities and that develop and maintain supportive social networks and nurturing relationships. There is increasing evidence that activities and supportive social networks are good for health, particularly the health of older people and for people with mental health problems. This is very much the role and remit of the voluntary and community sector. We need to move towards the social prescribing of activities that support and build sustainable social networks, particularly for isolated and vulnerable older people and for people with mental health problems.

19. Local health and social care economies need to find systematic ways of developing a range of quality assured social prescribing activities that include physical activity, healthy eating/cooking skills, befriending, welfare rights, arts and health and volunteering opportunities. This probably needs to be done through a single contract with a lead provider who has sub-contracts with a range of smaller local providers. We also need to find proportionate and robust ways of testing these models so that we can demonstrate that over time they save money rather than just add to costs. Part of this model will also need to include the development of local peer support through health trainers or health champions who are recruited from and work within local communities. A project funded by the NHS North East Innovation Fund and done in collaboration with the national Diabetes Year of Care Project, local GP Consortia and a voluntary sector provider, HealthWORKS Newcastle has recently produced a guide to commissioning such activities to support self-care for long term conditions www.diabetes.nhs.uk/year_of_care/commissioning/thanks_for_the_petunias__a_guide_to_developing_and_commissioning_nontraditional_providers/

20. Public Health Observatories should continue to have a role in the new NHS architecture. For each observatory, this should include one or more specialist areas together with a sub-national responsibility for providing information and comparative benchmarking data to support local commissioning. The North East Public Health Observatory currently has a national lead role in mental health and offender health as well as providing important regional information. The Alliance assumes that the National Commissioning Board will need to have sub-national outposts and it would make sense if the observatories and the Commissioning Board outposts were co-located.

21. The Alliance believes that a transparent outcomes based approach is the best way forward and we welcome the proposal to establish a range of national indicators under the five domains of: health protection and resilience; tackling the wider determinants of health; health improvement; prevention of ill health; and healthy life expectancy.

22. We do however have some concerns about the diagram on p14 of the *Transparency in Outcomes* document that shows only a very small central area of “shared local health and wellbeing issues for joint approaches” with much larger areas representing the individual responsibilities of Public Health, Adult Social Care and the NHS. We believe there should be a much greater focus on developing shared outcome measures for the local health and social care economy. Arguably the greatest threat to financially viable and sustainable public services is an ageing population and the projected increase in long term conditions. This needs to be a joint responsibility of all of the services and funding streams with pooled place-based budgets held by Health and Wellbeing Boards.

23. This will require work on the development of new outcome measures in order to track and benchmark progress. These measures should be framed around the themes of preparation for old age, active old age, vulnerable old age and dependent old age. What is being done about maintaining physical health and preventing the development of long term conditions in mid-life (local prevalence of Type 2 Diabetes), what is being done to promote active old age, including volunteering opportunities (number of volunteers over 65), how do we better identify and support vulnerable old age so that it does not become expensive dependency (criteria for and measurement of number of vulnerable older people) and how do we maintain and prevent progression of dependency (number of dependent older people living at home).

24. The added value of such an approach is that it will drive partnership working and prevent demarcation disputes between funding streams about who pays for what. A similar approach also needs to be taken to mental health with more shared outcome measures and pooled budgets for delivering mental health outcomes which is the other major area in which Public Health, Adult Social Care and the NHS need to work together.

25. Finally, in terms of the total number of indicators, we are not averse to a large national number of indicators which are collected centrally and which allow local areas to benchmark themselves against areas with similar demographic characteristics. We would however like the indicators to be seen as a menu from which local areas choose a limited number which have been identified as high priorities from their JSNA and their local health strategy. We believe that this will reflect the fact that different areas have different needs and that a focus on delivering a limited number is more likely to be successful. The only additional indicator that we would like to see is a measure of the willingness of the local system to pool separate budgets for joint activities. This is probably the most significant measure of effective partnership working.

26. Despite a ring-fenced budget, funding is still likely to be a problem. This can be addressed by setting clear local funding priorities and by ensuring that there is a public health contribution to reducing costs and demands for expensive NHS services.

27. The use of the health premium as an incentive to address inequalities is an over-simple approach to a complex problem and may have perverse consequences with areas being rewarded or penalised for getting better or worse as a result of changes in their population baseline or in local circumstances rather than as a result of anything the local area has or has not done.

28. There is a tension between public health as everyone's responsibility and public health as the responsibility of a professional workforce. We endorse the need for a well regulated professional workforce but at the same time we believe there is a need to both re-examine the core skills of this workforce and to look at ways of extending public health skills to other professional groups and to the wider community through peer support and community health champion models.

29. The current professional competencies place too much focus on collecting and analysing data and trying to produce evidence for action and not enough focus on engaging front line staff, communities and local people and in persuading them to take action and to change the way we live. If public health rhetoric is to be turned into delivery of cost-effective outcomes there needs to be more emphasis on the softer skills of facilitative leadership, effective partnership and persuasion and this should be recognised in the competencies framework.

30. In terms of wider dissemination of public health skills, the potential of GPs with a specialist interest in public health has already been mentioned in paragraph 11. We also believe there is an increasingly important and cost-effective role for community health trainers and for volunteer community health champions. These models depend on recruiting, training and supporting local people to take on the role of motivating and championing change within their communities. It is not clear from the current proposals how the training and support of such individuals is going to be funded or who will provide it. We believe this needs a systematic approach with Health and Wellbeing Boards working closely with their local voluntary and community sector who have the reach into and trust of marginalised groups that is not always the case with the statutory sector.

31. Addressing inequalities in an economic recession is not easy. Investing in providing opportunities for people to acquire training and skills as volunteers and peer support workers (see 30 above) is one small way of addressing this. We welcome the focus on improving healthy life expectancy, rather than life expectancy and we also welcome the notion of proportionate universalism. Nationally more poor people live in non-disadvantaged areas than in disadvantaged areas and we need to invest in improving the gradient for inequalities rather than just focusing on the most disadvantaged individuals or areas.

Written evidence from Dr Bruce Laurence (PH 12)

These are personal views and do not represent those of any organisation to which I am affiliated.

SUMMARY OF POINTS: DR BRUCE LAURENCE, FFPH ACTING DPH NHS DERBYSHIRE, WRITING IN PERSONAL CAPACITY.

1. Public health staff are being forced to undertake highly complex organisational change at a time when they should be focusing on core business. One way to minimise loss of time would be to ensure that the specialist public health workforce are employed in a single organisation and seconded to others as appropriate.
2. Public health training is threatened by this upheaval and needs protecting
3. The importance of second tier authorities has received little recognition in the policy documents so far.
4. The importance of the major role of PCTs in emergency planning and response and in major health protection programmes needs more consideration.
5. Public health funding is very complex and there are major risks for many important services as well as public health employees in trying to identify an appropriate budget. The health premium should not unduly skew organisational focus and a way of managing this is suggested.
6. The DPH needs to have sufficient power to act as a strong voice for the public's health.
7. The Health and Wellbeing board should have clear and defined powers in relation to commissioning.
8. Consortia need to be resourced and encouraged to take a public health informed view of commissioning and in particular to impact on health inequalities.

Some comments on the proposed changes to public health in England. These are my personal views and not that of any organisation to which I am affiliated.

1. IMPACT OF ORGANISATIONAL CHANGE

1.1 During these times of financial hardship the need for a strong public health voice within local communities to ensure that services to deprived communities are protected is more important than ever. It is therefore the worst possible time to undertake a wholesale reorganisation of the public health function within the health sector and doubly so because the health sector itself is under such pressure both from its financial constraints and from its own fundamental restructuring. While there are some exciting opportunities associated with the move of health improvement functions to local authorities, which are in many ways a natural home for many public health functions it is a dangerous time to uproot public health from the NHS and thrust it into an entirely new arena. This is exacerbated because LAs are under extreme pressure themselves and in many cases also restructuring in response to these pressures.

1.2 It is well recognised that it has taken PCTs and predecessor organisations up to two years to find their feet after previous relatively modest reorganisations. This is far more fundamental and disorientating than anything that has gone before and it seems likely that, at a time when we should be rigorously focused on delivery of health outcomes and improving efficiency, we will be massively distracted for at least two but more likely up to three years.

1.3 As an acting DPH I have major concerns as to how I will be able to successfully engineer the transfer of a large team into any or all of one upper tier LA, eight second tier authorities, five GP consortia and Public Health England. Some members of that team already in some cases have joint appointments between the NHS and upper or second tier authorities. Since the GP consortia and PHE are themselves only in the earliest stages of existence and since the terms and conditions of staff transfer and the overall budget are all unknown any planning that I can do is hedged round with uncertainty. All this has to be done in a PCT that has just become a cluster with another PCT and is spinning off most of its staff to GP consortia while losing others to voluntary redundancy. It should be noted that there are a very great number of contracts that will need to be reviewed and possibly unpicked and remade when we understand where responsibilities lie and what budgets are available and that this work will have to be done at a time when the commissioners and other support staff with whom we have previously worked are largely aligning themselves to emerging GP consortia or in some cases, looking to exit the service.

1.4 I labour the point to show what a complex piece of change management will have to be undertaken because of an unprecedented organisational change that will not only have uncertain benefits, not having ever been piloted, but that all political parties specifically agreed would not happen in their election manifestos. As faithful public servants, I and my colleagues will endeavour to work within the policies laid down for us, but it is difficult to find anyone locally who thinks that the benefits are likely to outweigh the costs of this upheaval.

1.5 The county council is, however, very positive about the transfer, and the GP consortia also interested in ensuring a public health input to planning and this is the bright spot in an otherwise difficult picture.

1.6 Fragmentation of the public health workforce will weaken its ability to work in any of its specialist areas. One solution to this would be to keep all elements of the specialist workforce within a special health authority or executive agency. This would also get around the considerable problems associated with transferring NHS staff to LAs. This transfer is problematic for LAs who are themselves losing staff through redundancy and public health staff themselves are hugely fearful of what this might mean for their own conditions of employment and pensions. People are already so concerned that they are looking for and taking other jobs outside of the sector.

1.7 Part of what makes the ph workforce successful is the synergy between different parts of the agenda and this is also weakened when people work more narrowly in multiple organisations with their own particular interests. Through public health profession having its strong root and substantial critical mass in the NHS it has been able to work effectively in partnership with a wide range of other organisations. A fragmented workforce will be far less effective while a unified one may have a chance of maintaining essential functions into the future. This would still leave an exceptionally challenging task but would make it rather easier in the short term and bring benefits in the long term.

2. PUBLIC HEALTH TRAINING

2.1 There will potentially be severe consequences for public health training. The NHS has long understood and accepted its heavy responsibility for training all types of health staff, but consortia and local authorities will not necessarily see it as their responsibility to ensure the workforce of the future and trainers forced down narrower career pathways will struggle to provide a wide and balanced training experience for trainees. It may be argued that these agencies will appreciate the need to keep a flow of well trained professionals coming through the ranks, but in practice this long term aim will not feature highly on their long lists of pressing and urgent priorities. There needs to be clear guidance in order to protect this function and ideally strong deaneries should be maintained that can champion this at regional and local levels.

3. TWO TIER AUTHORITIES

3.1 The second tier authorities are highly involved in public health work and there is very little in the policy documents that suggests that there is much understanding of this point. It is important not only that the ph budget is ringfenced but also that the DPH has sufficient power over its use that it can be channelled to whichever organisation is best able to use it whether that is upper or lower tier LA, NHS, voluntary agency etc. Clearly it is up to DsPH and colleagues to learn to swim more skilfully in the local political environment but there are special challenges for those working in two tier authorities.

4. EMERGENCY RESILIENCE AND RESPONSE AND HEALTH PROTECTION AT LOCAL LEVEL

4.1 One area of personal interest is emergency planning. I have seen the importance of the PCT coordinating the local health service response to an emergency such as the flu pandemic and promoting the planning and exercising that ensures that such a response is fast and effective. I am fearful that there is nothing in current policy that gives any assurance that this essential local work will continue.

4.2 I have also observed how much work there is undertaken by ph staff in PCTs that ensures the quality of core health protection programmes such as immunisations and screening. There seems to be a belief that this can be managed entirely by a national commissioning body and those who deliver the service on the front line in practices or hospitals. PCT staff are those who ensure high levels of vaccination and screening uptake, look at uptake across different groups and performance by practice, ensure that changes in screening programmes are implemented locally, and respond to untoward incidents. All this requires a lot of hard work by people with a sufficiently local focus to know the players on the ground and the characteristics of local systems. Where exactly this local work is hosted should be left up to local discretion. Also on the subject of health protection, it is important that it is seen in an integrated way across a health community. I would suggest that each locality should have a local health protection board chaired by the DPH that brings together major local health protection stakeholders such as PHE, consortia and major providers of relevant services.

5. HEALTH PREMIUM AND PUBLIC HEALTH FUNDING

5.1 Health premium. This should not be so large that it devastates local services where there has been poor performance. It must also not skew local activities too much towards indicator activities. I suggest that it is based on quite a wide range of outcomes so that a particular problem with one outcome or other does not affect the premium too much. I also suggest that the actual indicators to be used are kept secret till the end of the year and till the data is in so that people don't chase the indicators but are obliged to work across the whole spread of priority areas. I realise that this is rather a radical idea but time and again I see massive effort put into things that are more important because of their target value than their health value.

5.2 There is another problem around funding which is that ph work in PCTs and the NHS has developed over decades based on a very mixed funding model and with money for particular projects and sub-projects being put together and supplemented from a variety of recurrent and non recurrent pots coming down both via the NHS and other organisations and partnerships. Furthermore ph work is done in a vast array of providers in the NHS (primary and secondary care and mental health services), LAs at both tiers, voluntary sector

organisations, community groups, and other statutory agencies. The current exercise in identifying “public health expenditure” and the huge variance seen across different local authorities shows not only that this is almost unfathomably complex but also that there are—probably- great variances in what is actually spent between different areas. There are also major differences in the size of public health workforces in different areas. Therefore significant problems will be faced in practice whether funding is based on current expenditure or on some capitation based formula.

6. ROLE OF THE DPH

6.1 The role of the DPH is important. I don't really believe that a DPH will ever be totally independent of political or institutional interests, or if he/she was it would mean that they were so detached from the major stakeholder organisations as to be rather sidelined. However a degree of independence needs to be maintained and this may best be done by making PHE their primary employer with a joint appointment process with the LA and also giving them some level of authority with GP consortia eg having them as a statutory board member. To some extent the independence of the DPH to challenge local decision making on behalf of the community is a matter of culture and the way in which central authorities express the role of the DPH and support or undermine DsPH when they do challenge vested interests. Within the LA they need to sign off on the use of the ph budget and also, very crucially they need to sign off on the commissioning plans of GP consortia on behalf of the Health and Well-being board. There should also be some guidance from the centre that supported the need for the DPH having a sufficient rank within the LA that gave them the influence that they will require to establish PH priorities alongside all the other LA priorities. Otherwise there is a danger that PH priorities will be put second to much longer established ones.

7. THE HEALTH AND WELLBEING BOARD AND PROTECTING HEALTH SERVICE RIGHTS FOR VULNERABLE PEOPLE AND GROUPS

7.1 The H&WB needs to have some clear and defined authority regarding GP consortium plans. This means in particular some power to ensure that consortia take responsibility for a defined geography and that no vulnerable communities or individuals can be left without access to primary and secondary healthcare. It must be enshrined in guidance that if a practice chooses to remove someone from its list or not to register someone who requests it, the responsibility of ensuring that that individual receives a full range of health services lies with the consortium covering that geographical area. Where geography is not clear there must be a process by which this allocation can occur without vulnerable people being bounced around from practice to practice.

8. PUBLIC HEALTH ADVICE TO GP CONSORTIA

8.1 Consortia will have essential roles in ensuring equitable access to a full range of services, for maintaining primary care's role in health promotion and health protection and for reducing local health inequalities. They will also need to make the most efficient use of their resources. The best consortia will see that they have an important role in supporting local communities in improving their own health and wellbeing. As consortia will inevitably struggle to establish their basic governance structures and then take on the mighty task of commissioning the basic health services these other functions could easily be neglected. The best way of ensuring that consortia plans were well developed from a public health perspective would be to encourage consortia to obtain ph advice in the planning stage. This could be done through them employing their own ph capacity or through them accessing expertise from a central ph employing body on a secondment or contractual basis. The role of public health expertise in commissioning at a local level has been much neglected in policy guidance to date. This is a serious oversight particularly at a time when with the commissioning function in the throes of radical change there is a great risk of costs running out of control in the time between the PCTs falling away and the consortia really getting up and running. A good understanding of the evidence base for treatments and the cost effectiveness of different approaches is more important than ever.

8.2 The NHS is an essential service in managing and reducing health inequalities and particularly the primary care services and this is recognised in the proposed new duty on the Secretary of state to have some duty in this regard. The Health and well-being board needs to be able to demand of consortia that they are managing health inequalities in tangible, evidence based and effective ways. Once again having public health expertise available to consortia may be the most direct way of ensuring this planning but the duty needs to be emphasized in the guidance to consortia.

9. These are some of the issues that I have with emerging public health policy. There are positive elements to creating a strong public health England and to working more closely with local authorities, but there are also numerous concerns and an uncertain and demoralised workforce is being asked to take on an ever more complex and demanding task of change management that could be a major distraction from its primary roles of protecting and improving population health, informing effective commissioning of health services and reducing health inequalities in England.

Written evidence from Dr Alison Talbot-Smith (PH 13)

SUMMARY OF SUBMISSION

- Public Health aims to improve and protect the health of populations and to improve health services. Addressing health inequalities is also an important part of what Public Health does. Public Health effectively “treats” populations rather than individuals.
- Public Health therefore encompasses three domains—health improvement, health protection and health services Public Health.
- By separating these domains, and the organisations within which these functions will be carried out, the proposals fail to recognise:
 - the interdependencies between the three domains;
 - the difficulties fragmentation will create for the maintaining an effective, highly trained profession; and
 - the difficulties fragmentation will create for the training, recruitment and retention of Public Health specialists in the future.
- There is a serious risk that this fragmentation will rapidly lead to the demise of Public Health as a profession with obvious risks for the nation’s health.
- All commissioning organisations should have a specialist in Public Health as a full member of their board, and should be required to consult and take account of specialist Public Health advice so that best clinical practice is enshrined within commissioning.
- Public Health England should be responsible for all three domains of Public Health, and should be required to provide Health Service Public Health input into NHS commissioning organisations.
- Public Health England should be an independent NHS body in order to maintain the independence and credibility of the Public Health function, and the ability to work with ALL of its partner organisations—Local Authorities, NHS commissioning and provider organisations, and third sector organisations.

The Creation of Public Health England Within the Department of Health

1. Creating Public Health England within the Department of Health (DH) does not recognise the complexities of the Public Health agenda, which operates across organisational and structural boundaries.

2. The DH is a central policy and regulatory function. In contrast Public Health England will need to undertake effective programme delivery with a strong “locally based” component, that includes local strategic planning and commissioning of services, as well as local intelligence functions—none of which fit within the remit of the DH.

3. Public Health England will—or should—have a duty and responsibility to local populations, widely recognised as being discharged through the independent advocacy role of the Director of Public Health (DPH). It is important that this local independent advocacy is not constrained in any way by political processes nor by central DH policy. The current position of DsPH in Local Authorities and part of a central DH body provides two political and centralising constraints that pose a serious risk to this advocacy function.

4. It should also be noted that as it stands the creation of Public Health England is about a centralised Public Health function—this is true of Health Improvement, Health Protection and Health Intelligence. There is no mention of the vital component that Public Health England will need in order to deliver—ie a viable and effective Public Health workforce at local level. This should not be about DsPH being part of Public Health England, but about Public Health teams being part of Public Health England.

The Public Health Role of the Secretary of State

5. It has been widely recognised that the NHS should be a “health” service and not just a “sickness” service. To achieve this the Secretary of State for Health should have a primary duty in respect of the Public Health function.

6. To be effective this duty must recognise that the Public Health function is more than a sum of its parts— to be truly effective it must recognise that its three domains are interlinked through complex interactions, and need to be provided in their entirety. This means that the three domains of Health Protection, Health Improvement AND Health Services Public Health (with all three underpinned by the common theme of Health Intelligence) should all be the responsibility if the Secretary of State for Health—it is not possible to fragment the three domains and achieve a fully functioning Public Health function for any of the three.

The Future Role of Local Government in Public Health

7. The driver for placing Public Health in Local Authorities remains unclear to many of us working in Public Health, particularly as DsPH have been working across the NHS and Local Government for a number of years—most DPH appointments are now joint appointments between Local Authorities and PCTs, and in a

number of areas (eg Herefordshire), PCTs and the Local Authority have “deep partnership” arrangements with integrated commissioning of health and social care.

8. Like my colleagues I am fully cognisant of the important role to be played by Local Authorities in the Public Health Agenda, and welcome the emphasis placed upon their responsibility for improving health and well being of their local populations. However “carving up” Public Health and placing the Health Improvement element within Local Authorities is a naïve approach to achieving this, which poses serious risks for the effectiveness of the Public Health function and for the future of the specialty:

- Public Health staff are likely to become professionally isolated;
- The ability for Public Health to act as an independent and credible advocate for health will be diminished;
- Staff may be subject to local political and/or organisational pressures which inhibit their ability to act to improve or protect the health of the local population;
- Many DPHs are signalling that they will not be a board level position within Local Authorities, limiting their ability to influence strategic direction of the organisation—and yet this was one of the main reasons for placing Public Health in these organisations.
- Local Authority issues could be “rebranded” as Public Health in order to access the ring fenced budget and preventing its spend on non local authority Public Health issues.
- A real concern is the lack of ability to develop and train the Public Health workforce, in a specialty that is renowned for “growing its own.” As part of this there will be a complete lack of career structure for Doctors in Public Health—the reality of the Health and Social Care Bill is that many of us are considering returning to clinical practice.
- Removing Public Health from the NHS—with the Department of Health impact assessment of the Public Health white paper recognising that this will reduce the cost-effectiveness of NHS commissioning. In effect placing Public Health into a “silo”.
- Reducing the ability of Public Health to embed Public Health initiatives into mainstream NHS commissioning, limiting the effectiveness of the Public Health agenda to change the NHS from a sickness service into a health service.

9. I recognise and applaud the arrangements to try and “join up the system” through the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. However I would point out that these are all strategic bodies and functions, and there are no mechanisms in the new structures to enable such joined up working at operational level. There is a lot of discussion about “local solutions”, but in cash strapped systems there will be little or no resources for such solutions.

10. The role of Local Authorities in Public Health could be more effectively achieved by partnership working with a co-ordinated Public Health organisation (Public Health England) that recognises and provides all three domains of Public Health. As an NHS body such an organisation would have the ability to attract and retain high calibre staff. Such a body would also be able to work effectively across the wide range of organisational boundaries that need to be addressed to achieve an effective Public Health function—this includes Local Authorities but also includes third sector organisations, NHS commissioners, NHS providers, and a host of non-health organisations.

Arrangements for Public Health Involvement in the Commissioning of NHS Services

11. It should be noted that commissioning is fundamentally about providing quality services for populations (ie balancing the needs of one patient against another), and that Public Health specialists are trained in population health.

12. The DH impact assessment of the Public Health white paper recognises that removing DsPH from the NHS will reduce the cost-effectiveness of NHS commissioning. This will be partly due to reduced ability to embed health improvement into NHS commissioning pathways, but primarily as it takes out the massive body of work currently undertaken by Public Health to ensure commissioning is based upon evidence of clinical and cost-effectiveness.

13. There are no arrangements within the Public Health white paper for Public Health involvement in the Commissioning of NHS Services. There is a DH vision that GP consortia will “commission” this input from academic institutions and commercial organisations, with a belief that Public Health currently obtain a “large amount” of epidemiological data from academic departments.

14. At PCT level we get probably 5% of our data from academic departments, perhaps 40% if you add in central surveillance intelligence and PHO data functions. But this data can be out-dated and is often not applicable locally. **The fundamental point is that this is not the Public Health input to commissioning that is responsible for making it more clinically effective and crucially more cost-effective.**

15. The component of Public Health input that makes the difference to commissioning is not the data but the application of the data. It is not about commissioning single, time limited pieces of work that become outdated incredibly quickly in an era of modern health technology. It is about the work of the local Public

Health specialist—who has been trained in a 5 year training programme in a host of technical skills so that they can produce but also crucially interpret and apply locally the evidence base.

16. The input of such Public Health specialists to NHS commissioning is wide and varied and is based upon long term relationships and engagement—to develop clinical consensus, systems and policies over months and sometimes years. This can range from the production of “Low Priority Treatment Policies” which include national items but also address local practice, through to providing the evidence base on the most cost-effective services and interventions when re-designing care pathways, including interpretation of local patient flows and data analysis. It can include data and analysis to identify priority areas for reducing inefficiencies, development of robust and ethical frameworks for prioritisation, investment decisions and dis-investment, and work to ensure “marginalised” groups such as the homeless and vulnerable are not forgotten—these are just some examples of the range of work undertaken by specialists in Health Service Public Health.

17. Public Health works through sustained and dynamic partnership working with GPs/primary care and with hospital specialists—to provide and interpret the “evidence” and work with clinicians to implement it in the local context—it is this local interpretation and local implementation in partnership with clinicians that makes the difference.

18. Can the work of Public Health specialists be replaced by GPs supported by academic or commercial organisations? A key question is where the capacity for this support is going to come from—the academic units are already stretched, and most of the commercial organisations do not have clinicians/Public Health consultants working for them—they lack credibility amongst clinicians and in many instances their work fails to address complex clinical complexities and local issues. Such support is also expensive—especially when it needs to be iterative because of advances in technology.

19. A more fundamental point is that GPs will get a “static” piece of work—eg a literature review or a suggested service model—when what they need is an iterative and longer term piece of work that responds to changes in the international evidence base and also responds to local change—such as the provider “creep” we see so often as providers change practice to maintain income streams.

20. Crucially, it also requires a technical understanding of the evidence base to be able to discuss such issues with secondary care colleagues on a level playing field. The ability of GPs to engage with secondary care specialists to implement evidence based and cost-effective service change is consistently dependent upon an ongoing partnership between a local Public Health consultant and GPs. This is what currently occurs throughout the NHS—if this is not provided to all GP consortia then I am concerned that they are being “set up to fail”.

21. I recognise the value of “local solutions” in providing Public Health input—but in a cash strapped system failing to specify that Public Health input to NHS commissioning “must” be provided is tantamount to abolishing it. This in effect will deny consortia access to robust, sustainable and good quality Public Health input.

22. Will consortia be able to get Public Health input from their local Public Health department? Under the new structure DsPH/LAs will not be “required” to provide this—this is bizarre since its a core component of Public Health and it is currently provided to NHS commissioning. I recognise there will be far more commissioning organisations, but many will be undertaking risk pooling and joint commissioning arrangements for particular topics. The number of consortia is not a barrier to PHE providing this input—a PH consultant working across a number of consortia on common themes represents a major efficiency and cost-saving for the new system.

23. Perhaps more fundamentally, why should consortia have to pay for Public Health input? The UK taxpayer has spent large amounts of money training high quality Public Health Consultants/specialists—this should be provided by Public Health England to consortia and other commissioning organisations.

24. What is needed to achieve ongoing support of NHS commissioning is a requirement for Public Health representation on consortia boards—to influence strategic direction—and statutory provision (free) to consortia of the operational “day to day” work of Public Health consultants and their teams.

Arrangements for Commissioning Public Health Services

25. Public Health budgets must be clearly-defined, ring-fenced and sufficient to achieve required population health outcomes.

26. The commissioning arrangements as suggested have become complex and almost unintelligible. The Public Health budget will be fragmented and divided through a host of commissioning and funding streams, making it difficult to re-allocate resources in response to changing priorities or population needs.

The Future of the Public Health Workforce

27. The fragmentation created by the current proposals would make training of future Public Health and dental Public Health specialists extremely difficult. It will have a negative impact on the future recruitment and retention of high calibre Public Health specialists.

28. The training of future Public Health specialists must encompass all three domains to Public Health in order to produce a high quality, effective specialist Public Health workforce.

29. Bringing Public Health staff from all three domains together into Public Health England would ensure an appropriate coordinated system is in place for training future Public Health specialists and practitioners, and for ensuring the ongoing professional development of existing Public Health professionals.

30. National and regional coordination and oversight of Public Health training and workforce planning should be maintained in order to protect the standards and credibility of the profession.

June 2011

Written evidence from Mr Matthew Ashton (PH 14)

The following provides an overview of issues for consideration as part of the inquiry into public health. These issues are highlighted along with potential solutions in order to suggest ways that current proposals can be improved.

SUMMARY

- All public health staff should be employed by Public Health England, with access to appropriate training, development and leadership, and then deployed to where relevant issues are best addressed, for example within a local authority setting.
- Medical and Non medical consultants in public health should be employed on the same contract with the same terms and conditions, with no distinction made between medical and non medical status.
- The JSNA should be a requirement for all parties, rather than just “joint” in name, with an expectation that public health will deliver it by itself.
- Public Health Intelligence, knowledge, and expertise should be developed at a local level, as well as at a regional and national level. Intelligence can only truly be developed and applied at a local level.

1. PUBLIC HEALTH WORKFORCE

Wherever their working location (public health specialists have roles in universities and trusts and may in future work in other areas in addition to local authorities and consortia) the public health workforce should have access to appropriate training, development and leadership. There is also a danger that DsPH could become an isolated specialist function in local authorities if they are not able to retain and call upon designated public health trained staff. Without this, it would be difficult maintain an overview of population health needs, outcome performance, intelligence and evidence to inform the role of public health advisor to a wide range of partners.

The separation of roles between PHE (national leadership and population based issues) and local authorities (local needs and solutions) could be managed effectively by employing all public health staff in PHE and then deploying them to where relevant issues are best addressed. As an example, many issues that need to be addressed in local authority areas will be common across bigger footprints and may be better addressed in collaboration through pooled resources and influence. This would also facilitate sharing resources when surge capacity is required. Maintaining the centralised coordination of the specialist training programme within this structure would also be beneficial to enable experience to be gained through placements across all public health delivery agencies, managed by the existing Deanery network.

Consideration should also be given to equalising the contracts for medical and non medical public health consultants. At the moment, non medical consultants in public health are paid less and on a different contract of employment, even though as far as public health qualifications are concerned they are the same.

2. UNDERSTANDING NEEDS

Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment process has been a joint responsibility of Local Authorities and Primary Care Trusts. Much of the input to JSNA will have been public health expertise and capacity. The Strategic Needs Assessment process should not be “Joint” in name, but through the requirement on all parties to engage. The current proposal to share responsibility for ensuring the process is undertaken between GP Commissioners and Local Authorities with a lead role for the DPH needs to be underwritten with a requirement for any health and social care funded body to contribute information and expertise, and for Local Authorities to be able to contribute the same in relation to economic, social and environmental determinants of health.

Public Health Intelligence

Public health intelligence is the driver for evidence based commissioning for population health and is required at a local, regional, and national level. Public health provides strong tools for assessment, such as asset based approaches, impact assessment and participatory research. Public health also takes a population view of consultation, engagement and involvement, recognising that health, care and wellbeing are whole population issues, rather than just the population accessing services. Sufficient resource and capacity needs to be retained both at local levels and in PHE to ensure this collation, analysis and interpretation of data can continue to be available. It is essential that the reforms do not block existing access to data from its widest sources that are key to the development of local intelligence that informs commissioning. Robust transfer of data between health and local authorities needs to be established.

June 2011

Written evidence from the Centre for Public Scrutiny (PH 15)

INTRODUCTION

This submission is informed by our responses to consultation documents issued in 2010: *Healthy Lives, Healthy People: Our strategy for Public Health in England*; *Funding and commissioning routes for public health*; and *Transparency in Outcomes*. The submission draws on our experience of supporting scrutiny programmes, our work with local councils and their partners and findings from our *Health Inequalities Scrutiny Programme*, which has helped councils and their partners to understand public health issues and respond to some of the health inequalities that exist in their communities.

SUMMARY

- Handing councils responsibility for public health sits well with their community leadership role. But principles of transparency, inclusiveness and accountability need to be embedded so that solutions to problems are “co-produced” between councils and citizens.
- We welcome health and well-being boards—they could be crucial to the success of the health reforms if they can generate a commitment to real partnership working. We think they should become the health and social care commissioning boards for their areas.
- The Health and Social Care Bill should be amended so that current health scrutiny powers are not diluted, especially in relation to greater executive influence and restriction of referrals of service changes. Health scrutiny is a cornerstone of constructive accountability arrangements across healthcare, social care and health improvement.
- We support the approach to improving the health of the population set out in the white paper. Empowering individuals to make healthy choices and giving local communities the tools to meet their own health needs have been themes of our national public health programme that we have been running for the last two years.
- District Councils have a vital role to play in public health, given their role in housing, planning, regulation, environmental health and leisure. Not enough detail has been set out about the role of district councils in tackling inequalities.
- Reducing inequalities is complex but not impossible. We have demonstrated through our programmes the value of scrutiny, which can be a powerful tool in the development of joint strategic needs assessments, health and well-being strategies and commissioning plans.

ABOUT CfPS

CfPS is an independent charity which promotes transparent, inclusive and accountable public services by influencing policy and providing a range of practical support. The Centre is widely regarded as the leading national voice for public scrutiny and accountability. We work across government (for example with the Department of Health, Communities and Local Government, Home Office, Department of Work and Pensions), with the Local Government Group and with stakeholders across primary and acute care.

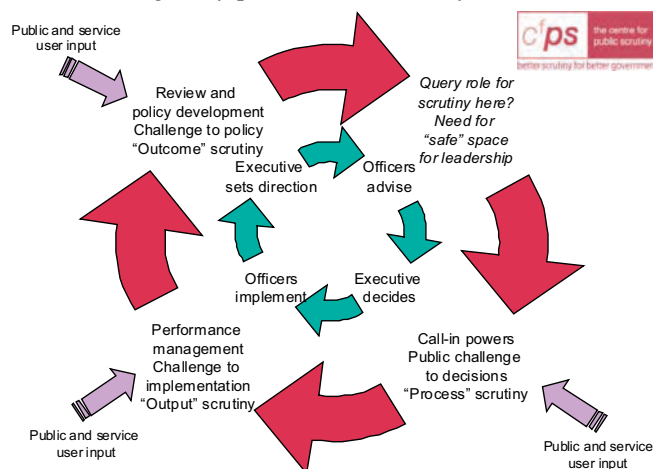
WHY SCRUTINY AND ACCOUNTABILITY ARE IMPORTANT

Good scrutiny and accountability involves different people in different ways—citizens, patients and service users, elected representatives, inspectors and regulators. Four mutually reinforcing principles need to be embedded at every level:

- constructive “critical friend” challenge;
- amplifying the voices and concerns of the public;
- led by independent people who take responsibility for their role; and
- driving improvement in public services.

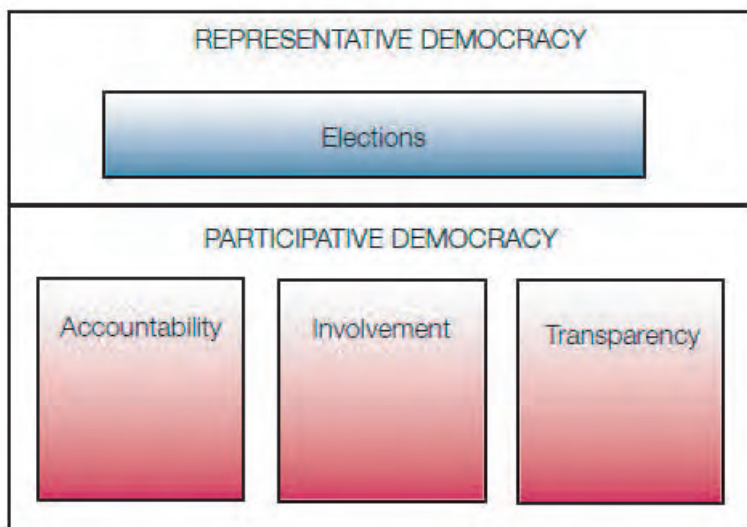
What do we mean by “overview and scrutiny” and “holding to account”?

The language of “overview and scrutiny” can give a misleading impression of what the function can achieve. For example, “holding to account” is not always about reacting to decisions that have been made, it is much more than this—it is about influencing every part of the business cycle, as illustrated in the diagram below:



We have a wealth of evidence that scrutiny works, right across the public sector (for example our Good Scrutiny award winners for 2010 and shortlisted entries for 2011). This indicates that “non-executives” are able to work in creative and imaginative ways, providing value for local people.

This submission builds on our policy papers “The Anatomy of Accountability” and “Accountability Works!” These argue for a joined up approach that links “non-executives” together at local level and encourages the development of “co-production” ie professionals, the public and their representatives finding solutions to problems together. The need to improve outcomes at a time of economic challenge makes this an imperative.



LOCAL COUNCILS AND PUBLIC HEALTH

The Centre supports the proposals to transfer public health responsibilities to local councils. Local councils have the wider remit needed to tackle inequalities and improve health through non health services.

The vision that Healthy Lives, Healthy People sets out for the role of the Director of Public Health in local government includes identifying health inequalities and developing and implementing local strategies to reduce them. This is an extraordinarily complex and difficult assignment the success of which will require ownership and active engagement by the whole of local government, and most importantly of councillors.

All councillors will have a concern to see health inequalities being effectively tackled by the Director of Public Health but health scrutiny councillors will have a particular opportunity to help ensure health inequalities remain (or become) a central concern rather than a marginal interest of the council. In achieving this, health scrutiny can make a unique contribution to helping shape how local authorities and the Directors of Public Health in particular develops and implements the strategies for tackling health inequalities.

The local vision for health and well-being boards will be crucial. Restricting the local agenda for Boards to healthcare and social care will not enable councils, Boards or DsPH to tackle the “Marmot” challenge effectively—they must treat public health equally alongside health and care services. The co-ordination role of Boards provides an opportunity to connect needs assessments to practical health and well-being strategies and commissioning plans that are driven by needs and aspirations of citizens. It will be important for Boards to take a proactive view to membership—for example, it will be important to include leaders in education and business on Boards.

Three principles need to be embedded into the operation of health and wellbeing boards and to the wider reforms so that they can successfully deliver improvement— **transparency, inclusiveness and accountability**. Arrangements for Healthwatch and extended scrutiny powers for councillors will help promote “intelligent involvement” at each stage of the commissioning cycle, combining the benefits of participatory and representative democracy and balancing professional judgement and public opinion. Accountability for quality and outcomes needs to be matched by accountability for “responsiveness”—the extent to which Boards listen, understand and change.

DISTRICT COUNCILS

Many of the wider determinants of health are influenced by District councils, as they have statutory functions such as housing, leisure, planning, regulation and environmental health. District Councils are also closest to their communities.

It will be important for each local area to determine how they engage with the different tiers of government, some top tier areas already do this well, however for others it may need to be encouraged. It is also important to recognise all tiers of government (parish and town councils and community and neighbourhood fora) and the unique perspective that they can bring to public health.

DATA AND INTELLIGENCE

A large amount of data and information already exists about public health, healthcare and health services—however much of this data and information is either not used or not used properly. The growth in detailed performance management arrangements led to a generation of data and information being collected to satisfy those regimes alone, with the focus on process rather than outcomes. We welcome the shift to measuring outcomes but the wealth of data that exists already should not be lost. Without proper arrangements in place to gather and make sensible use of data and information there is a risk that patients and the public will not have access to useful information to inform choice or to hold commissioners and providers to account.

Public Health Observatories have played a key role in holding and interpreting data about the state of public health, health inequalities and outcomes for patients. This kind of information will be vital if health inequalities are to be tackled.

One of the most effective of ways making data available in an accessible form is by having a sufficiently developed Joint Strategic Needs Assessment (JSNA)—that has a broad remit and takes account of the wider health determinants. It needs to be a holistic assessment of the well-being of the population together with their health and care needs and be developed and informed by relevant local partners and citizens themselves. If it is to inform a sustainable health and well-being strategy that can drive commissioning plans, a JSNA needs to be “co-produced” between professionals and citizens. Such an approach will help to tackle the “Nicholson challenge” and the “Marmot challenge” together.

The JSNA not only needs to present an analysis and interpretation of local data, it also needs to tell the story of the community itself. This has been a particular strength of our Scrutiny Development Areas. Most of the Scrutiny Development Areas developed creative and innovative ways to understand communities and the issues affecting their health.—using scrutiny as a magnifying glass—getting to understand issues holistically.

An overarching principle should be that information is transparent, presented in ways that local people can use to make judgements about how health and wellbeing boards, commissioners and providers are working to improve health and wellbeing generally and the safety, quality, value and responsiveness of services. The key is to provide information in ways that people can find it, understand it and use it. This is especially important in the drive to help people set higher aspirations for their health and well-being and providing opportunities for them to fulfil these through enhanced life chances.

SCRUTINY—AN EFFECTIVE PUBLIC HEALTH TOOL

The current “health scrutiny” powers represent the strongest model of democratic accountability in public services. They enable councillors to engage with commissioners, providers and patients and the public across primary, acute and tertiary care at every point in the commissioning cycle in creative and innovative ways. Councillors have shown that they can operate very successfully locally and across boundaries (particularly when tackling service reconfiguration and health inequalities).

Scrutiny can make a uniquely valuable contribution to a council’s strategic approach to health inequalities. In many places, health scrutiny councillors and Directors of Public Health work well together on a range of

specific health inequalities issues and in future this should come to represent practice everywhere. The respective perspectives that the public health professionals and councillors bring to health inequalities are complementary and each can learn from the other.

Public health often focuses on “deficits”—problems, needs and deficiencies—that characterise communities experiencing health inequalities. But local councillors are aware of the social capital, community resources and resilience that frequently characterises challenged communities. So a scrutiny inquiry can highlight community assets around which communities can build their future.

Because health inequalities are complex, deep-rooted and not quickly solved, it can be difficult to persuade decision makers to invest resources to tackle them. Scrutiny inquiries can be an effective way to focus wider attention on issues and strengthen the evidence-base for investment.

LEARNING FROM THE CfPS NATIONAL PUBLIC HEALTH PROGRAMME—SUMMARY

This programme is defining the added value of scrutiny reviews in tackling Health Inequalities.

Over the last two years, 47 local councils in total have been using the scrutiny process to understand and respond to local health inequalities. Each of the areas has sought ways to develop innovative solutions to deep seated inequalities.

The causes and effects of health inequalities are complex. And tackling them is not easy. One of the last places you might look to find solutions is in a local overview and scrutiny committee. However these committees probably contain some of the most qualified people to help public services understand the issues that their communities face—locally elected councillors. The Centre recognised this “expert” role and set out to demonstrate the active and vital role that “scrutiny” can have in helping its partners understand issues so that gaps in inequalities can be narrowed.

What was different about this programme is that it is not focused on satisfaction with operational services, but focused on unpicking the “causes of the causes” of health issues. Each of the SDAs worked with different partners to focus on a different local challenge, including mental health, geographical health inequalities and the effect that poor housing has on health.

FUNDING AND COMMISSIONING

Under current plans, Health and Wellbeing boards will be responsible for the production of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy. They will also have a crucial role in determining commissioning plans—we think this can be strengthened to increase democratic legitimacy and local accountability. To exercise this function effectively, funding will be required. However the public health budget will be allocated to the local council and not the health and wellbeing board. Therefore the relationship between health and well-being boards and the NHS Commissioning Board will be crucial, along with robust local accountability arrangements to ensure that Boards have the resources needed to make a difference and that they are subject to scrutiny about the investment they are making and the outcomes they are achieving. This will need to extend across the healthcare, social care and health improvement aspects of the work of Boards. Council Leaders will also need to be accountable for their approach to improving inequalities in their areas.

Commissioning works best where patients are involved in their own care, local communities are able to influence service design and delivery, and governance arrangements are established in ways that demonstrate they are open and accountable. Our ideas about this are set out in more detail in our paper with the NHS Alliance “Towards transparent, inclusive and accountable GP Commissioning”.

New arrangements for commissioning through the NHS Commissioning Board and GP consortia need to have health improvement at their heart alongside service improvement. Only in this way can the “Nicholson challenge” and the “Marmot challenge” be tackled together.

The Health and Social Care Bill needs to be strengthened to provide a “backstop” against which to judge **transparency, inclusiveness** and **accountability** in the new system can be judged, but what would make the system work is good relationships between GPs, councillors and communities at practice, neighbourhood and area level. Relationships between Consortia, Health and Well-being Boards and the NHS Commissioning Board would need to emphasise and facilitate local decision-making, in line with the Coalition’s principle of localism.

Our framework for public service accountability, “Accountability Works for You,” will enable commissioners and providers to demonstrate their commitment to transparency, inclusiveness and accountability in every aspect of the commissioning cycle.

CfPS’ March 2010 guide about Practice based Commissioning would be a useful learning tool for the future. It highlights areas where Commissioners could be held to account during transition and in the longer term:

- understanding needs and aspirations of communities;
- their capacity to change the status quo;
- supporting long term conditions; and
- improving health and well-being.

TRANSPARENCY, ACCOUNTABILITY AND INVOLVEMENT

Transparency and accountability need to be threaded through arrangements for funding and commissioning. The documents highlight the accountability arrangements for Public Health England and local authorities; however these need to be strengthened so that the arrangements emphasise and facilitate local decision-making. The performance management arrangements for DsPH between councils and Public Health England need to be clearer and DsPH should be appointed as members of the council senior management team.

TRANSPARENCY IN OUTCOMES

A large amount of data and information already exists about public health, healthcare and health services—however much of this data and information is either not used or not used properly. Providing information to help people understand public health gives them a powerful tool to take part in discussions and debates about how services work and how they are responding to people's needs. It is about giving people information about services, performance and outcomes but also about how they can influence change.

Giving people information could lead to greater involvement but there needs to be a balance between giving information directly and pointing people to sources of information that they can analyse themselves.

Making data available without commentary or context setting would also provide challenges. In order to be fully transparent, data needs to be meaningful. Considering ways of visualising data for local people would be one way of helping with this challenge.

Greater transparency about the way councils, health and wellbeing boards, commissioners and providers work together, how services are performing and how services can be improved is likely to lead to greater involvement from patients and the public

RELATIONSHIP WITH OTHER OUTCOME FRAMEWORKS

The existence of three overlapping outcome frameworks for the NHS, Public Health and Adult Social Care does not seem to simplify the system—and could be a burden on local councils and their partners. Whilst the three frameworks are overlapping and complementary, CfPS supports the development of a single framework that ensures all partners are working together on the same priorities.

With any framework it will be important to recognise the different aspects of local government in an area. It is not enough to simply say that district councils will be able to play their role. The framework needs to facilitate this by ensuring that information is broken down for individual neighbourhoods that are meaningful to local people, providers and commissioners. The contribution that District Councils can make to achieving good local outcomes needs to be more robustly recognised.

June 2011

Written evidence from NHS Knowsley Public Health Directorate (PH 16)

The following provides an overview of issues for consideration as part of the inquiry into public health. These issues are highlighted along with potential solutions in order to suggest ways that current proposals can be improved.

SUMMARY

- There is a risk that the current specialist public health advisory roles located throughout health trusts and other organisations will be lost if public health is removed in its entirety from the NHS. The future location of public health within local authorities and the Department of Health risks leaving the NHS to further embed its role merely as an illness service.
- The training and development of the public health workforce should remain with the Deaneries as is the case with other speciality training schemes.
- NHS organisations and local authorities should be required, through the powers of the Health and Wellbeing Board to jointly make data available and produce strategic needs assessments and performance monitoring of health and wellbeing strategies. This will strengthen the joint accountability for improving the health of the population beyond caring for the vulnerable.
- The proposed fragmentation of leadership and commissioning for children's services needs to be resolved with local areas maintaining control for designing and implementing systems that are integrated and meet the needs of local families.

1. LINKS BETWEEN PUBLIC HEALTH AND NHS COMMISSIONING

Public health leadership is well established as a central support to the commissioning of health services. This has been essential for the development of evidence, needs assessment, intelligence and outcome feedback. Separating the development of a new public health system from the discussion about reforms to health and social care may lead to lost opportunities to integrate functions to better achieve efficiencies and improved

outcomes. It was notable that the “Pause, Reflect, Listen, Improve” listening exercise was based on the future NHS model without public health and there was no reference to public health even under the “Advice and Leadership” topic. Specific consideration needs to be given to how public health leadership can be retained within the new health and care system, possibly through retaining employment within the NHS of public health staff.

The web channel on health and care changes on the Department of Health website is titled “Modernisation of health and care” rather than NHS reform, highlighting the barrier of regarding the NHS as a static entity dealing with “health” or “ill-health” rather than as part of a complex system. We would suggest that a return to the aims of improving health, care and wellbeing outcomes through modernisation may clarify possible relationships of health system elements and the role of public health as part of that system.

2. ROLE OF PUBLIC HEALTH ENGLAND

Public Health England (PHE) is expected to form through taking on the functions of other existing agencies including the Health Protection Agency, and the Public Health Observatories (PHOs). If PHE becomes part of the Department of Health, this could cause adverse constraints for these two functions in particular, the independence of their advice and expertise that is relied upon, and the generation of income from supplying knowledge and expertise.

Health Protection

The structures through which health protection will be delivered and the accountabilities within those structures are not clear which is concerning given that these proposals form the majority of the specification of PHE. The responsibilities of local health protection units and Directors of Public Health (DsPH) need to be specified more completely, both for ongoing health protection work and emergency situations. DsPH must have the power to require any agency to respond if needed in preparation for or during incidents. This is particularly the case for when surge capacity is required from NHS organisations as part of a public health response.

Public Health Observatories

Public Health Observatories (PHOs) located in universities are a valuable academic link and take both a regional perspective and a lead on agreed areas of public health intelligence. Nationally, public health information needs to be more closely linked to the Information Centre which will process inputs and outputs relating to the NHS and Social Care Outcomes Frameworks. PHOs provide input at all stages of the population health commissioning cycle and its subsets. Clarification on what resource would be available through the PHOs for local authorities and NHS bodies would be necessary. The reduction in funding for PHOs and the loss of expert staff through uncertainty will result in a lack of capacity for an already scarce resource just as GP Consortia and Local Authorities need intensive support.

If the NHS is to become a “health” service rather than an “ill-health” service then the logic of removing a population prevention and protection function from it is not apparent, particularly if part goes to the Department of Health and part into Local Authorities, breaking the NHS link in two directions.

Public Health Leadership

PHE has been proposed as a “national” public health service but currently has only specified roles for the agencies that are to form it, and for Directors of Public Health. It is unclear how PHE expects to fulfil its national leadership role for the whole of public health across the three domains of health improvement, health protection and health services, or what its relationship would be with the National Commissioning Board. PHE needs to be established as an NHS body such as a Special Health Authority to fully utilise its specialist public health functions.

3. PUBLIC HEALTH WORKFORCE

Wherever their working location (public health specialists have roles in universities and trusts and may in future work in other areas in addition to local authorities and consortia) the public health workforce should have access to appropriate training, development and leadership. There is also a danger that DsPH could become an isolated specialist function in local authorities if they are not able to retain and call upon designated public health trained staff. Without this, it would be difficult to maintain an overview of population health needs, outcome performance, intelligence and evidence to inform the role of public health advisor to a wide range of partners.

The separation of roles between PHE (national leadership and population based issues) and local authorities (local needs and solutions) could be managed effectively by employing all public health staff in PHE and then deploying them to where relevant issues are best addressed. As an example, many issues that need to be addressed in local authority areas will be common across bigger footprints and may be better addressed in collaboration through pooled resources and influence. This would also facilitate sharing resources when surge capacity is required. Maintaining the centralised coordination of the specialist training programme within this

structure would also be beneficial to enable experience to be gained through placements across all public health delivery agencies, managed by the existing Deanery network.

4. ROLE OF THE DIRECTOR OF PUBLIC HEALTH

Directors of Public Health will oversee and direct work in all three areas of public health. The DPH role is that of the linchpin of the local NHS, social care and public health system, bringing structures together and making them stronger by their presence. In order to fulfil the “Vision of the role of the Director of Public Health” (Annex A Healthy Lives, Healthy People) the following will need to be implemented:

- The DPH must have the skills and knowledge required to fulfil the vision for the role which can be assured through the current specialist registration and appointments process. By maintaining these standards, it will be clear that appointed DsPH will have abilities across all the 10 public health competencies
- In order that the DPH is able to influence strategically they should have accountability to the Chief Executive, executive team membership and direct access to elected members and their executive group.
- The DPH must be able to express professional, independent views as the advocate for the health of the local population and advisor to the Health and Wellbeing Board.
- The DPH must have sufficient resources including professionally trained staff with the knowledge and skills to deliver strategic public health advice and plan and implement public health programmes across the three public health domains.

5. FUNCTION OF HEALTH AND WELLBEING BOARDS

Health and Wellbeing Boards (HWBs) should be the driving force behind needs assessment, prioritisation and collaborative commissioning for local population health and wellbeing. They will work towards the integration of NHS services, social care and public health in its wider social and environmental context, with the aim of achieving improved health and wellbeing outcomes. HWBs should also include the strategic responsibility for health protection and reducing health inequalities. A Health, Care and Wellbeing Strategy should set out how the outcomes are to be achieved. Commissioning plans should then set out the specifications for the services to deliver the outcomes and how resources will be used. The HWB should be charged with ensuring the commissioning plans meet the expressed needs within the population through the use of locally determined evaluation and performance management.

Partners should be mandated to fully engage with the remit of the HWB. Local authorities should be given powers to engage support of the NHS Commissioning Board if there is an issue with compliance from partners to their role or an unresolved dispute regarding the contribution of commissioning plans to the health and wellbeing needs of the population. This includes ensuring that GPCC are responsible for contributing to public health outcomes.

6. UNDERSTANDING NEEDS

Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment process has been a joint responsibility of Local Authorities and Primary Care Trusts. Much of the input to JSNA will have been public health expertise and capacity. The Strategic Needs Assessment process should not be “Joint” in name, but through the requirement on all parties to engage. The current proposal to share responsibility for ensuring the process is undertaken between GP Commissioners and Local Authorities with a lead role for the DPH needs to be underwritten with a requirement for any health and social care funded body to contribute information and expertise, and for Local Authorities to be able to contribute the same in relation to economic, social and environmental determinants of health.

Public Health Intelligence

Public health intelligence is the driver for evidence based commissioning for population health and is required at national and local level. Public health provides strong tools for assessment, such as asset based approaches, impact assessment and participatory research. Public health also takes a population view of consultation, engagement and involvement, recognising that health, care and wellbeing are whole population issues, rather than just the population accessing services. Sufficient resource and capacity needs to be retained both in PHE and at local levels to ensure this collation, analysis and interpretation of data can continue to be available. It is essential that the reforms do not block existing access to data from its widest sources that are key to the development of local intelligence that informs commissioning. Robust transfer of data between health and local authorities needs to be established.

Public Health Outcomes

The Public Health Strategy for England and the Public Health Outcomes Framework were both issued for consultation some months after the proposals in Liberating the NHS and the NHS and Social Care Outcomes Frameworks. The government has yet to respond to the public health consultations, but the initial NHS and

Social Care Outcomes Frameworks have both been finalised. The outcome frameworks to deliver population health have therefore been agreed prior to consideration of wider issues, not only the determinants of health, but international and global priorities such as demographic change and health threats. One outcomes framework with associated responsibilities for implementation would be preferable.

The result of the Strategic Needs Assessment process that engages all relevant bodies should be a strategy that is owned by the local authority and its population. The strategy should describe the activity that is to be prioritised, the evidence for it and what it aims to achieve.

7. PUBLIC HEALTH INVOLVEMENT IN COMMISSIONING

Public health involvement in commissioning must be recognised at all levels from the National Commissioning Board to GP consortia, with a requirement for all commissioners to seek and take account of public health advice. The expertise of public health in commissioning of health services should be highlighted.

Responsibility for Public Health commissioning should originate at local authority level through the DPH. PHE should be positioned in order that it can act on behalf of DsPH to drive national level action in order to give power to local authorities or achieve whole population level interventions where these are more cost effective and publicly acceptable. DPH should have the power to invest the ring fenced public health budget collaboratively to achieve economies of scale where local interventions are less effective or cost efficient.

Anomalies such as the divide in children's commissioning must be resolved. Local areas should determine what the needs of the local population are and then be able to utilise the expertise of commissioners on a large scale (through PHE and NHSCB), where local commissioning is less effective or standardised services and procedures are required

8. PUBLIC HEALTH BUDGET

The proposal for a ringfenced public health budget holds out the illusion of dedicated funding for population health activity but is a tenuous concept with no indication of what it might have to fund and who might be able to access it. If local authorities are to embrace their population health responsibilities, it must be clear that any ringfenced budget is funding the transition of a public health service, while core funding will be used to deliver outcomes. Public Health departments should be asked to list essential public health delivery functions for sustainable inclusion in local authority responsibilities, rather than list what a (possibly time limited) ringfenced budget should fund. There is also a risk that the ringfenced budget will be further reduced by public health departments having to contribute towards Local Authority on-costs, for items such as Accommodation, HR and Finance support. These have not been included in any consideration of PH current expenditure as they are generally absorbed within PCT costs.

Public health funding proposals offer perverse incentives, literally in the case of the health premium. Premiums should be attracted to populations with the worst health and wellbeing without performance conditions. Evidence of collaborative use of premiums directed through the HWBs would be more appropriate.

Considerable efforts have been made by health and wellbeing partnerships to maximise the impact of health inequalities funding such as Neighbourhood Renewal Fund and single budgets such as Area Based Grant on population health and wellbeing through public health delivery programmes. The 2010–11 in year savings requirements and abolition of Area Based Grant caused the loss of exactly those partnerships and integrated programmes that the Public Health White Paper exhorted public health to develop on its publication three months later. It is concerning that the government appeared unable to recognise the impact withdrawal of Area Based Grant would have for health and wellbeing commissioners across the health economy. Consideration needs to be given to how with reducing resources and increasing demands for care from vulnerable individuals, sufficient resources can be made available to local authorities to fund preventive programmes. This is especially the case where individuals and families living in deprived areas or vulnerable groups require more than just information and access to services in order to make healthy choices.

June 2011

Written evidence from Dr Fiona Day (PH 17)

I am responding in a personal capacity.

Thank you for inviting responses to the Health Committee on Public Health. Please find enclosed a summary of my concerns about the proposed changes to Public Health. I am an NHS Consultant in Public Health Medicine, a Fellow of the Faculty of Public Health, and a registered medical practitioner with the General Medical Council.

1.0 SUMMARY

1.1 I agree with the Public Health white paper and the Faculty of Public Health that there are three domains of public health: health improvement, health protection, and health services public health.

1.2 I share the same concerns as the Faculty of Public Health, Royal Society for Public Health, and Association of Directors of Public Health (<http://www.fph.org.uk/uploads/Letter%20to%20David%20Cameron.doc>) with regards the proposed changes to Public Health in England and believe that these concerns have been overshadowed by other issues relating to changes to the NHS.

1.3 I have particular concerns about the proposed reforms in the following two areas, outlined in more detail below:

- 1.3.1 Lack of standard setting and professional regulation of public health specialists if employed by local authorities.
- 1.3.2 One of the three domains, health services public health, is integral to health services commissioning and is not an add-on. It is unlikely that this can be delivered from a local authority setting, yet separation from the rest of the Public Health workforce may lead to fragmentation of the public health system.

2.0 LACK OF STANDARD SETTING AND PROFESSIONAL REGULATION

2.1 Like most public health specialists, I am a Fellow of the Faculty of Public Health. This gives the public reassurance in my professional standing, Continuous Professional Development, my qualifications and training and sets the rigorous standards which all members of my profession are required to meet.

2.2 Like all public health doctors I am also fully registered with the General Medical Council and have a “certificate of completion of training” (CCT) therefore all medical advice I give is within the confines of my professional training and covers my licence to practice and revalidation, ensuring that the quality of my work is above a minimum standard.

2.3 I am concerned that public health specialists in the Local Authority will not, as plans currently stand, be mandated to be above this quality line. Public health is a professional undertaking with defined competencies and standards in order to protect the public’s health. Not mandating that public health specialists require this status in my opinion puts the health of the population at risk.

3.0 HEALTH CARE/HEALTH SERVICES PUBLIC HEALTH SPECIALISTS

3.1 I qualified as a doctor in 1996. After 8 years of junior doctor experience including working in general practice, I commenced higher specialist training in public health medicine. This took an additional five years training with associated additional professional qualifications and study. I fully qualified to be a public health medicine consultant in 2010, 14 years after qualifying as a doctor. This is a normal length of time to train to be an NHS consultant in public health medicine. All this time in training has given me a broad and deep understanding of the NHS and the health needs of the population, and I have subspecialised in the area of public health practice relating to NHS commissioning, that commonly known as healthcare public health.

3.2 Healthcare public health specialists’ input into commissioning health services is integral on a day-to-day basis. No-one else has the academic rigour and practical experience of commissioning nor the understanding of the health needs of the population, the evidence base, and is able to balance complex interrelated disease pathways with health economics within the context of finite monies to pay for services.

3.3 A population perspective to health service planning has been integral to the NHS for decades now and has ensured rationing of finite resources in a fair and equitable manner. We have worked alongside GPs, hospital specialists, nurses, other clinicians, social care and NHS managers for years to ensure a multiprofessional clinical input into commissioning.

3.4 It has been suggested during the recent NHS “listening exercise” that GP commissioners would be able to buy health needs assessments from local universities in order to make commissioning decisions. If only it was as simple as that. The reality is that commissioning is a hugely complex juggling act. Health care public health specialists provide leadership and strategic direction as well as managing health service quality improvement projects and programmes.

3.5 I am employed by a large Primary Care NHS Trust in the North of England where I have responsibility for commissioning health services for people with long term conditions (cardiac, diabetes and respiratory). I lead our “QIPP” long term conditions programme, ensuring that a mixture of generic and disease-specific services are commissioned for the needs of our local population. This involves daily decision making around investment and disinvestment, based on the evidence, the needs of the population, resources available, and to reduce inequalities, and with constant reference to clinical colleagues and patients. Whilst we do buy some one off specific epidemiological work from local academics from time to time, this is very far removed from the day to day clinical and cost effectiveness work using epidemiological skills that healthcare public health specialists are involved in, which requires ongoing and sustained work within the NHS.

3.6 I understand that our local GP commissioners recognise that they do not have the time nor the skills of balancing the needs of a whole population with the evidence base with reducing inequalities with commissioning services which offer value for money, and like all other GP commissioners in the country are keen to have public health support in the future. However I do not believe that I can directly influence NHS

commissioning from the Local Authority, as is currently planned, and respectfully suggest that it is naive to believe that this could be the case.

3.7 In my personal and professional opinion, without healthcare public health specialists doing the balancing act which they alone are trained to do, the costs of the health service will continue to spiral, services commissioned will lead to greater health inequalities and will be based on good intentions which will fail to meet the many and complex needs of the population. As there are only approximately 200 healthcare public health specialists in the UK. I believe that these specialist staff need to be fundamentally part of the NHS, ie NHS employees and mandated to influence NHS commissioning decisions such as mandatory posts on GP Consortia Boards, or Commissioning Support Units, or through Public Health England so long as it is an NHS authority.

I would be pleased to provide further information on request.

June 2011

Written evidence from the UK Centre for Tobacco Control Studies (PH 18)

1. This submission is made on behalf of the UK Centre for Tobacco Control Studies, a UKCRC Public Health Research Centre of Excellence established in 2008 and comprising a network of leading tobacco control researchers from nine UK universities. A full listing of the researchers involved in the Centre, and information on the objectives and activity of the Centre, are provided at www.ukctcs.org.

2. Tobacco smoking is the largest avoidable cause of premature morbidity and mortality, and of social inequality in life expectancy in the UK. Smoking prevention should therefore be the highest priority in public health.

3. Effective policies to prevent smoking have been identified for over 50 years. Therefore, whilst smoking prevalence has fallen substantially over the past half century, the facts that 10 million people in the UK are still regular smokers, that smoking prevalence is still highest among young people, and that smoking rates have changed little among the most disadvantaged in society in recent decades reflect a systematic failure of UK public health policy in dealing with a major health risk.

4. In contrast to both food and alcohol, eradication of smoking and the industry that drives the smoking epidemic would represent a major benefit to society, with little if any disadvantage. The failure of public health policy to prevent smoking in the UK therefore bodes ill for likely success in dealing with the more complex problems of obesity and alcohol misuse.

5. The proposal to reform public health in the *Healthy lives, healthy people* white paper is therefore welcomed in principle, as an opportunity to create a system better able to deal with smoking, obesity, alcohol abuse and other “lifestyle” problems.

6. Sadly the principles of the reform of public health in the White Paper, and detailed Tobacco Control Plan for England that has followed, exhibit serious flaws in the approach to dealing with tobacco, and hence also for the likely success of approaches to these other lifestyle problems.

7. First and foremost of these is the lack of clear leadership responsibility for national level population strategies that discourage uptake of smoking, and encourage existing smokers to quit. The plan delegates tobacco control activity to local authorities and communities, but many key policies to make cigarettes less accessible and affordable, and reduce the perception (particularly for children) that smoking is a normal adult behaviour, need to operate across all such communities. Comprehensive implementation of all of these policies has proved key to the success of some countries and states in achieving much more marked declines in smoking prevalence in recent years than has been the case in the UK. Examples of policies that need to be implemented nationally include:

- 7.1 Using price to reduce the affordability of cigarettes. Above-inflation price rises have not kept pace with incomes, so cigarettes are now more affordable in the UK than they were in 1965.
- 7.2 Preventing illicit trade in tobacco, which undermines price policy and is a source of tobacco for children.
- 7.3 Protection of children and adults from exposure to smoking behaviour through wider extension of smoke-free policy to outdoor areas not currently covered by smoke-free legislation, and prohibition of smoking in private vehicles.
- 7.4 Delivery of innovative and varied media campaigns promoting non-smoking as the norm, discouraging uptake, encouraging cessation, and explaining and promoting harm reduction.
- 7.5 Default adult (18) classification of films containing smoking imagery.
- 7.6 Changing the retail environment of tobacco by removing point of sale displays, licensing retailers to concentrate tobacco sales into a smaller number of outlets with effective sanctions on those that sell to children.
- 7.7 Introducing plain and standardised tobacco product packaging.

7.8 Reforming nicotine regulation to encompass all nicotine products and promote the use of safer alternatives to tobacco smoking in a proactive harm reduction strategy.

The 2011 Tobacco Control Plan for England acknowledges most of these needs, but provides little if any concrete indication of how they will be pursued or delivered during the term of this government, and indeed substantially delays the implementation of point of sale display prohibitions enacted under the 2009 Health Bill. This lack of leadership at national level, and of clear identification of who will be responsible for coordinating the many government departments that need to be involved in this activity in relation to tobacco and other health threats, is a major omission.

8. Second is the extent of reliance on personal enablement and responsibility for healthy choices. Whilst welcoming the recognition of the importance of these factors, and agreeing that change arising from voluntary or self-motivated actions is preferable to that achieved by regulation or coercion, experience of the smoke-free legislation in 2007, and indeed from many other areas such as seat belt and drink-drive legislation indicates that legislation is also key to ensuring that change happens quickly. As an example, the Tobacco Control Plan promotes a voluntary approach to non-smoking in cars carrying children, when recent evidence from Canada demonstrates that exposure of children falls more quickly and more substantially when campaigns promoting individual responsibility are supported by legislation. Effective smoking prevention requires the balanced and pragmatic use of all relevant policy levers; dependence on any to the exclusion of others is illogical and detrimental to public health.

9. Third is the reliance on voluntary agreements rather than regulation of industry to protect public health. Although the tobacco industry is specifically excluded from the responsibility deal, experience in tobacco indicates very clearly that voluntary agreements generally fail. The promotion of voluntary agreements with the alcohol and food industries in the responsibility deal thus reflects a failure to learn from past mistakes.

10. There are some aspects of the Tobacco Control Plan that are strong; particularly in the commitment to extend the use and variety of smoking cessation interventions in the NHS and wider society. However the uptake and success of local services is highly dependent on motivation to quit, and that in turn is driven by national as well as local policies.

11. Thus in our view overall the Plan disappoints, and as outlined above, particularly by failing to recognise the importance of a pragmatic approach to prevention that uses all viable options, and coordinates the activities of different government departments.

12. We also share broader concerns outlined by others in the public health community that Public Health England at national level, and Directors of Public Health at local level, must be provided with the resources, independence and executive power necessary to deliver their contributions to dealing with these and other crucial threats to public health.

13. We therefore request the Health Committee to consider solutions to these deficiencies, and to the problem of cross-department coordination in public health policy, in its deliberations.

June 2011

Written evidence from the Public Health Directorate of NHS Lincolnshire (PH 19)

SUMMARY

1. The Public Health Directorate of NHS Lincolnshire is delighted that the Health Select Committee has decided to inquire into the public health function in England, and has prepared this submission for the Committee. In summary:

- We welcome the creation of Public Health England but believe that its roles and responsibilities should be clarified.
- We believe that the Health Protection Agency should remain as a non departmental public body, to ensure that it can deliver its roles by working in a fully integrated manner with the NHS, local authorities and universities.
- We welcome the enhanced public health role of the Department of Health and the Secretary of State for Health. The NHS should be less of a disease treatment service, and much more in the business of promoting health and disease prevention.
- We welcome the enhanced role for local authorities in public health but wish to see the preservation of the independent voice of the director of public health as an advocate for the public's health, and a strengthening of the powers of the Health and Wellbeing Boards.
- We believe that public health specialists are vital to the success of the commissioning of healthcare services. As such, whichever agency employs public health specialists should be required to provide public health advice and support to GP Commissioning Consortia.
- We believe that there should be a clear definition of which public health services should be commissioned from within the proposed ringfenced public health budget. This would stop local authorities from diverting this money to spend on their current statutory functions.

- We wish to see the work of public health observatories maintained and preferably enhanced.
- We believe that all public health specialists should be subject to the same robust mechanism of regulation.
- We believe that all public health specialists should be employed by a single agency, and then seconded to work within local authorities and GP Commissioning Consortia.
- We believe that measures should be taken to protect the capacity of the specialist public health workforce, during the current reorganisation.
- We welcome the Coalition Government's endorsement of the Marmot Review, and believe that Public Health England and the Health and Wellbeing Boards should be mandated to progress its recommendations.

PUBLIC HEALTH ENGLAND

2. We welcome the creation of a national public health service, Public Health England, but believe that its roles and responsibilities should be clarified.

3. As currently proposed this agency will be part of the Department of Health, and its employees will become civil servants. This is inappropriate as many of its functions (eg those currently performed by the Health Protection Agency) are direct services provided to the NHS and other agencies, rather than the formation of policy. Public Health England should be constituted as a Special Health Authority.

4. There are three domains to public health practice: health improvement, health protection and healthcare public health. Currently, most public health consultants have expertise in defined areas but their work encompasses aspects of all three domains. This allows for an integrated approach to tackling public health issues and problems. This integration of work would be lost if Public Health England were to employ only a proportion of public health specialists. We believe therefore that all public health consultants should be employed by a single agency, and seconded from there to work for local authorities and GP Commissioning Consortia. Such an arrangement would have the additional advantage of ensuring an equitable distribution of public health specialists to all areas of the country.

HEALTH PROTECTION AGENCY (HPA)

5. We believe that the creation of a single specialist agency able to deliver local health protection services as well as national surveillance and research has been a very successful model. The current status of the HPA as a non departmental public body has enabled it to work closely with the NHS, local authorities and universities. We cannot see what advantages there are to be gained by abolition of this agency and its integration into the Department of Health.

6. An alternative model would be to transfer the public health specialists who currently work in the HPA's Local and Regional Services into the local authority, if that is where public health specialists are employed. Prior to 2002 all public health staff, including those working in health protection, were located in single public health departments. This co-location of senior staff enabled those public health consultants who did not primarily work in health protection to maintain their skills, which is essential if they are to be on the health protection on-call rota, and ensured that there was surge capacity to deal with major incidents.

PUBLIC HEALTH ROLE OF THE SECRETARY OF HEALTH

7. We strongly welcome the enhanced public health role of the Department of Health, and in particular an enhanced public health role for the Secretary of State for Health. Since its inception in 1948 the National Health Service has concentrated on the treatment of disease rather than the promotion of health. As we increasingly move away from a model of health service delivery that concentrates on the treatment of acute episodes of disease towards one where the management of long term conditions is much more to the fore, it is clear that the public health role of the department will become increasingly important.

8. Many long term conditions are preventable—for example, Type II diabetes is mainly caused by obesity. There are actions we can take to reduce the burden of obesity, leading to a reduction in the numbers of people with diabetes, and thus a reduction in costs to the NHS.

9. Primary prevention services should be adequately resourced and we support the emphasis in the White Paper on effective use of the current evidence base, and the emphasis on the need for further research and effective evaluation. This should be actively encouraged and supported by Public Health England and NIHR, and where possible research and evaluation from across the country should be supported and good practice shared in a more systematic way.

LOCAL GOVERNMENT

10. The wider determinants of health (employment, education, transport, environment, housing etc) are not under the control of the NHS. Local government can directly and indirectly make a substantial difference in these areas and thus public health staff have always worked closely with local authorities to improve health through influencing the wider determinants of health. Organisational boundaries have sometimes got in the

way and thus having senior public health staff employed by local authorities, or seconded to local authorities, would enhance our capabilities to improve health. This will be supported still further by the need to develop joint health & wellbeing strategies, with clear outcome frameworks.

11. We welcome the proposal to make joint appointments of directors of public health mandatory, although of course many areas, including Lincolnshire, already have joint appointments. To be credible with the public, the director of public health needs to have an element of independence from local government; to be able to constructively criticise the policies of their local authority where such policies harm the health of the population. It is worth noting that when medical officers of health (the predecessors of directors of public health) were employed by local authorities their contracts specifically allowed them such a degree of independence.

12. The position of director of public health is key to ensuring that public health is at the heart of all that local authorities do. It is therefore essential that only those staff properly qualified to do this role are appointed. We therefore believe that it should be mandatory for directors of public health to be on the GMC Specialist Register or the United Kingdom Public Health Register. Directors of public health should also report directly to the local authority's chief executive.

13. We welcome the creation of Health and Wellbeing Boards. These Boards have the potential to be powerful levers to drive health improvement and address health inequalities in each locality. They can only do so however if they are perceived as being at the centre of these reforms. The Health and Social Care Bill should be amended to strengthen their role and powers.

14. We have some concerns that if the whole public health function is transferred to local authorities that the core NHS functions of emergency planning, vaccination and immunisation, and screening, will not be accorded a sufficiently high priority by local authorities, who will almost certainly give a higher priority to promoting the general wellbeing in their area.

PUBLIC HEALTH INPUT TO THE COMMISSIONING OF HEALTHCARE

15. Currently, public health consultants play a crucial role in the commissioning of healthcare: we contribute our skills and expertise in health needs assessment, critical appraisal of published evidence of effectiveness, leading the production and implementation of care pathways, and as credible leaders who can "hold the ring" between primary, secondary care and community service clinicians and providers.

16. Our input to commissioning is therefore crucial to improving the effectiveness and the efficiency of health services. The NHS and Public Health White Papers have failed to understand the vital role that public health specialists play in commissioning. We are particularly concerned at the failure to ensure a future role for public health specialists in the commissioning of specialised services.

17. We believe that it is vital that all GP Commissioning Consortia should have ready access to public health advice and support. This would be best provided from a single agency which employed all public health consultants. If local authorities are to be the employer of public health specialists they should have a legal duty to provide the Commissioning Consortia within their area with public health advice and support, funded from within the ring fenced budget for public health.

COMMISSIONING OF PUBLIC HEALTH SERVICES

18. Public health services have been a notable success in recent years: NHS Stop Smoking services have played a large part in reducing the numbers of people who smoke, which will lead to a reduction in the burden of illness from this cause.

19. We are pleased that public health will have a ringfenced budget but are concerned that local authorities may seek to use this budget to prop up their statutory services rather than spend this money on true public health services. There could for instance be demands to spend this money on filling in potholes and gritting pavements. It is essential that legislation is very clear on what the ringfenced public health budget should be used for.

20. Preventive services should be included as part of the commissioning pathways work of consortia to ensure that there is clinical buy in and support.

PUBLIC HEALTH OBSERVATORIES

21. Public Health Observatories have played a vital role in enhancing our knowledge of health needs, in particular by providing us with comparative data. In each locality we need to know how our needs compare to other areas, and it is impractical and inefficient for analysts in each area to attempt to replicate this work. The role of public health observatories should be maintained and strengthened.

ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES

22. If local authorities hold the ringfenced public health budget it should remain ringfenced, and there should be very strict accountability on what it should be used for. This should include funding the local public health service, regardless of who employs public health specialists.

23. In setting public health budgets care needs to be taken to ensure that all current expenditure is included. Arguably, there should be an increase in the public health specialist workforce to meet all the requirements of consortia and all branches of local government.

PUBLIC HEALTH WORKFORCE

24. The training programme for public health consultants is designed to be equivalent, as far as is practicable, to hospital specialities. Entrants have to be medically qualified, or have a good degree and relevant postgraduate experience. The training programme lasts for at least five years, and progression requires trainees to pass a two part exam and to complete defined work-based learning outcomes. At the end of this programme, employers and the public can be confident that public health consultants will have been trained to the highest possible standards.

25. Once the training programme has been completed, medically qualified trainees are eligible to be on the Specialist Register, and are regulated (like all doctors) by the General Medical Council (GMC). Action can therefore be taken to deal with poor performance or misconduct.

26. Non-medically qualified trainees are eligible to be included on the United Kingdom Public Health Register. But this body is much more limited in its powers than the GMC.

27. We believe that all public health specialists, doctors and non-medically qualified practitioners, should be subject to the same degree of regulation and by the same body, to protect employers and the public from poor performance and misconduct.

28. Previous NHS reorganisations have led to a substantial drop in the number of public health consultants. The uncertainties in employment prospects caused by the current reorganisation, and financial restraints, are already leading to some public health consultants seeking voluntary redundancy or early retirement. A further reduction in what is already a very small profession (there are only around 1000 public health consultants in total) will threaten our ability to improve the health of the population, to contribute our part in the commissioning of health services, and to deliver our input to the response to major incidents and emergencies. Measures should be taken to preserve public health capacity at this crucial time.

GOVERNMENT RESPONSE TO THE MARMOT REVIEW

29. We are encouraged by the Coalition Government's support for the Marmot Review and would encourage active support for ongoing implementation of their recommendations. This should be a key function for Public Health England, and a requirement for Health and Wellbeing Boards to progress.

June 2011

Written evidence from S Peckham, A Hann, A Wallace, S Gillam, S Kendall, K Nanchahal and R Rogers (PH 20)

WHITE PAPER: CONSULTATION QUESTION—ROLE OF GPs AND GP PRACTICES IN PUBLIC HEALTH

This is a response to the Committee's request for submissions on the proposed public health changes in England outlined in the White Paper. This submission focuses on the implications for primary care and addresses key questions raised by the White Paper "*Healthy Lives, Healthy People*", and subsequent consultation on commissioning for public health. Our focus here is specifically on how the proposals affect the delivery of public health in general practice and primary care. The response has been prepared by a research team currently undertaking research on public health in general practice funded by NIHR.³ The research team would be happy to discuss any aspects of our response and contact details are given below.

THE ROLE OF GENERAL PRACTICE IN PUBLIC HEALTH

GPs and their practice teams have a crucial role in promoting health and preventing disease. Every consultation is an opportunity to detect early-warning signs that prevent illness and disease. The Royal College of General Practitioners agree GPs should be pro-active in carrying out public health activities and interventions, and it expects GPs to possess a wide range of skills related to ill-health prevention and public health. However, research continues to find that the relationship between public health and general practice in England focuses primarily on secondary prevention (Boyce et al 2010), and many GPs state they lack the skills needed to delivery effective health promotion. For example, GPs currently more frequently respond to requests for support in smoking cessation, rather than proactively engage their patients. Therefore, there is an enormous

³ Peckham S, Hann A, Wallace A, Gillam S, Kendall S, Nanchahal K and Rogers R. *The contribution of general practice to health improvement: synthesis review and a scoping study* NIHR SDO funded study 09/1001/52.

potential for general practice to take a more pro-active role in ill-health prevention and public health. National Institute for Clinical Excellence (NICE) public health guidance advises primary care professionals, such as GPs, to opportunistically and pro-actively carry out activities such as brief interventions. The White Paper on public health acknowledges this role, stating that GPs “have huge opportunities to provide advice, brief interventions and referrals to targeted services.”

It is important that GPs and the wider primary health care team stay involved in public health, and to encourage an even greater level of participation. However, we are concerned by several aspects of the government’s proposals. This response lays out some challenges we see in accomplishing this goal given the restructuring of the public health service, but also includes some suggestions for how to enhance GP involvement in public health planning and delivery.

FRAGMENTATION OF FUNDING AND COMMISSIONING:

The first potential problem is that public health will be fragmented on two levels—on the level of funding and commissioning, and on the level of delivery. In terms of funding, the splitting of public health resources across GP consortia, local authorities and Public Health England/NHSCB is a key concern. It is not clear what level of resources local authorities will have to spend locally nor what mechanisms will be available nationally to contract local public health activities in general practice. Grouping commissioning of similar services together can have great advantages, if there is enough funding behind it to make the services worthwhile. For example, drug, alcohol and mental health services will all be commissioned via local authorities. These important public health challenges are often overlapping and are best dealt with by joint services, which may include GPs in shared-care arrangements if locally appropriate. However for just that reason they are often expensive to deliver in the short term and will require a large financial contribution that the local authorities may or may not have. These services are a good example of how by commissioning similar public health services by one body (in this case, local authorities), there can be streamlining of service delivery and inclusion of GPs where beneficial, but this grouping together will only be effective if there is enough funding to support these joint endeavours.

Recommendation 1: Assign commissioning responsibilities so that services that are best delivered together can be grouped, and provide commissioning bodies with enough funding to support these joint services

There is also the question of when a service is commissioned nationally, how will GPs be incorporated when necessary? For example, public health for under-5s, which include pre-established programs and services that fall outside the NHS, will be contracted centrally by the NHSCB, yet GPs play a huge role in the care of under-5s and work collaboratively with local health visiting teams and other community staff. The commissioning consultation makes it clear that the NHS (presumably mostly GPs) will still be responsible for the treatment of under-5s, but for this age group so much of routine care is based in prevention and health promotion. It is reasonable to try to standardize under-5 care by commissioning it at the national level, but it is not clear how the necessary linkages will be made between GPs and community services when it comes to the care of under-5s. Encouraging and maintaining these linkages and essential to keeping GPs involved and to providing well-coordinated and high quality care. The organisation of commissioning for under-5s needs to be re-examined to ensure continuity and good local co-ordination.

Recommendation 2: Either commission services locally or ensure that GPs are connected up with other services that are commissioned and delivered nationally

The last concern regarding fragmentation of commissioning is in situations where individual aspects of one public health service are commissioned by different groups. This is the case for screening, immunizations and sexual health services, where commissioning is split. In each case, part of the service will be provided by GPs as part of the GP contract (cervical cancer screening, childhood and elderly vaccinations, and contraception services, respectively), but other, similar services are not (ie additional cancer screening, booster vaccinations, and STI screening and treatment). Those services that are not part of the GP contract may be commissioned to other community providers (as part of the “any willing provider” model), which could lead to a situation where similar services that can be most effectively provided side by side (most obviously, contraception and STI services) may be available from different providers because they are commissioned by different groups. This runs the risk of confusing patients and making GPs feel that they cannot provide adequate public health services to their patients.

Recommendation 3: Keep commissioning of all aspects of one service under one roof. This applies specifically to sexual health, vaccination, and screening services

Fragmentation of Delivery

Beyond the potential problems that arise when commissioning of similar services is done by different bodies, there is a more general likelihood of fragmentation of delivery of public health services due to the “any willing provider” model. While the idea behind this approach to commissioning is to increase quality of care via a wider field of competition, and while it is possible that this increased competition will drive out poor providers and reduce the total number of providers, there is still a risk that the overall effect of this policy will be that

public health-related care is divided over a larger number of providers. The effect on GPs may be twofold. The first is simply that services that were once provided by GPs will be provided elsewhere (this will be especially true given the suggestions of future “flexibility” of the GP contract when it comes to public health measures). The second effect, which will likely be the more common one, is that patients will have to seek out many geographically separated providers for services such as STI treatment, cancer screening, and nutrition advice. This may be confusing and frustrating to patients as well as GPs. Good communication between local authorities, the local Health and Wellbeing Board, and all local GPs will be necessary to minimize this confusion. GPs must be kept aware of which providers are providing which services so they can properly advise their patients on where to seek care. Additionally, GPs must be able to keep track of what care their patients have received from other providers. Coordinating with other providers and keeping detailed record of their patients’ care, particularly when it comes to routine screening and immunization, are key roles of the GP. It will be crucial to build in a way for all commissioners and providers of public health services to share their knowledge and records with GPs so that GPs can continue to do their jobs effectively.

The “any willing provider” model also calls into question the future role of entire categories of providers already working in public health, including health visitors, midwives and school nurses. Investment in health visiting is discussed in the white paper and is welcomed, but other key members of the local primary health care team who deliver public health are not mentioned. For example, the crucial role of School Nurses is not mentioned in the documents and it is not clear where this service will need to focus its attention or how it will be integrated into the rest of public health delivery. More clarity is needed about how essential local public health services will be worked into future commissioning, otherwise there could be a lack of co-ordination between local authorities and GP consortia for many key public health services, or worse, a loss of the currently-existing services all together.

Recommendation 4: Develop an information-sharing system such that GPs are always aware of where their patients can seek various public health services, and streamline the sharing of health records between providers, where appropriate

Recommendation 5: Make clear how services from existing groups of primary care-based public health providers (midwives, school nurses, etc) will be commissioned and what their roles will be

GP-led Public Health Delivery

We should not just see GPs as public health coordinators; we should ensure that GPs stay involved in public health on the delivery side as well. The three current methods for payment for public health activities within the GP contract are core standard tasks expected in normal practice (advice, information etc), aspects of the Quality and Outcomes Framework (QOF), and Local Enhanced Services (LES) elements of the contract. LESs have been particularly effective in involving GPs in locally-driven public health efforts. To date, LESs have been used in many areas to support a wide range of evidence-based public health activities, such as identifying CVD risk and providing long-acting contraceptives, and in 2009–10 they accounted for some £370 million (Marks et al 2011). Having the option of LESs in the contract has provided a way for GPs to reduce preventable morbidity, and it could continue to do so in the future. This option would be especially helpful in the context of a more diverse provider landscape. However, many of the activities currently funded through LESs, such as health check programmes, sexual health services falling outside the core GP contract, smoking cessation, prevention and treatment of alcohol misuse, falls prevention, and mental health promotion will now be commissioned through the public health budget of local authorities, and the GP contract will in future be done by the NHSCB. Will there be a mechanism for local authorities to engage with contracting processes and negotiate agreements that allow for local delivery of services that go beyond what is included in the nationally-based GP contract? Maintaining some mechanism for GPs to provide services that address local needs but are not included in the contract or in QOF may be an effective way to keep GPs involved in delivery of public health, and to keep our communities healthier.

Recommendation 6: Retain a mechanism for local adaptations to the GP contract, either LES or something similar

Changes to QOF

Experience from LESs suggests that while financial incentives are effective in changing practice, outcomes-based contracts rather than activity-related incentives could encourage a more proactive approach. Similarly, a key criticism of much of general practice (when it comes to public health) is that it focuses either on secondary prevention or simply information and advice. While both of these activities are useful, other interventions can be more effective. All of these considerations and criticisms are of particular importance when it comes to QOF. QOF is a key driver of GP practice, and could be another way to increase GP involvement in public health. A main proposal in the White Paper is that NICE adjust QOF to ensure that 15% is devoted to “evidence-based public health and primary prevention indicators.” Currently QOF has two indicators that it designates as “primary prevention”, and otherwise it focuses mainly on secondary prevention and uses proxy or process outcomes. Findings of a research study examining QOF and public health suggest that QOF has led to more systemisation of public health activity with a secondary and medical focus (Dixon et al 2010). The upcoming changes that NICE and QOF enact, and whether they truly make the focus on primary prevention

and actual outcomes, will to a large extent dictate how much GPs are involved in improving the health of their patient population.

Recommendation 7: Take due notice of the potential for general practice to deliver public health when adjusting QOF to make sure the focus is truly on primary prevention and outcomes

GPs and the Public Health Outcomes Framework

Conversely, whereas the QOF is an incentive program for GPs that can be adjusted to insert public health, the Public Health Outcomes Framework (PHOF) is a public health incentive program that could be used to bring more GPs into the delivery of public health. As it currently stands, the PHOF indicates the few places that responsibility for achieving indicators is shared with the NHS—just eight indicators in the entire list refer to the NHS, and most of them are around reducing premature death in people with chronic diseases rather than disease prevention or health promotion. It is not clear what this shared responsibility refers to—provision of funding or delivery/planning of services. Looking at the entire list of public health indicators it is clear that GPs, and therefore the NHS, can be instrumental in delivering many services beyond the ones singled out—in services relating to sexual health or smoking cessation, to name just two areas. When local authorities and local health and wellbeing boards are considering how to best respond to these indicators (which they will be driven to due by the “health premium” payments), they should keep GP services in mind for many indicators beyond those with designated NHS involvement. Hopefully the GP presence on the health and well-being boards will help to keep GP services on the table. Additionally, the boards may find that GPs are particularly well-primed to the idea of indicators, having now been working with QOF for six+ years. While these two sets of indicators are very different in character (though they will hopefully become less so, as discussed above), GPs may be comfortable with the idea of indicators and may have ideas for how to incorporate this new set into their practices.

Recommendation 8: Include GPs services in the discussion of how to best deliver on the public health outcomes framework

GP Consortia

GP consortia will be represented on health and well-being boards and will be involved in local decisions about public health resource allocation, which is an important piece of maintaining GP involvement in public health. However, the most dominant role of the GP consortia will be in commissioning, which provides a new set of challenges as well as opportunities for improvement in public health and ill-health prevention. Research on Practice Based Commissioning (PBC) found that GPs focused more on preventing “unnecessary” hospital admissions than on primary prevention (Thorlby and Curry 2007). Analyses of private primary care similarly found GPs used traditional models of general practice and did not address key public health problems (Coulter 2006; Kai and Drinkwater 2003, Peckham 2007: 43). However, this is not a reason to take public health out of GP commissioning responsibilities. In fact, researchers have suggested GP budgets for commissioning health services be aligned with budgets for commissioning public health (Smith and Thorlby 2010), which is similar to what may happen with the new expanded responsibilities of GP consortia. By giving GPs responsibility for standard health services commissioning as well as some public health services, they may be forced to think more broadly about their communities. In order to integrate ill-health prevention into general practice, it is essential that future contract negotiations and consortia commissioning responsibilities discuss and assign responsibility for primary and secondary prevention. More specifically, GPs should have responsibility for commissioning those public health activities that most closely relate to the ones they provide themselves via the GP contract (like contraception services and cervical cancer screening). Aligning these responsibilities puts GPs’ already existing knowledge of service provision to work, and helps to ensure that patients have access to the most streamlined pathways for these services (as well as the best quality ones).

We welcome the emphasis on GP Consortia being responsible for the well-being of their whole community. However, systems developed within PCTs for supporting GPs with epidemiological analyses are likely to be disrupted with changes to public health departments. New relationships, systems and processes will need to be developed to provide what is critical support for the new commissioning bodies. Additionally, this will have to be done at a time when new organisational structures for public health also need to be developed and new relationships forged. While consortia provide an opportunity for GPs to take a broader community focus it is not clear whether the scale of change and focus on other aspects of commissioning and organisational change will allow this to occur. To best support GP Consortia in their public health responsibilities during this tumultuous time, local epidemiological responsibilities should be maintained and transferred to local authorities, who will then provide information to GP consortia.

Recommendation 9: *GP consortia should commission those activities that are most similar to the ones in the GP contract, for better streamlining of care*

Recommendation 10: *Local health monitoring and epidemiological services should be kept intact and active during the transition to GP consortia and should maintain an open stream of communication with the consortia*

Research

One final measure that will benefit everyone from GP consortia to the NHSCB in their commissioning of public health activities is good sharing of existing evidence and increasing the evidence base related to GP delivery of public health. Our research group is currently engaged in a scoping study of the role of GPs in health promotion and disease prevention, with particular focus on service organization and delivery.⁴ Our initial literature search has shown that the number of studies on this topic is large and growing daily, but it is difficult to define the topic precisely, and therefore it is challenging to access all relevant information. To combat this challenge it is essential that this large body of literature be thoroughly explored, then shared and put to good use in commissioning and shaping practices. At the same time, it is clear that quality studies on the best methods for delivery of health improvement services are lacking. General practitioners, other primary care providers, public health officials and academics need to work together to improve this evidence base.

Recommendation 11: *Fund additional research on how GPs can deliver public health interventions, and create improved mechanisms for sharing research and effective practices*

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Written submission from Lancashire Public Health Network and Cheshire and Merseyside Public Health Network (PH 21)

1. We welcome the opportunity to respond to the Select Committee new public health inquiry. We are committed to protecting and improving people’s health and wellbeing and reducing health inequalities. Whilst we recognise that the Government’s call for a public health system that can deliver world-class outcomes raises huge opportunities for public health, with such changes there are also risks and unfavourable unintended consequences. In light of these major changes proposed by the Government the following issues need to be considered by the Committee in order to effectively deliver public health to all in the new public health system.

2. The variety of commissioning routes may lead to fragmented commissioning for a number of public health functions and priorities which will threaten the meeting of local needs as well as compromising quality service provision and accountability. Public health expertise and input needs to be provided to all the different commissioning routes for the identified public health priorities/functions and the delivery of health care. Public health expertise in evidence based decision making and prioritisation is key to ensuring services are efficient and commissioned according to need. For many services a whole pathway approach to commissioning is vital to ensuring that efficiency savings are met eg tackling increasing alcohol admissions needs to be addressed through interventions along the entire pathway from prevention to treatment.

⁴ Peckham S, Hann A, Wallace A, Gillam S, Kendall S, Nanchahal K and Rogers R. *The contribution of general practice to health improvement: synthesis review and a scoping study* NIHR SDO funded study 09/1001/52.

3. The commissioning of children's services is particularly fragmented. It is currently proposed that Children five to 19 is to be commissioned by local authorities while under five services is to be commissioned by the National Commissioning Board (NCB) and at some time transferred to local authorities. There is a strong evidence base to suggest that the healthy child programme will improve health and wellbeing. Local authorities should commission the complete healthy child programme from 0 to 19. This would also encourage a whole life-course approach, with potential impacts on positive outcomes and would enable local authorities to integrate commissioning for children's public health with their other responsibilities for early years, school and young people's services.

4. The division of the public health function between Public Health England (PHE) within the Department of Health and locally in local government creates a fragmented rather than a unified workforce; different people employed by different organisations on different terms and conditions (civil servants, NHS, local government) creating inequities in the PH workforce. Currently the proposals to position the functions and staff of the Health protection Agency and the Public Health Observatories within the Department of Health as Public Health England may rise to the following, additional issues of conflict:

- it compromises the independence of public health workforce to act as advocates of health;
- leads to a fragmented rather than a unified workforce. If all resources, capacity and capability are held at a national level PHE will not be able support local delivery and be responsive to local differences; and
- lack of influence from the local level on national policy.

By establishing PHE as a special Health Authority or Executive Agency of Department of Health its credibility and independence will be increased. PHE should act as the employing body for public health specialists, seconding them to other organisations as necessary, to ensure their primary responsibility is to the public.

5. Clear lines of accountability for GPs, GP Consortia and Health and Wellbeing Boards (HWBs) need to be nationally agreed—with clear levers for influencing commissioning by GP Consortia and the National Commissioning Board. HWBs need to be more than advisory bodies, they need to be given more power and influence for the implementation and delivery of the Health and Wellbeing Strategy by different partners.

6. The Director of Public Health (DPH) is the only defined role at local authority level when the NHS public health function moves to the local authority and the local authority becomes responsible for population health improvement. The DPH needs to be responsible for and in control locally of the three key domains for delivery of the public health function—health improvement, health protection, and health services. Currently the relationship of the Director of public health with Public Health England is unclear. The DPH needs to be able to give independent, professional advice and have a strong and pivotal role on Health and Wellbeing Boards for NHS and Local Authority influence.

7. The role of the DPH therefore should be defined as:

- Public health adviser to the LA Health and Wellbeing Board.
- Responsible for developing, implementing, performance managing and reporting on the population health of the area.
- The integration of health, care and wellbeing delivery through the Joint Strategic Needs Assessment, the Joint Health and Wellbeing Strategy and the Public Health Annual Report on behalf of the Board.
- Provision of advice and leadership for area population health and wellbeing.

It is proposed that to reflect these roles:

- statutory powers should be invested in the role to ensure control of resources and accountability to and from other public functions;
- the DPH must retain the independence of the public health function, able to speak at all times on behalf of the health and wellbeing of the local population rather than from a political or administrative position; and
- the DPH must be positioned at Executive Director level in the local authority, directly accountable to the Chief Executive and with strategic overview of all local authority functions rather than restriction to health and social care. Lines of accountability need to be nationally agreed.

8. There are issues around the proposed arrangements for funding public health services:

- ring-fencing risks encouraging silo working by dividing public health activity from non-public health activity;
- that local authorities may not receive sufficient funding to commission and deliver health improvement services because the national formula for public health resource allocation will not be sensitive enough to identify current variation in PCT investment;
- the substantial financial restrictions that both LAs and PCTs are experiencing may put public health spend at risk; and

- the PH budget will come with commissioning commitments attached which then reduces flexibility to respond to local public health priorities.

9. Since a local budgeting approach to the health of the public has been shown to promote innovative, joined-up and whole-systems approaches to improving health, where appropriate the public health budget needs to be aligned and/or pooled with other budgets to maximise overall public health impact in local areas. Current investment in health prevention should be acknowledged in the pace of change adjustment (alongside health premium allocations) so as not to penalise those areas that have invested in public health spend. An audit of prevention spend in LAs (similar to the NW 2009–10 prevention spend audit in PCTs) would help to strengthen the baseline on PH spend across key partners. It is acceptable that there should be some broad conditions/agreements on the use of the ring-fenced budget in the early transition periods. But in the longer term local areas must be free to identify their own public health priorities and given the power to address them through a democratic and accountable structure.

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Written evidence from Lynn Emslie (PH 22)

OFFENDERS AND THOSE AT RISK OF OFFENDING

- Evidence shows^{i, ii, iii} that the offending population (prisoners and those exhibiting offending behaviour), have very high rates of physical and mental morbidity and are socially excluded. Their access to health and social care services is poor.
- It has been announced^{iv} that all healthcare in custodial settings will be commissioned by the National Commissioning Board. However, the needs of offenders will overlap with the proposed Health Equalities role of Public Health England.^v Governance and scrutiny structures for the above, through the National Commissioning Board and Health and Well Being Boards, are still being debated.
- Care pathways for vulnerable adults and those with complex needs, span organisational, governance and geographical boundaries and so a commissioning structure which can accommodate the development of care pathways and partnership working will be required.^{vi}

1. In order to continue and further develop the Public Health role of reducing Health Inequalities, the needs of offenders and those at risk of offending should be an integral part of the strategic thinking and local planning for the development of Public Health England.

2. The needs of individuals and groups who exhibit chaotic lifestyles, complexity of need and poly morbidity; including mental health, learning disability, learning difficulty, illicit drug use, prescribed medication abuse, alcohol dependence and physical disability/long term conditions are not mainstream and may require a more focussed and proactive approach. Development of an effective care pathway which cuts across agencies and organisational boundaries is key to effective engagement and outcomes. People with complex needs frequently need support with housing, budgeting, basic education and employment services, which are traditionally provided by social care services, including the voluntary sector. Bringing Public Health England into the Local Authority framework could create a positive environment for integrating these services, based upon identified need.

3. Under the current proposals, custodial healthcare (prison and police custody) will be commissioned by the National Commissioning Board, which may also have a monitoring function. Offender healthcare in the community will probably be commissioned through the General Practitioner Consortia and Public Health England, with the Health and Well Being Boards having a locality needs assessment (Joint Strategic Needs Assessment) role and also providing the forum for local scrutiny (the public voice, HealthWatch and Local Authority processes). This fragmentation of commissioning, delivery and accountability could be counter-productive to the care pathway/integrated approach which is vital for increased access to services and the continuation of care for people with complex needs. Existing partnership working with criminal justice colleagues will also require further development in order to achieve positive outcomes.

4. Current economic pressures provide an opportunity for working collectively, not in silos, in order to be more efficient and cost effective. Integrated management, joint commissioning and clearer outcomes could be developed and refined in order to provide early interventions and reduced escalation of need. Marginal groups, especially those perceived to be non-compliant or challenging should not be further excluded from services as their issues will potentially escalate and be even more complex and expensive. Including the needs of offenders within the scope of Public Health England would provide an appropriate philosophical base and organisational structure for the future development of this work.

5. Significant momentum has been gained over recent years in identifying and increasing access to services for offenders and those at risk of offending and this should be further developed. The “localism” agenda requires organisations to have the capacity and capability to respond to the needs of excluded groups as well as the mainstream population but duplication of services, multiple governance frameworks and the growth of local infrastructures could be prolific; especially if there is division between the role and function of the National Commissioning Board (NCB), Specialist Commissioning, General Practice Consortia and Health and

Well Being Boards. The potential for fragmentation of existing services is a challenge so operational frameworks need to be clear enough to ensure effective delivery of agreed policy, standards and priorities but sufficiently flexible for local interpretation, innovation and cost effectiveness. The role and function of Public Health England could provide a championing and co-ordinating role which focuses on the outcome of reducing health inequalities. Evidence-based practice and epidemiological intelligence would inform the work.

6. There is a need for ownership of the demands placed upon the NHS by individuals and all groups of people; some of whom may be outside the remit and expertise of mainstream services. These people require systems which will support and encourage their access to services, in the context of their complex needs, and local services may need to draw upon specialist hubs or services in order to help them achieve positive outcomes. The integration of care pathways with partner agencies may enhance the outcomes to treat and care for individuals in an effective and compassionate way but they may also achieve a reduction in anti-social behaviours and prevent offending/reduce reoffending.^{vii, viii}

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Written evidence from Dr Stephen Watkins and Dr Vicci Owen-Smith (PH 23)

EVIDENCE BY THE DIRECTOR OF PUBLIC HEALTH AND DEPUTY DIRECTOR OF PUBLIC HEALTH FOR STOCKPORT

SUMMARY

1. DPHs treat populations as their patient, using health advocacy as a change agent, caring for people they cannot identify whose human tragedies reflect in health statistics.

2. Key health issues:

- alcohol;
- heart disease, cancer and inequalities;
- active ageing;
- active travel addressing obesity;
- strong social networks and civil society; and
- early years establishing inequalities.

3. Key health care issues:

- rising demand;
- alcohol-related hospital admissions;
- prevention reducing demand;
- optimising resources for greatest benefit;
- more efficient patient pathways;
- rationing treatments with minor or experimental benefits;
- pharmaceutical R&D making new drugs too expensive; and
- healthy ageing reducing cost of demographic ageing.

4. Implications:

- DPHs serve populations not agencies:
 - professional independence;
 - acting across the local authority, NHS bodies and other agencies; and
 - relating to business, community and voluntary sectors.
- Public Health England should be a ministerially-chaired NHS body.
- Health values apply across Government policies:
 - Government departments need Public Health Directors.
 - Alcohol, active ageing, and active travel need action.
 - Strengthening civil society is essential.
 - Without willingness to regulate, responsibility deals will fail.
 - Health Acts should improve health not just reorganise the NHS.
- Local authority NHS involvement should be done properly or not at all:
 - Doing it properly means:
 - councils being NHS bodies for health functions;
 - the NHS including council public health (as in 1948–74);
 - Health and Well Being Boards having real powers; and
 - councils receiving non-commissioning PCT duties.
 - Doing it not at all means:
 - not transferring public health;
 - constituting DPHs as NHS corporation soles; and
 - with both NHS and local government. powers and duties.
 - Our preference would be to do it properly.
 - Doing it not at all is preferable to separating public health from the NHS.
- Every NHS body needs public health input to its governing body.
- A population perspective is needed in commissioning:
 - NHS funding helps people—wasting it is unethical.
 - Health care public health organisation must address professional capacity and critical mass:
 - Direct local input and responsibility to local populations is important.
 - So is avoiding duplication and working with a population large enough for epidemiological stability.
 - Health care public health professionals need to work locally but cooperate in larger groups over larger populations.
- Dividing funds into prevention and treatment budgets is problematic:
 - Prevention costs less per QALY than treatment so the financial allocation needs rebalancing.
 - The Health Premium should apply to small areas to avoid disadvantaging deprived parts of polarised districts.
- Community organisers should be employed in public health.

WHO WE ARE/NATURE OF EVIDENCE

5. Stockport contains the five most affluent wards in Greater Manchester and the fourth worst LSOA nationally.

6. For 20 years it has reduced death rates from heart disease and smoking related diseases more than nationally and reduced inequalities.

7. This progress is threatened by adverse trends in alcohol related diseases in younger people.

8. Locality commissioning originated here. We have a single united Pathfinder consortium.

9. DPHs treat a population as a patient—recognising threats to health and prescribing responses. They care for people they do not know and cannot identify, whose human tragedies are reflected in health statistics. That is our job. Our evidence focuses on it.

10. It is personal professional opinion not corporate evidence. However using the office of DPH implies professional obligations about remit and scientific integrity. Like a judicial decision or an NHS prescription, it is neither personal nor corporate. That public health opinion falls in this category must be understood.

PUBLIC HEALTH ENGLAND

11. Public Health England (PHE) within the Dept of Health (DH) will have a civil service ethos, inappropriately for:

- separating delivery from policy;
- services directly provided by PHE;
- directly commissioning services in more interventionist styles than policy/regulatory roles;
- PHE performing duties to the political process and public rather than just Government;
- research—using academic contracts, applying for research grants, academic freedom, scientific integrity and the right to publish;
- workforce development; and
- external consultancy which PHE should offer and charge for.

12. PHE should be an NHS body, without increasing managerial cost or complexity. For direct line of sight ministers could chair the NHS body

THE PUBLIC HEALTH ROLE OF THE SECRETARY OF STATE

13. Secretary of State should articulate health within Government.

14. *Alcohol*—Life expectancy will fall if alcohol's impact on the post-1970 birth cohort continues as it ages. By 2040 two generations could enter dependency simultaneously. Russian experience suggests difficulty reversing an initially neglected epidemic.

15. *Government is too timid*—We believe in minimum price. It will impact on pre-loading (drinking at home before going out, to get drunk more cheaply) and remove the incentive to drink away from social pressures. Politicians may disagree, but should then pose an alternative.

16. *Healthy ageing*—As the first generation of men living their entire adult life in peacetime continues to age, the post-war baby boom enters old age and immigration is reduced by economic and policy pressures the choice is a dependent or active elderly population. The difference could be 5% of NHS resources. Active ageing is essential.

17. *Responsibility deals*—To negotiate seriously with business, public health needs an underpinning option of regulation

18. *The relationship to other departments*—Each government department needs a Public Health Director (not “DPH”—it serves an agency not a population).

19. *Legal proceedings defending public health*—The Chief Medical Officer could evaluate the public interest—the Attorney General, legal implications.

20. *The duty to promote equality* should affect outcomes not just access

21. *Health Acts should legislate to improve health*—Examples might include alcohol, transport and health, spatial planning or pricing of energy for heating.

The public health voice in major Government issues

(i) The Big Society

22. See later Marmot section

(ii) Health and Safety

23. Locally we distinguish safety from risk-aversion in child protection, defensive medicine and health messages. In safe societies mountaineers use proper equipment, watch the weather, report their route and expected return time and have a mountain rescue service. In risk-averse societies nobody climbs mountains.

24. Health and safety is a public health purpose. Bevan wanted it as part of the NHS.

25. DPHs could be empowered to promote sensible risk management and intervene in absurd bureaucratic risk-averse behaviour.

(iii) The Economy

26. Good health contributes to economic productivity, pleasant and healthy living conditions attract knowledge-based industries, patterns of economic activity influence health, economic dislocation causes health damage, well being measures economic success and disparities between economic and well being indicators might warn of emerging speculative bubbles.

27. A Public Health Director for the Bank of England should work with a Public Health Director for the Treasury and the DPH for the City of London.

LOCAL GOVERNMENT AND DPHs

Local Government in the NHS

28. Distinguishing “the health service” from the “NHS” wasn’t done from 1948–74 when local government last provided part of “the health service”. Public and environmental health was then part of the NHS. Bevan had them in mind when he said the NHS would improve the health of the nation. The NHS cleared the slums and cleaned the air. Local authorities will again have a “health service” role. The 1948–74 definition should be restored.

29. Public health’s proposed removal from the NHS contributed to massively declining support for transfer to local government. Involving councils in the NHS should be done properly. In their health service role, councils should be NHS bodies picking up non-commissioning PCT functions and having real powers for the Health and Well Being Board to enforce the health and well being strategy and for Healthwatch. Some NHS managerial resource should transfer.

30. If the transfer isn’t done properly it shouldn’t be done at all. DPHs should be NHS corporations sole with formal roles in local government and NHS commissioning and provider bodies. We could describe how this option might work. It isn’t our preference.

The Role of the DPH

31. The Bill defines DPHs as council officers overseeing public health functions transferred from PCTs. They should primarily be health professionals treating a population and independent advocates for health across public, commercial, voluntary and community sectors.

32. People can better be helped and nudged towards health by doctors or health professionals than by officials.

33. Public health specialists are change agents for the health of the people, using corporate authority and independent advocacy in appropriate balance. Guarantees of professional independence are needed.

34. The following roles require more than corporate authority:

- An independent annual professional report.
- Advocating public health across council decision making, for example provision of walking and cycling infrastructure.
- Health impact assessments of policies, programmes, and services.
- Public health advice to other agencies.
- Professional views influencing public opinion. From the 1930s to 1950s MOHs argued for clean air. From the 1980s DPHs advocated tobacco control. The town’s doctor must articulate a healthier future and contribute to opinion forming.
- Community cultural determinants of health won’t change in response to bureaucratic messages—DPHs must address communities openly and honestly as professionals committed to them.
- DPHs must deal with local businesses as experts and custodians of health not as council officers (although council contacts are also useful—environmental health officers locally have done good work with food businesses, including introducing salt shakers with fewer holes in fish and chip shops).
- The public health contribution to local professional leadership must not be lost or become a bureaucratic role.
- DPHs should be statutory consultees in planning, transport and environmental issues participating according to professional judgment.
- When DPHs conduct, or comment on, health impact assessment only professional public health opinion should influence their judgment. Pressures shouldn’t be brought to bear.

35. DPHs must be properly professionally qualified, necessitating statutory provision on appointments processes and qualifications.

36. Secretary of State’s reluctance to protect professionalism or establish appointments procedures was another major factor in support for the transfer (initially widespread) falling to only 11% of public health consultants.

37. This was aggravated by authorities and organisations making comments neglecting or rejecting the broad public health role, undermining authorities (like our own) which value it.

Small Districts and Two Tier Local Government

38. Stockport is a reasonably sized single tier authority.

39. District councils are close to communities. Important public health roles include housing and environmental health.

40. Any population sufficiently distinct to deserve a district council deserves its own DPH. Districts in shire counties should be included. However a full department may be unnecessary. Even larger organisations may share support functions.

41. DPHs in small districts will be part time with a department shared with other districts or, in shire areas, the county. The role could attract part-time applicants or dually accredited doctors combining part time general practice with part time public health or be combined with a consultant role at county level or in a shared department.

HEALTH CARE PUBLIC HEALTH

42. The NHS should protect and promote the health of the population, and commission services considering the impact on population health as well as individual patients.

43. Services must be matched with identified needs of patients. However, simply responding serially to individuals' needs (or wants), leads rapidly to uncoordinated services, uncontrolled financial resources, and increasing inefficiency.

44. Commissioning health services systematically needs a population health perspective, considering issues wider than only the identified patient. Integrating health care public health (HCPH) experts into commissioning systems incorporates those issues into commissioning decisions.

45. The HCPH subspecialty optimises the contribution the health care system makes to the health of the people through.

- healthcare's contribution to health;
- optimising resources;
- applying population perspectives to evidence;
- applying evidence to health service organisation; and
- assessing and prioritising population healthcare needs.

46. NHS funding helps people. Wasting it is unethical. Resisting NHS resource-optimisation isn't the moral high ground!

47. Locally our PCT has encouraged patients with wetAMD to use a service utilising the cheaper drug avastin rather than much more expensive lucentis. We have come under immense pressure without national support.

48. In the health bill, GP consortia have a duty "to secure continuous improvement in the quality of services provided to individuals for or in connection with—(a) the prevention, diagnosis or treatment of illness, or (b) the protection or improvement of public health" and "have regard to the need to (a) reduce inequalities between patients with respect to their ability to access health services (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health service". Separating Public Health from the NHS is unhelpful. GP consortia will require clinical public health expertise and associated resource to discharge these duties.

49. About 200 specialists practise HCPH.

50. Each health and well being board should have such a specialist. GP consortia need direct HCPH input. This can be achieved if local authority and consortium boundaries align and HCPH serves that population not specific agencies.

51. HCPH needs:

- a critical mass of analytical intellectual capacity; and
- epidemiological stability—a population large enough that predicted needs will not vary randomly to a destabilising degree.

52. To achieve this, whilst retaining local links, locally appointed HCPH specialists should cooperate over an epidemiologically stable population (at least a million) in a team with critical mass (at least four). (This describes team and population size not guideline ratios).

53. NHS providers need HCPH. Public health is needed on their boards.

FUNDING PUBLIC HEALTH SERVICES

54. We perceive dangers.

55. *Inadequate ring fencing*—NHS providers might increase funding by characterising growth areas as "preventive".

56. *Inadequate funding*—funding based on 2009–10 sums institutionalises past underspending. Preventive measures cost considerably less per QALY than treatment services. The system needs re-optimisation.

57. *Lack of access to NHS benefits*—local authorities funding alcohol prevention programmes need benefit capture to reflect savings from stemming the alcohol-fuelled rise in A&E attendances. We are locally exploring benefit capture to support risk investment through a Social Development Bond.

58. *Inclusion of destabilising areas in the funding.*

59. *PHE might have to pay for changes in NHS practice*—Primary care and secondary care should do more prevention. This involves changed practice not new resources but providers might expect payment. We have a local example with breastfeeding, smoking cessation and midwifery. This is an allocation of professional energy, a planning and managerial task rather than a financial burden, which should not have to compete with other spending priorities for actual money. A “money go round” should be set up.

60. *PCTs are cutting public health budgets*—Many PCTs are cutting public health budgets. Our own has been compelled to do so against its wishes. This may affect ongoing funding and anyway may mean loss of important skills and human resources with local authorities having to start from a position of neglect.

61. *Too much resource may be consumed centrally.*

62. *Will the cost of health visiting expansion be a call on the NHS budget as a whole or on a static PHE budget?*

63. *Will overheads be included in the budget* or will local authorities have to buy back or replace NHS support services such as buildings, training, communications, IT etc where previous public health access has not been accounted for.

64. *Errors (or deliberate protection of treatment budgets) could impact disproportionately*—The difference between cutting public health expenditure by 25%, keeping it constant or increasing it by 25% is the difference between NHS healthcare efficiency targets of 19%, 20% or 21%, (less than alcohol-induced pressures).

65. *Only NHS public health expenditure is protected*—An issue locally is the new city-region’s commitment to walking and cycling.

66. *Polarised authorities could be disadvantaged* if the Health Premium is allocated to districts rather than small areas.

WORKFORCE AND REGULATION

67. Non-medical specialists, valued colleagues appointed to roles identical to those occupied by public health doctors, should have statutory registration equal to that of medical specialist registration.

68. There should be transitional provisions for people now working on health issues in local government—several people locally deserve transitional allowance towards public health training. At least one is fit to be a consultant.

69. There are public health workforce development needs from transition to new employers and from shortages resulting from past decisions.

70. Government has not fully engaged with this problem. PHE should have a workforce development role, including powers to ration scarce resources and apply training levies.

71. Training must continue within the medical professional training system with a broader range of training placements.

72. If training is disrupted, new entrants are lost, and specialists in their 50s and 60s take retirement from disliking the new arrangements the shortage of specialists could become disastrous.

THE MARMOT REVIEW

73. Government is responding well with conventional healthcare responses but not in areas, like spatial planning or income inequality, requiring wider action.

74. We welcome commitment to health visiting and family nurse partnership and to screening uptake. We are locally prioritising uptake in deprived areas.

Spatial planning and transport

75. Incoming Ministers wound up a NICE PDG on spatial planning. A new PDG on walking and cycling has a remit excluding transport interventions.

Community development

76. There is strong evidence that social networks and civil society benefit health. Areas in Eastern Europe where membership of clubs and societies was above 46% avoided the alcohol epidemic.

77. Locally people are establishing a voluntary organisation Stockport4Health

78. The BMA in 2010 suggested community organisers in public health.

79. General practices, NHS bodies, local authorities, parish councils or voluntary organisations could provide, according to local interest and commitment.

80. One whole time equivalent community organiser per 10,000 population (on average—more in deprived areas and fewer in affluent areas) and a grants budget of £2 a head in the two most deprived quintiles could cost between £150 million and £200 million, less than 0.2% of the NHS budget

June 2011

Written evidence from the Chartered Institute of Public Finance and Accountability (PH 24)

THE ARRANGEMENT FOR PUBLIC HEALTH INVOLVEMENT IN THE COMMISSIONING OF NHS SERVICES

1. CIPFA believes it is particularly important that Public Health input into the Commissioning of NHS services continues and that NHS investment decisions continue to be supported by robust Public Health evidence.

2. There is the risk that with significant organisational changes, the NHS becomes focused on providing a treatment only service as Public Health responsibilities are transferred to Public Health England (PHE) and Local Authorities (LA)

3. The major risks within the NHS at the moment are as below:

- Budgetary constraints.
- An ageing population.
- Significant organisational change.
- Significant reduction in management capacity.
- Increasing prospect of competition and financial difficulties within current NHS providers, (particularly those with significant PFI commitments that cannot decommission services and reduce longer term fixed PFI costs).
- The revenue cost of new drugs and new technology.
- Increasing medical negligence costs.
- Increasing costs as a result of lifestyle choices relating to obesity, alcohol, smoking, poor housing and environmental factors.

The case for investing more in preventative strategies to reduce the longer term burden on the NHS has never been so persuasive.

4. The development of Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS) are key tools in the development of an integrated commissioning framework.

5. It is recommended that the duty of Partners to “have regard” to an agreed JSNA & JHWS when exercising their functions should be more clearly defined. We are concerned that the commissioning of complete care pathways for defined conditions may become more fragmented under these proposals.

6. CIPFA believes that Partners should demonstrate that recommendations in the JSNA and/or JHWS are given “due consideration” and that where material recommendations within these strategies are not or cannot be addressed the reasons for this are provided and recorded. A “comply or explain” principle should be applied here.

7. The need for a joined up approach to Commissioning, inclusive of Public Health input, is demonstrated in the example below.

The fragmentation of Commissioning is well illustrated within certain long term conditions where public health prevention, NHS care provided by GPs and specialists may all be commissioned by separate bodies. These arrangements will make service planning and commissioning around the patient more complex.

It must be recognised that there may be no single responsible Commissioner. An example for Diabetes is shown below.

- (a) Prevention and detection of Type 2 Diabetes via healthy weight & diet strategies and NHS Health Checks will be commissioned by Local Authorities.
- (b) (Local Authorities being responsible for health checks for Heart Disease, Stroke, Diabetes and Kidney Disease).
- (c) Treatment of Type 2 diabetes will be mainly by GP Practices commissioned by the NHS Commissioning Board.
- (d) Treatment of Type 1 Diabetes will be mainly by Specialists commissioned by Consortia.
- (e) Highly Complex Diabetes & Islet Transplantation carried out within specialist national centres could be expected to be commissioned via the NHS CB.

The example highlights the risk that comprehensive whole service strategic planning, the commissioning of integrated services, and the accountability and responsibility for services become more fragmented requiring the development of robust governance arrangements.

8. CIPFA supports the overriding principle that significant changes to NHS services should be accompanied by both a Public Health Needs Assessment (PHNA) and a Public Health Impact Assessment (PHIA) that confirms the need to address service gaps and the optimum solution for change respectively.

9. A public health needs assessment (PHNA) will determine whether health needs are being met by current service models or would be better met under proposed new service models.

10. The results of PHNAs are similar to those of value for money (VfM) assessments. The results can be categorised as:

- Needs are being met (consequence—move on to next assessment).
- Needs are not being met because there is no service (consequence—put forward for reform proposal).
- Needs are not being met because the current service cannot deliver its objectives.

The types of questions which need to be included in a PHNA are:

- What are the required public health outcomes of the service area?
- Is the target population clearly identified?
- What are the different models for achieving the outcomes and which is most suited to the local population?
- Does the management structure for the service facilitate the most suitable model?
- What are the local health inequalities and access issues pertaining to the service and does the current/proposed service model facilitate resolving them?
- What are the preventative measures available pertaining to the service and does the current / proposed service model facilitate achieving them?

The Public Health Impact Assessment (PHIA) is an integral part of the business case process and its purpose is to:

- Identify the potential health consequences of a proposal on a given population.
- Maximise the positive health benefits and minimise potential adverse effects on health and inequalities.

11. A Public Health Impact Assessment should be carried out during the planning process for early involvement activity. The main output is a set of evidence-based recommendations to inform the decision-making process for that proposal.

12. NHS organisations should consider undertaking a PHIA for most proposals affecting health services. Although there has been no statutory requirement to do this in the past, their preparation and publication make sure that professionals and service users can:

- Understand why change is being proposed.
- Understand how and to what extent proposed changes may impact on them.
- Understand the estimated costs and benefits of proposed measures.
- Identify potential unintended consequences.

13. A PHIA should include an examination of a proposal's potential impact upon each of the equality strands—ethnicity, disability and gender. It is good practice to consider other dimensions such as age, sexual orientation and religion or belief.

14. It is also important that NHS policy-makers continue to acknowledge the three aspects of Public Health.

- Health improvement.
- Health prevention.
- Quality and effectiveness of service provision.

15. It is equally important that the Public Health function can support both LAs and GP Commissioning Consortia (GPCC) without being critically fragmented.

16. PHE also have an important role to support this model with back-up information, intelligence and networking opportunities so that organisations having limited Public Health capacity and expertise can be supported.

17. Different Local Authorities may have different preferences for supporting or not supporting certain types of public health provision. Examples might include sexual health services, drug treatment services, HPV vaccination, children's height and weight measurement. PHE should consider developing a consistent set of principles to enable LAs to provide a consistent and core offer to vulnerable groups.

18. Principles could include a duty to reducing health inequalities and to promote social inclusion, and a duty to provide interventions that are evidence-based.

19. Public Health England can address current gaps in public health evidence by:

- Developing an information strategy to address information and evidence requirements.
- Commissioning of research for new evidence.
- Ensuring adequate resource for public health research and dissemination.

20. Partners nationally and locally can contribute to improving the use of evidence in public health by developing Community Health Profiles. Health and Wellbeing Boards (HWBs) should have resources for training and development in evidence-based decision making.

21. Nationally the NHS and PHE should make it clear that this evidence should be used.

22. Public HIA is also a useful tool for ensuring that evidence is used to underpin and delivery decisions.

Arrangements for Funding Public Health services, including the Health Premium

23. The ringfenced grant to Local Authorities for Public Health should initially be accompanied by:

- A clear definition of Public Health activities and services.
- A current schedule of NHS public health budgets.
- NHS Public Health commitments.
- Changes to NHS budgets to provide a transparent transfer from the NHS. These should include a baseline position of pay and non-pay budgets and staffing Whole time equivalents, together with efficiency savings that have been made prior to any transfer.

24. When introducing a health premium to incentivise reductions in inequalities there should be a regular re-assessment of requirements to ensure that health outcomes improve in practice.

25. In areas of higher deprivation that also face a significant reduction in Local Authority budgets account should be taken of the potential for public health outcomes to diminish as services to a number of vulnerable groups/charities are re-assessed.

26. It may be worth considering an allocation approach similar to the developed by the Accounting Advisory Committee for Resource Allocation (ACRA) for the NHS with appropriate pace of change policies to move departments to a fair share of resources.

27. It may also be useful to consider the introduction of some form of peer support similar to the schools “special measures” process. There is also a significant emphasis on improving children’s deprivation though an increasing number of Health Visitor posts and other initiatives. It is important to acknowledge that children’s deprivation may stem primarily from their parents’ deprivation (resulting from multiple and complex factors).

June 2011

Written evidence from the Food Standards Agency (PH 25)

SUMMARY

- The Food Standards Agency is a non-Ministerial Government Department with UK-wide responsibility for food safety. We have a vital public health protection role through policy development, statutory duties and direct enforcement in certain sectors.
- We welcome the proposal to increase the priority given to improving public health and will work closely with the Department of Health during the planning and implementation of proposed changes to ensure the continued protection of public health from food related risks.
- Particularly important to maintaining the FSA’s ability to carry out its statutory roles in public health and consumer protection will be ensuring that support currently provided by the Health Protection Agency is continued when its functions are incorporated into Public Health England.

INTRODUCTION

1. The Food Standards Agency (FSA) is a non-Ministerial Government Department operating at arm’s length from Ministers, and governed by a Board appointed to act in the public interest. The FSA has UK-wide responsibility for food safety and protecting other consumer interests in relation to food and our remit is set out in the Food Standards Act 1999. Our priority is to deliver safer food for the nation.

2. The FSA was set-up following the food safety crises of the 1980s and 90s—*Salmonella* in eggs, BSE and the 1996 Scottish *E. coli* O157 outbreak—with the dual aims of an enhanced focus on controlling public health risks associated with food and re-building public confidence in the safety of food. Our remit includes protecting the public from microbiological, chemical, and radiological risks that could be transmitted via food.

3. The FSA is a science and evidence-based organisation with openness and transparency at its core. Policy development is based on the best independent scientific advice and evidence available and this has been crucial in improving food safety and re-building public trust in the safety of food.

4. Until October 2010, in addition to our responsibility for food safety, the FSA shared responsibility with the Department(s) of Health for nutrition policy across the UK. The FSA had an integrated nutrition policy programme with the overall aim of making it easier for consumers to choose a healthier diet. Strategic targets included reducing population salt and saturated fat intake, contributing to achieving a balance between calorie intake and energy output and encouraging improved nutrition labelling to help consumers make healthier choices.

5. There was considerable synergy between the FSA's work on food safety and nutrition. For example, work with the food industry by FSA nutrition teams to support and encourage re-formulation of products to reduce salt, sugar and saturated fat levels was supported by FSA food safety experts via an assessment of any food safety risks inherent in undertaking re-formulation. There was also considerable work at a local level to promote both health improvement and health protection activities jointly. This included provision of grants to support local initiatives on food safety and healthy eating and the development of a food competency framework for schools covering both food hygiene and nutrition. The FSA's national consumer facing campaigns (eg on salt and saturated fat reduction) were amplified at local level through joint work with the health sector, local authorities (LAs) and voluntary and community organisations.

6. Following Machinery of Government changes in 2010 nutrition policy in England and Wales moved to the respective Health Departments, although responsibility for nutrition policy is currently maintained by the FSA in Scotland and Northern Ireland. In England, this change will enable work on public health improvement through improved dietary health to be fully incorporated within the proposed Public Health England (PHE) framework. However, to ensure that FSA responsibilities in this area are fully supported in Scotland and Northern Ireland it is important that the FSA and the Department of Health (DH) work closely together. This will minimise the potential for policy divergence across the UK and ensure that the FSA has continued access to independent scientific advice (eg from the Scientific Advisory Committee on Nutrition) and critically important UK-wide datasets such as that collected through the National Diet and Nutrition Survey.

CURRENT ROLE OF THE FSA IN PROTECTING PUBLIC HEALTH

7. Food safety is the FSA's main priority and the reduction of foodborne disease is a key FSA objective. We undertake a wide range of activities to ensure food safety and work closely with public health professionals to deliver this.

8. Foodborne illness is a significant public health problem. Annually there are estimated to be about a million cases of microbiological foodborne disease in the UK, leading to around 20,000 hospitalisations and 500 deaths at a cost of £1.5 billion to the UK economy. Allergens and food intolerances also add significantly to the public health burden with around 3,500 hospitalisations due to allergic responses and around 5,000 due to the most common food intolerance (coeliac disease) in 2008–09. Burden of disease attributable to chemical and radiological risks associated with food is more difficult to define, particularly for chemical contaminants where risk accumulates over a lifetime and is difficult to link to health outcomes. However, more than half the food contamination incidents that the FSA deals with every year are due to chemical contaminants—around 890 incidents in 2010.

The FSA's role as a regulator

9. The FSA is the Central Competent Authority responsible for Official Controls for food and feed in the UK. The FSA Operations Group has overarching responsibility for the implementation and effective delivery of these Official Controls across the UK through direct enforcement or through other enforcement delivery partners.

10. Official controls are delivered directly by FSA Operations Group staff in slaughterhouses and meat plants throughout England, Wales and Scotland to ensure that meat is produced safely and hygienically. Official Controls are delivered on behalf of the FSA as the Central Competent Authority by over 400 Local Authorities in UK. LAs have regulatory responsibility for the food and feed safety, hygiene and standards official controls of the majority of UK food businesses, and at UK borders (sea ports and airports). The FSA's role as the central regulator is to monitor the delivery of LA official controls, which it does through the support provided by regionally based staff and by performance monitoring and audit.

Specific FSA programmes to reduce public health risks from food

11. In addition to the regulatory activities we undertake there are a range of specific programmes of work that have been established to help improve public health by reducing the burden of UK foodborne disease—either by tackling it directly or working to improve standards in food businesses, resulting in the production of safer food. In developing and delivering these programmes of work we actively collaborate with partners at the local level and with a range of public health professionals including LAs and the Health Protection Agency (HPA).

12. A key programme is the introduction of the Food Hygiene Rating Scheme in partnership with LAs in England, Wales and Northern Ireland. The scheme provides consumers with easy to use and understand information on hygiene standards in the places they eat out or shop for food and draws on the power of the choices they make to incentivise businesses to improve standards. Since its launch in November 2010, momentum for the scheme has gathered and it is anticipated that all the LAs in Wales, around 70% of LAs in Northern Ireland and 40% of LAs in England will be operating it or preparing to launch it by the end of June 2011. The aim is that it will be operating across England in time for the 2012 Olympics & Paralympics. A similar scheme, the Food Hygiene Information Scheme, is being introduced in Scotland with 60% of LAs having launched it to date.

13. The FSA's responsibility for ensuring food safety was highlighted in the Public Inquiry of the *E.coli* outbreak in Wales in 2005. As a result we have developed the Food Hygiene Delivery Programme, which is enabling us to strengthen our work with food businesses and LAs. We have already published comprehensive guidance for food businesses on controlling cross-contamination, provided focused update training for local enforcement officers, introduced sense-checking of LA inspections to ensure they are not an exercise in "box ticking", carried out a review of legal powers and commissioned research on food safety culture in businesses. This enables us to push for change and will contribute to our overall strategic objective of safer food for the nation.

14. We are also assisting food businesses, particularly small and medium size enterprises, to produce safer food by helping them to comply with food safety management (HACCP) requirements of food hygiene legislation. To do this we have developed and issued practical advice and guidance through systems such as "Safer Food, Better Business".

Microbiological foodborne disease

15. We are specifically tackling the root causes of microbiological foodborne illness through our Foodborne Disease Strategy. This aims to reduce microbiological foodborne disease by targeting the pathogens that have been identified as causing the greatest burden of disease. FSA food chain analysis has shown that the pathogens whose reduction and control offer the greatest potential for public health gains are: *Campylobacter* (causes the most cases of food poisoning—estimated to be around 630,000 cases in the UK in 2009); *Listeria monocytogenes* (responsible for approximately 30% of food poisoning deaths) and viruses (responsible for an increasing number of cases). The strategy is based on a farm-to-fork approach, with the aim of reducing contamination of foods during production and processing and of promoting good food hygiene practice in the kitchen, both commercially and in the home. Crucial to this work is our active partnership with, and support from, the HPA.

Chemical and radiological risks from food

16. The FSA is also responsible for protecting consumers from chemical and radiological risks in food. We provide risk assessment and risk management advice, drawing on in-house expertise in toxicology and exposure assessment as well as advice from relevant independent scientific advisory committees. A key strategic aim is to increase horizon scanning and improve forensic knowledge of, and intelligence on, global food chains to identify and reduce the impact of potential new and re-emerging risks—particularly around chemical contamination. We are also seeking to increase the provision of information about allergens, including in catering establishments.

Incidents

17. The FSA leads the Government response to food contamination incidents (chemical, microbiological and radiological) and is increasingly involved in the cross-departmental Government response to wider food contamination incidents such as radiation, flooding, fires, chemical leaks and oil spills; that call for advice on food safety. The FSA has managed more than 10,000 incidents of varying nature and complexity during its lifetime, including 1,505 incidents in 2010. The Agency works closely with the HPA (in England), enforcement authorities, food business operators, and other key stakeholders in order to manage incidents appropriately and proportionately.

PUBLIC HEALTH ENGLAND

18. Outlined in the white paper "Healthy Lives, Healthy People: Our Strategy for Public Health in England" is the intention to create Public Health England (PHE), incorporated within DH and accountable to the Secretary of State for Health. The intention is that PHE should lead health protection in England, set the overall outcomes framework for public health and work across Government, with the NHS Commissioning Board and national partners to support local public health action, including through funding, the provision of evidence and data, and professional leadership.

19. However, responsibility for leading health protection activities relating to food safety remains with the FSA, as part of our statutory duties, outlined in the Food Standards Act 1999. PHE and the FSA will therefore need to work closely together to ensure appropriate alignment and prioritisation of food safety-related health protection outcomes delivered through PHE, FSA and local government activities.

HPA support for the FSA

20. The HPA provides a range of specialist services and scientific support and advice vital to enable the FSA to discharge its public health responsibilities.

21. The HPA currently collects, analyses and publishes data for England on a number of notifiable diseases including gastrointestinal infections caused by foodborne pathogens. The high quality monitoring and surveillance data on these infections currently provided by the HPA (including those caused by *Salmonella*, *Campylobacter*, *E. coli* O157, *Listeria* and Norovirus) is vital to the FSA and underpins the FSA Foodborne Disease Strategy. The FSA's work on the investigation and management of outbreaks of foodborne disease is made possible by the results of microbiological testing, allied to sophisticated typing work carried out by the HPA, which enables the epidemiology of the spread of disease to be determined and controlled. Although many outbreaks can, and are, managed locally, where they have an impact that extends beyond local boundaries and resources, HPA resources and its established links with equivalent bodies in the devolved nations (eg Health Protection Scotland) are vital in ensuring that we are able to deal with national or international incidents. An example where the importance of this support is fully demonstrated is the current large and very serious *E. coli* outbreak centred in northern Germany.

22. Regional HPA Food, Water and Environmental microbiology laboratories are equipped to carry out a range of specialist microbiological tests on food, water and environmental samples. Specialist testing (ca 180,000 tests/year) is conducted to determine the microbiological quality of food and water samples and to check on a regular basis that they are safe for human consumption, for LAs and other stakeholders.

23. The UK Food Surveillance System (UKFSS) is a real time system which collates data on chemical and microbiological analysis of official control samples taken by Food Authorities. The system can be used to monitor trends, track foodborne illness outbreak sampling, identify food hazards as they arise and help LAs verify food businesses' food safety controls. The FSA are currently rolling out UKFSS to LAs across the UK. In England linking the system to Public Health Laboratories for microbiological samples is being done in partnership with the HPA, for all laboratories in time for the 2012 Olympics, to increase public health protection by improving recording of sample data and streamlining of LA resources.

24. HPA scientists also undertake substantial amounts of research for the FSA, particularly supporting our work on microbiological foodborne disease. This includes undertaking large projects to explore the epidemiology of *Campylobacter* infection and being a major participant in the recent large second study of infectious intestinal disease (IID) in the UK—designed to allow a greater understanding of the burden of IID in the UK population, including foodborne disease.

25. The HPA are an advisory body to Government on radiological protection issues and provide important support for the FSA's duties in this area (including in Scotland). The HPA assess proposed changes to radiological protection standards and methods and provide advice on interpretation of international standards and methods to ensure consistency of approach across Government.

26. Since the Chernobyl accident in 1986, the HPA have aided the FSA's preparations for emergency response and supported them during nuclear exercises and during the recent Fukushima incident. They are an important source of advice during policy development on setting of acceptable levels of radiological contamination in food. HPA radiological laboratories offer an analytical service for mixed diet samples collected under a European requirement as part of the UK's show of compliance for Articles 35 and 36 of the European Atomic Treaty.

Impact of the abolition of the HPA and formation of PHE on the FSA

27. The abolition of the HPA and the integration of its function into a Ministerial Government Department has some important implications for the work of the FSA. As outlined above (paras 20–26) the HPA provides substantial support for our work. This will need to be continued, supported and appropriately prioritised when these functions become integrated into PHE.

28. In particular, there is a substantial body of scientists with international standing within the HPA in the field of foodborne pathogens, epidemiology of foodborne disease and radiological protection, which will be integrated into PHE. The FSA is keen to ensure that we can continue to rely upon them for independent scientific advice and can continue to commission high quality independent scientific research from them to support our policy priorities. Given the remit of the FSA and our ability to publish the advice we give to Ministers it is crucial that scientific advice and data we base our policies or advice upon is seen to be independent.

29. In addition to supporting FSA activities in England certain HPA functions (including advisory and monitoring services for chemicals and radiation as well as particular specialist laboratory services) are also accessed to support health protection activities in Scotland and it is important to ensure continuation of this support.

THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

30. LAs are key to the delivery of official controls in the food chain. They operate through regulatory teams (environmental health and food standards), often with a wide range of allied responsibilities and statutory duties which they perform for the FSA and other authorities. Their work underpins public health in the widest sense, and ensuring high standards of food safety and food standards is an integral part of their wider work to support community health and well-being. The FSA actively supports LAs in the work they deliver on food safety through provision of advice, guidance and training. The FSA and PHE will need to be clear about roles and responsibilities, align work and identify synergies to make effective use of local authority resources, for example to reduce levels of foodborne disease in vulnerable groups.

CONCLUSION

31. The FSA is a UK statutory body with responsibility for leading health protection activities relating to food safety. We welcome the proposal to increase the priority given to improving public health and emphasise the importance of DH working closely with the FSA to ensure that the proposed changes do not adversely impact on our ability to deliver safer food for the nation.

June 2011

Written evidence from LighterLife (PH 26)

EXECUTIVE SUMMARY

LighterLife programmes provide a multi-component, effective and cost efficient weight-management solution for people who are heavily obese and have large amounts of weight to lose. Problems with public health in England have meant that such programmes have often been overlooked when it comes to treating overweight and obese individuals.

The reforms proposed by the Coalition Government present a number of potential improvements to the system. However, questions remain about a number of areas. LighterLife would make the following recommendations:

- LighterLife welcome this Government's evident interest in tackling the pressing public health issues that affect this country and commitment to public health, the funding of which has been ring-fenced. We consequently hope that sufficient resources will be allocated to effectively improve public health. With the Foresight report estimating that two thirds of men could be obese by 2050, LighterLife would like to see appropriate and sufficient investment in the provision of effective, and cost-effective, weight-management options.
- It is encouraging to see central government planning to work more and more with local government on improving public health, as both have a considerable financial stake in ensuring that England's population becomes healthier. As it stands, however, there are considerable fears that the systems and processes that should be in place to ensure that the two work effectively with each other are not there. This threatens to undermine the Government's stated aims and set back improving public health.
- The experience of many obesity professionals with the QOF incentive scheme for GPs has shown that simply incentivising people to register the numbers of overweight and obese people is ineffective. LighterLife would like to see the Public Health Outcomes Framework recognise this by measuring the number of people that are treated for overweight or obesity instead.

INTRODUCTION

1. LighterLife is a UK company offering weight loss and weight-management programmes for people who are clinically obese or overweight. Our programmes are based on the recognition that lasting weight-management success can only come by addressing the underlying reasons behind weight gain. Without this understanding, weight re-gain is highly likely.

2. The LighterLife programme was researched and developed over many years before finally being launched in 1996. In 2007 LighterLife for Men was established—the only national weight-management and coaching programme developed specifically for men. In November 2008 LighterLife Lite was launched—a weight-loss programme for overweight people, with one to three stone to lose (BMI 25–29.9).

3. LighterLife is supported by expert teams, including nursing and nutrition advisors, a medical director, psychotherapist support and a medical advisory board, comprising international experts in obesity, metabolism, endocrinology, clinical nutrition and psychology. The board's role is to review all clinical aspects of LighterLife, and provide advice and direction to ensure compliance with best practice applicable to the use of very-low-calorie diets (VLCDs) and low-calorie diets (LCDs), current evidence-based research and health guidelines, including NICE guideline 43 on obesity. This ensures the best possible programmes are delivered, thus facilitating safe and effective weight loss.

LIGHTERLIFE PROGRAMMES IN DETAIL

4. LighterLife offers multi-component programmes, with increased physical activity, behavioural change and healthy eating being key features. The emphasis is on identifying personal psychological drivers of obesity and overweight. This enables individuals to achieve a healthier and manageable BMI by making sustainable changes to the way they eat, think and live.

5. Weight loss is initiated via either:

- LighterLife Total—a VLCD for the obese (BMI $\geq 30\text{kg/m}^2$) or for women/men with BMI $\geq 28\text{--}29.9\text{kg/m}^2$ and a waist circumference $>88\text{cm}/102\text{cm}$, using four nutritionally complete Foodpacks per day

OR

- LighterLife Lite—an LCD for the overweight (BMI $25\text{--}29.9\text{kg/m}^2$), combining three nutritionally balanced Foodpacks (including soups, shakes, bars and porridge) per day with a meal from a selection of specified foods to provide key nutrients and energy during weight loss.

6. In conjunction, LighterLife Weight-Management Counsellors work with participants in single-sex, weekly groups (maximum 12) to facilitate techniques from transactional analysis and cognitive behavioural therapy. Developed for behavioural modification in weight management, these techniques aim to help participants understand their relationship with food and develop new skills to support healthier eating and lifestyle behaviours, including being more active.

7. Following weight loss, LighterLife's Management Programme focuses on establishing a healthier lifestyle through the continued development of a healthier psychology. It empowers people with coping mechanisms developed in the weekly group meetings to support ongoing change, both physical and emotional. This enables sustainable weight management and a reduction in the risk of weight-associated co-morbidities. The Management Programme progresses individuals to a healthy, balanced and varied diet, consistent with current advice on healthy eating, and support meetings and weight checks are free for life.

8. We would like to thank the Health Select Committee for the opportunity to comment on the Coalition Government proposals for public health. While our comments will focus, for obvious reasons, on obesity, we hope that these examples illustrate wider issues with the Government's planned changes in public health.

ANSWERS TO SPECIFIC QUESTIONS

The creation of Public Health England within the DH

9. Although LighterLife welcomes the establishment of Public Health England (PHE) as a co-ordinating body for public health, we have some concerns that its remit is too narrow.

10. Ideally, LighterLife would like to see PHE take a strong role in guiding the myriad commissioning bodies towards treatment options that are both effective and cost-effective and based on clinical evidence. Such guidance will ensure that there is a more uniform national approach towards obesity solutions, which will help to reduce not only inequality across the country but will also allow for more innovative solutions to be taken forward and applied.

11. PHE should also find a role as a provider of the latest clinical evidence, underpinning the services that local commissioners wish to use. This would complement and enhance NICE's already existing role. The need for this is explained by the fact that NICE clinical guidance is only reviewed at most once every three years.

The public health role of the Secretary of State

12. LighterLife welcomes the Secretary of State's role in improving public health in England. There is no doubt that for this improvement to happen strong political leadership is needed; considerable resources are required to slow the rising obesity rate in this country, let alone to actually reduce it. The 2007 Foresight Report on obesity predicted that by 2050 obesity alone could affect 60% of adult men, 50% of adult women and 25% of children. The resulting costs to the NHS could be in the region of £10 billion a year, with wider costs to society reaching nearly £50 billion annually.

13. Resources targeted at treating obesity now will benefit not just the individual who is able to lose weight, but also the future NHS and taxpayer, who will not have to pay to treat illnesses related to obesity, such as Type-2 diabetes. Priority must be given to ensuring that public health programmes are properly funded.

The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)

14. There is plenty to recommend the involvement of local government in public health. Although not responsible for direct healthcare costs, local authorities will be responsible for related costs, and it is right that

they should have a say in how public health spending is prioritised in their area not least because they are in a better position to be more familiar with local needs.

15. Localities can also act as laboratories, enabling them to experiment and innovate with approaches that work best for them and sharing best practice with other local authorities.

16. This all assumes that central government and local government will be able to work effectively together; we are concerned that this is too big an assumption. Though it is vital for improving public health outcomes that the centre and the regions work well together, LighterLife is concerned that the systems that will ensure this are not in place.

17. A related concern is about funding. The Government has promised £4bn in ring-fenced public health spending, something to be welcomed considering that such spending has too often been the first to disappear in previous times of austerity. Nevertheless, with local authorities suffering a considerable cut in funding they may be tempted to stretch the definition of public health and divert funding away from more pressing concerns, such as obesity treatment.

18. In addition, our experience with local designs for public health interventions finds that they are often a poorly designed intervention with unrealistic funding expectations. The programme that current local public health providers such as PCTs want to commission for their obese population often seeks a small total weight loss of 5kg to be achieved by end of the 12 week intervention period, with a long term maintenance weight loss of only 2.5 kg six months after the intervention. However, for a significant health benefit to occur, most obese people would need to lose much more than that, and at least 5–10% of their weight. Such weight loss could be achieved by an effective programme such as that provided by LighterLife.⁵

19. Furthermore, in most cases of local public health interventions, the budget provided per person per week is low; for example, as little as £3 is provided, per person, per week, while private providers are more expensive (LighterLife's programmes that replace the totality of a person's diet cost £72 per week, which does include all of the person's meals). As such the public health intervention as proposed by a PCT often leads to a loss of money/investment while contributing neither to the reduction of obesity nor the reduction of the prevalence of obesity related illnesses. Effective, yet privately provided, programmes are deemed to be too expensive and the rate of weight loss experienced on the programme too high to be successful at the tender. In the longer term, however, use of effective weight-loss and weight-management programmes will help many people lose weight and prevent a great many people from becoming obese, preventing them from developing obesity-related conditions, such as Type-2 diabetes, that are expensive to treat.

Arrangements for public health involvement in the commissioning of NHS services; arrangements for commissioning public health services

20. As a provider of weight-management programmes, LighterLife has concerns that the commissioning of weight-management/obesity services in particular has become confused. There are three types of treatment for obesity, two of which are provided by the NHS—bariatric surgery at one, extreme end; drug treatment at the other, milder end. Weight-management services, which fill a crucial gap in between expensive surgery and often ineffective drugs, are to be commissioned by local authorities. The potential for confusion is clear and clarification is required.

21. Despite this, LighterLife strongly believes that there should be strong cooperation between the different institutions/authorities that share responsibility for tackling public health and weight-management issues in particular. Such cooperation will help to ensure the much needed balance between national guidance that can help to increase the provision of uniform solutions for obesity and the specific needs required at local level.

The structure and purpose of the Public Health Outcomes Framework

22. Although LighterLife appreciates the Government's intentions with this Outcomes Framework, obesity is one of the most important pressing public health issues as it affects so many people. The Outcomes Framework needs to reflect this and one way it can do this is by featuring indicators that measure an area's progress in lowering the obesity rate, rather than simply measuring the prevalence of healthy weight.

23. Simply doing the latter, as this Outcomes Framework proposes, will not have the impact required. The experience of many public health professionals with the GP incentive scheme, the QOF, has shown this.

24. If the Outcomes Framework is adjusted so that it highlights those authorities that are most successfully tackling obesity, other local authorities will also be incentivised to learn and share best practice.

25. Developing an indicator that measures progress in tackling obesity would encourage transparency in local authorities, as they would be required to demonstrate that they are actively tackling the problem identified and thereby helping to reduce health inequalities.

⁵ Hallam C *et al*, *Evaluation of LighterLife Total VLCD programme run in an NHS GP practice to provide weight-loss treatment for obese patients with BMI ≥37*, European Congress of Obesity Paper 2011.

Arrangements for funding public health services (including the Health Premium)

26. It is significant and welcome that the Government has chosen to ring-fence the public health budget, particularly at a time of austerity. Too often in the past this budget has been targeted for cuts and the least well-off have suffered accordingly. In view of the number of people whose lives are blighted by this condition and past inadequate designs for interventions, LighterLife hope that Local Government will allocate sufficient and much needed funding from this budget to effective weight-management treatments.

27. A Health Premium will only produce results if it is spent on services that actually help an individual improve their health. As noted above, the Outcomes Framework should measure an area's progress in lowering the obesity rate, rather than simply measuring the prevalence of healthy weight, to enable better targeting of the Premium.

How the Government is responding to the Marmot Review on health inequalities

28. 2010's Marmot Review into health inequalities noted that "as in other high-income countries, in England, obesity is associated with economic and social deprivation...and is becoming increasingly common". Prevalence of overweight and obesity is strongly linked to lower socioeconomic groups and the areas of England with the highest obesity rates are amongst the poorest.

29. Well directed and well targeted use of extra money distributed under the auspices of the Health Premium will incentivise Local Authorities to actively try and bring down the local obesity rate. In particular, use of private providers who can provide clinically effective and cost-effective weight-management services will demonstrate value for the extra money invested.

30. Private providers such as LighterLife are especially well equipped to deal with health inequalities as our local Weight-Management Counsellors are often able to access hard-to-reach groups (eg ethnic minorities). Government can help through increased use of Personal Health Budgets, which give the user greater choice and control over their own treatment.

CONCLUSION

31. Whilst LighterLife broadly welcomes this Government's plans for an appropriately funding public health service, there are still a great many issues which require clarity. It is not clear, for example, how much funding will be available to treat obese and overweight patients and thus help prevent future public health problems.

32. Similarly, LighterLife has considerable concerns about the practicalities of the system that the Government has proposed. Who will ensure that central and local governments work effectively together? How will the Public Health Outcomes Framework encourage steps to actively tackle obesity in certain areas? We hope that this inquiry casts some more light on these proposals.

July 2011

Written evidence from the Academy of Medical Sciences (PH 27)

OVERVIEW

The Academy of Medical Sciences welcomes the opportunity to respond to the public health inquiry from the Health Select Committee. As the independent body in the UK representing the whole spectrum of medical science, with a Fellowship that includes some of the UK's foremost experts in public health, the Academy is well placed to contribute to future public health strategy in England. We would be happy to provide additional evidence and advice to the Committee.

Researchers in public health and epidemiology in the UK are amongst the best in the world and they have made valuable contributions to improving the health of the UK population. Enormous potential exists to nurture and develop these strengths. To address future health challenges effectively, a well-rounded strategy that includes public health measures is required.⁶

The Academy welcomes the emphasis that the Government's White Paper "Healthy lives, healthy people" places on research evidence, the social determinants of health, health inequalities, disease prevention and a life course approach, as well as the creation of a National Institute of Health Research (NIHR) School for Public Health Research and the NIHR Policy Research Unit on Behaviour and Health.⁷ However, we are concerned about the scale and speed of the changes proposed. It is essential that adequate time for effective piloting and evaluation is built into a timetable for change.

⁶ Academy of Medical Sciences (2010). *Reaping the rewards: a vision for UK medical science* <http://www.acmedsci.ac.uk/p48prid78.html>

⁷ Department of Health (2010). *Healthy lives, healthy people: our strategy for public health in England* <http://www.dh.gov.uk/en/PublicHealth/Healthyliveshealthypeople/index.htm>

In this response we will recommend that:

- There should be a duty to promote and engage with public health research throughout the new public health structures including Public Health England, the National Commissioning Board, Commissioning consortia, all “willing providers”, Monitor and local authorities.
- Public health policy should be informed by evidence from rigorous public health research.
- The function of providing independent advice to the Government currently performed by the Health Protection Agency must remain independent from the Department of Health.
- The Secretary of State and the rest of the Government should promote knowledge exchange and continuity of public health work.
- Public health doctors should be encouraged to engage with the new public health structures and should retain their NHS terms and conditions if employed by local authorities or the civil service.

The development and use of evidence

The field of public health evolves continually as populations and society change. Therefore it is essential that the findings of rigorous public health research inform new policies and practices and are utilised in the necessary ongoing evaluation of existing policies. There should be a cross-governmental understanding of the importance of using public health research evidence in developing public health policies and practices. Furthermore, there should be a duty to promote and engage with public health research throughout the new public health structures including Public Health England (PHE), the National Commissioning Board, Commissioning consortia, all “willing providers”, Monitor and local authorities.

The manner in which public health research is communicated is crucial to our ability to capitalise on the potential benefits. Knowledge exchange between researchers, policy-makers and service providers that is open and bi-directional both facilitates sensitive and relevant research and informs timely and effective policy-making. Institutions involved in public health should play an active role in facilitating this exchange. Without effective knowledge exchange, increased localisation and fragmentation of public health activities can lead to duplication of work. Fragmentation could also make it more difficult for organisations to maintain the critical mass of expertise that will ensure that public health work is of world-class quality.

Where public health interventions are deemed necessary, the level of intervention should be based on the best available research evidence. We are concerned that the evidence to support the use of nudging as a means of improving public health is weaker than that which supports other forms of intervention. The Government should aim to design interventions that are supported by the best available research evidence.

The Government’s White Paper proposed a new Public Health Responsibility Deal that aims to make use of voluntary agreements with business and other partners such as the food and drinks industry.⁸ While it is important to engage with a wide range of stakeholders, the commercial interests of such industries can conflict with public health goals and should thus be kept in perspective.

The creation of Public Health England within the Department of Health and the abolition of the Health Protection Agency

Public health research is widely recognised as a fundamental part of healthcare provision. As previously stated, a unified approach to public health is key to effective policies and practices and a commitment to research must run throughout the new public health structure. As the new professional public health service, PHE must lead on promoting and engaging with research.

Independent research evidence is critical for responding effectively to and understanding public health crises. One of the key roles of the Health Protection Agency (HPA) has been to advise the Government on strategies for dealing with public health emergencies, such as pandemic influenza. The research evidence that informs the HPA’s advice can be controversial and it is important that the Government receives unbiased information.

If the role of the HPA as a source of independent research and evidence is undertaken within government, its ability to provide independent advice will be threatened. Therefore this role should be placed outside of the Department of Health.

The HPA is a highly respected research body and a large proportion of its current research funding comes from research councils, the National Institute for Health Research and charities such as the Wellcome Trust.⁹ Many of these funders’ eligibility criteria exclude Government Departments. The proposed move to the Department of Health is already threatening the HPA’s ability to apply for and undertake independently funded research.

⁸ Department of Health (2010). *Healthy lives, healthy people: our strategy for public health in England* <http://www.dh.gov.uk/en/PublicHealth/Healthyliveshealthypeople/index.htm>

⁹ Wellcome Trust (2011) *Wellcome Trust response to “Healthy Lives, Healthy People”* http://www.wellcome.ac.uk/stellent/groups/corporatesite/@policy_communications/documents/web_document/wtvm050959.pdf

The public health role of the Secretary of State

Under the proposed public health structures, commissioning of public health services will be divided between different government and NHS bodies. Within these new structures, knowledge exchange becomes more critical to achieve a cohesive approach to public health.

To promote continuity, the role of the Secretary of State should reflect the duties and responsibilities of the entire public health structure. The Secretary of State should lead in promoting medical research—including public health research—and putting evidence into action.

The Secretary of State should also take a lead role in facilitating knowledge exchange between those bodies involved in public health research, service provision and funding. This knowledge exchange should run throughout the Government Structures, with academia and the NHS.

The Academy welcomes the establishment of the Cabinet Public Health sub-Committee. Research evidence from a variety of reliable sources, including public health bodies, the NHS and academia should inform their discussions.

The future role of local government in public health

The Government's proposal to bring public health responsibilities under local authorities presents a number of opportunities, but several concerns must be addressed in order to capitalise on them. Local authorities should be supported to promote and engage with public health research, especially as they do not have the same history of engagement with this field as other areas of the health system. This will enable them to fully capitalise on the potential benefits of research to patients and communities. To achieve this goal, issues of fragmentation, resource allocation and addressing the needs of public health doctors must be addressed.

Fragmentation and duplication of work by local authorities in different regions should be reduced by encouraging effective knowledge exchange laterally and vertically within public health structures. There should be clear and direct lines of communication between local authorities and PHE regarding public health research, policies and practice.

The Academy welcomes the Government's proposal to ring-fence local authority budgets for public health. Local authorities are coming under increased pressure to make efficiency savings on already stretched budgets. Efforts should be made to ensure that this does not cause existing local authority activities to be re-branded as public health, diverting funds from genuine public health needs.

The Academy recognises the potential benefits of increased localisation of the public health system, which could encourage a more cross-cutting approach to public health across government. A great deal of activities under the control of local authorities influence public health, such as education and transport. To capitalise this continuity of service, local authorities should be given greater regulatory power in the area of public health.

The Academy welcomes the Government's recognition that public health doctors are important for delivering an effective public health service at a local level. However, efforts must be made to ensure that those doctors are not isolated from their colleagues in the NHS and academia. If public health doctors are employed by local authorities or as civil servants they will lose their NHS terms and conditions of employment. This could generate a two-tiered workforce, creating disincentives for doctors to specialise in public health. Local authorities can benefit from the wealth of experience that top specialists—such as clinical academics—bring and care should be taken to ensure that public health remains an attractive career choice. Links with higher education institutions for training, validation and research collaboration should be preserved.

Future public health research goals

Extraordinary recent advances in science and technology offer major research opportunities in public health. Priorities for future research include:

- The use of large datasets derived from routine patient care.
- The use of genetics to provide molecular epidemiology for tracking infectious disease.
- The relationship between population level research and genetics such as understanding the interaction between environmental and genetic factors in disease causation.
- Pharmacoepidemiology through mechanisms such as the General Practice Research Database (GPRD) and Yellow Card System.
- Changing health behaviours using interventions that can be delivered at population, community and individual levels, that can improve population health as well as reduce health inequalities.
- Evaluation of public health interventions, particularly those that prevent disease.
- Standardisation of research outcome measures and service delivery outcome measures to allow better exchange of knowledge.

- Understanding the distribution of disease within the population including the use of surveillance data for research such as cancer registries and community serological surveillance for influenza to understand the distribution of disease within populations.
- Epidemiological research into chronic diseases with “softer” endpoints that are more difficult to measure such as musculoskeletal or mental health.
- Health services research.
- Further research into the social determinants of health including effective interventions to reduce health inequalities.
- Investigation of the impact of environmental change, including climate change on public health.
- Evaluation of the benefits of sustainable low carbon technologies and lifestyles for public health.
- Studying the impact of policies across a range of sectors for public health—e.g. education, social policy, housing, transport.

The Academy of Medical Sciences

The Academy of Medical Sciences promotes advances in medical science and campaigns to ensure these are converted into healthcare benefits for society. Our Fellows are the UK’s leading medical scientists from hospitals and general practice, academia, industry and the public service.

The Academy seeks to play a pivotal role in determining the future of medical science in the UK, and the benefits that society will enjoy in years to come. We champion the UK’s strengths in medical science, promote careers and capacity building, encourage the implementation of new ideas and solutions—often through novel partnerships—and help to remove barriers to progress.

The Academy’s Officers are:

Professor Sir John Bell FRS HonFREng PMedSci (President); Professor Patrick Sissons MedSci (Vice-President); Professor Ronald Laskey CBE FRS FMedSci (Vice-President); Professor Robert Souhami CBE FMedSci (Foreign Secretary); Professor Susan Iversen CBE FMedSci (Treasurer); Professor Patrick Maxwell FMedSci (Registrar).

June 2011

Written evidence from The King’s Fund (PH 28)

1. The King’s Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

2. This submission sets out our views on the key principles of the reforms under the Committee’s core questions. It does not address detailed organisational issues, such as the regulation of the workforce.

3. Much of this submission is drawn from our consultation response (The King’s Fund 2011) to the White Paper *Healthy Lives, Healthy People* (Department of Health 2010a) in which we made 40 recommendations to the government on how it could improve its proposals.

SUMMARY

4. We welcome the government’s intentions to increase the involvement of local government in public health. However, we have major concerns about several aspects of the proposed reforms. In particular:

- the level and proposed allocation of resources for public health;
- the balance of accountabilities, incentives and levers in the new system. Too much confidence is being placed in the health premium to incentivise performance. There is a risk that without penalties or stronger accountability, performance will decline;
- the lack of responsibility for population health of GP consortia. There is a risk that primary care’s role in public health will be marginalised;
- the challenges of co-ordinating local commissioning and supporting data flows as a result of multiple commissioning routes and loss of co-terminosity between local government and primary care trusts;
- the need for improved alignment between the NHS and local authorities with regards to duties to reduce inequalities in health; and
- the timing of the reforms in the context of major organisational change in the NHS and local government and severe budgetary pressure.

THE INQUIRY'S KEY ISSUES

The creation of Public Health England within the Department of Health

5. We feel Public Health England (PHE) needs to be part of government to maximise influence over the actions of central departments that affect public health. However, there are good arguments for some functions to be independent of government to secure public trust, particularly its information, intelligence and evidence functions. The Chief Medical Officer's unique position as a professional, independent voice needs to be retained. But further independent assessment of PHE's activities will help to reassure those that fear the independence of public health advice to government is at risk.

- PHE should have a charter setting out clearly its objectives, including the explicit reduction of inequalities in health. Its performance should be independently assessed and reported on annually.

The public health role of the Secretary of State

6. The Sub-Committee on Public Health could be a powerful mechanism at the heart of government. Radical improvements in public health depend on co-ordinated action across government based on well-informed evidence and tools. For instance, recent research suggests that government spending on social welfare (excluding health) has seven times as much impact on mortality rates as changes in GDP (Stuckler *et al* 2010).

- *The Sub-Committee on Public Health should be a more powerful, formal decision-making body*, assessing major government decisions that affect health and its determinants through Health Impact Assessments (HIAs) and other techniques.
- PHE should develop the tools to support the Sub-Committee, local authorities and others to assess the impacts of their actions on health and inequalities in health. This should include quantitative and qualitative approaches and explore the use of equity weights in standard techniques such as cost-benefit and cost-effectiveness analysis of health-related interventions.
- The Secretary of State should set up a mechanism through the Sub-Committee to monitor health inequalities. He should commission and publish a report on the public health impacts of budget changes.

The future role of local government in health

7. We welcome the intention to give local authorities the role of leading health improvement and to create statutory health and wellbeing boards. This could help to ensure that public health is better aligned with social care and other local services.

8. However, we are concerned that they will not have the power to drive local public health strategy and to ensure that all partners play their full role. They could easily become "talking shops" rather than bodies with system leadership and accountability at their core.

9. We are particularly concerned about whether the boards will have sufficient engagement and influence with GP commissioners (The King's Fund 2010a). It is not clear, for example, whether decisions made by the boards following joint strategic needs assessments (JSNA) will influence GP consortia's allocation of resources.

- *The government should place a duty on GP consortia to promote the health of their local population* and to base their plans on the local JSNA and health and wellbeing strategy. This will ensure closer engagement with health and wellbeing boards.
- *The experience of early implementer sites should be documented and evaluated* so that governance issues in the local public health system are worked through before the reforms go live.

Arrangements for public health involvement in the commissioning of NHS services

10. Public health specialists have a unique combination of skills combined with in-depth clinical knowledge. These include interpreting scientific evidence and research, improving and redesigning services, providing independent and objective advice on treatment and funding decisions, and ensuring that decisions are based on the needs of the whole population and on best available evidence.

11. These skills need to be accessible to GP consortia. There is a danger that the transfer of responsibility to local authorities and the formation of a large number of variably sized GP consortia will spread these skills too thinly. It may be appropriate and efficient for input on public health commissioning to be provided from a "cluster" of public health specialists.

12. Current proposals mean that the prime commissioning responsibility for primary health improvement services such as smoking, alcohol and obesity control will sit with local authorities, though the NHS will be expected to deliver some related brief interventions in primary care. It is not clear whether these primary care interventions will be commissioned through PHE, the NHS Commissioning Board (NHSCB) or local authorities or how this will, or should, differ by area.

13. There is a risk of fragmentation. For example, GPs may not fully engage with their role in preventive public health; the full breadth of the population may not be covered by public health services in areas where there are multiple and complex commissioning routes; and opportunities for jointly commissioning and co-ordinating service redesign and integrated pathways may not be realised. Ultimately, the government's view may be that these are local decisions, but if so it needs to be clear how responsibility for these potential problems relates to public accountability for outcomes through the Public Health Outcomes Framework (PHOF), health and wellbeing boards, PHE or the NHS Commissioning Board (NHSCB).

- The Department needs to set out a coherent structured approach to how specialist public health skills will be available to the NHS, in particular to GP commissioners.

The future of the Public Health Observatories

14. Without accurate, up-to-date information on public health trends and outcomes, the system will not function. PHE can provide information, evidence and benchmarking from the centre. However, local intelligence functions are also critical. Absorbing Public Health Observatories (PHOs) into PHE may save the centre some money in the short term but it risks creating a less effective local public health intelligence network and significantly higher overall costs as directors of public health (DPHs) each seek to replace the lost capability in their own patches.

15. One of the achievements of the previous government was to move towards more co-terminous boundaries and data flows between local authorities (LAs) and PCTs. The “free” clustering of GPs into consortia means that their boundaries do not align with LA boundaries in many cases, presenting massive challenges to the use of information to support accountability and governance in the new system.

- *The Department should reconsider the decision to absorb the functions of PHOs into PHE in terms of independence, regional intelligence and the economies of scale and scope that 10 PHOs bring compared to 150 DPHs (and GP consortia) commissioning local intelligence separately.*
- *The government needs to prioritise the mapping of data from GP consortia boundaries to local authorities to ensure that the public health intelligence function supporting health and wellbeing boards, GP consortia and the delivery of the PHOF are fit for purpose.*

The structure and purpose of the Public Health Outcomes Framework

16. We support the proposed domains within the PHOF of health protection through to the wider determinants of health, behaviour change and the final outcomes in terms of morbidity, quality of life, life expectancy and infant mortality.

17. However, we have consistently recommended (The King's Fund 2010b) that the Department should use an integrated outcomes framework across social care, public health and the NHS. The NHS has a greater role in public health, prevention and tackling health inequalities than indicated by the PHOF.

18. The number of indicators in the PHOF are to be reduced. This runs counter to the declared intention for more public transparency of outcomes. Local areas should have access to the widest array of information the centre can provide, from which they can choose their priorities and understand how they compare with others.

19. There is a presumption that accountability will flow purely from public transparency of the PHOF. This is flawed. There are no plans for PHE to have any role in overall performance. No-one is therefore, in the end, accountable for the outcomes that are expected from the billions of pounds of taxpayers' money that will be given to local authorities for public health. This is in stark contrast to how GP consortia will be held to account for their contribution to the NHS Outcomes Framework through the Commissioning Outcomes Framework (COF) with strong accountability to the NHSCB. This imbalance in accountability for outcomes is potentially damaging to public health.

20. The Department needs to learn from the experience of the previous government's public health and inequalities targets. It is widely accepted that they have helped to foster local action. The Committee recommended the former be continued (Health Select Committee 2009).

21. We remain extremely concerned that in a system with no clear accountabilities, public transparency of information and small incentives payments will not be strong enough to deliver improved public health and reduce inequalities.

- The Department needs to integrate the PHOF with the NHS and social care outcomes frameworks to incentivise the proper care for patients and public health.
- If the PHOF continues as a separate framework, more of the indicators in domain 3 and 4 of the PHOF need to be represented in the NHS outcomes framework and there should be no limit set on the number of indicators. This will help to: ensure that GPs fully contribute to public health outcomes, reduce the risk of fragmentation, and ensure that local areas have the best information from which to prioritise.

- *PHE needs to develop accountability and commissioning frameworks for public health learning from its experience with the previous public health and inequalities targets. It should not rely solely on the health premium to deliver results.*

Arrangements for funding public health services (including the health premium)

22. The Department has attempted to measure how much is currently spent on public health in order to transfer funding to local authorities. Given the scale of the public health challenge, outlined in the evidence paper (Department of Health 2010b) published alongside *Healthy Lives, Healthy People*, we are concerned that public health will be underfunded at the outset.

23. The local public health budget will be dwarfed by the local NHS budget. The NHS budget needs to adequately reflect the role of the NHS in public health and inequalities reduction. In recent years the Advisory Council on Resource Allocation (ACRA) has been asked to reflect that one of the core objectives of the NHS is tackling preventable inequalities in health. This objective will remain if the Health and Social Care Bill retains—and, as we argue below, extends—the duty on the NHSCB and consortia to tackle inequalities.

24. In 2010–11 the NHS formula included a weighting of 15% for health inequalities; this will be reduced to 10% in 2011–12 (Gainsbury 2011). This decision is arguably more significant than anything that happens to public health budgets.

25. The allocation system for the public health budget will be new. It needs to adequately reflect the distribution of inequalities in health, within local authorities as well as between them.

26. The current intention seems to be for the formula to be based on a “one-shot” strategy and for all future changes in allocations (beyond up-rating for prices) to be based on achievements rewarded through the health premium. This is far too crude and risks consigning parts of the country to a vicious spiral of chronic underfunding.

- *The Department needs to set the public health budget on a proper assessment of need and not solely on basis of estimates of what is currently being spent. This needs to be closely aligned with an assessment by the Department for Communities and Local Government on how much local authorities are currently spending on health improvement and broader activities so there is a good understanding of local baselines before resources are transferred.*
- *We urge the Department to fully assess the impact on public health and inequalities of the decision to reduce the weight on deprivation in the NHS allocation formulae.*
- *The public health allocation formula needs to reflect inequalities in health outcomes both within and between areas.*
- *The Department should revise its current position of only up-rating allocations for prices. It must also include broader elements outside the control of local authorities, such as population churn, so that areas are appropriately funded for public health.*

27. The current model for the health premium is for a payment based on relative performance between areas on a small number of indicators in the PHOF, with larger payments for more disadvantaged local authorities. This is transparent and recognises that local authorities with high deprivation have further to go and will find it more costly and harder to make changes.

28. However, it runs the risk that local authorities will hit the qualifying criteria by focusing on the “easy wins”, helping people from wealthier areas who are easier and cheaper to reach, rather than those in poorer areas where social norms are harder to address. It also incentivises making short-term gains, rather than investing in the wider determinants of health. It could therefore simultaneously improve population health and widen inequalities within local authorities.

29. Local authorities need to be stretched. The premium should be designed so that they are not incentivised to do the minimum to meet the payment threshold in-year. Population health churn also needs to be taken into account to reduce the likelihood of misattribution of rewards to actions.

- *The premium’s design needs to focus on a combination of within-area inequality reduction in final outcomes and short-run shifts in the known major causes of inequalities that the local authority can influence. Within-area life expectancy and within-area smoking rates are the leading candidates for inclusion in a relatively simple formula.*
- *The premium needs to be piloted, due to the evident complexities and high chance of perverse outcomes.*

How the government is responding to the Marmot Review on health inequalities

30. The commitment to duties on the NHSCB and GP consortia to tackle inequalities in health is a major step forward. However, they are not strong or comprehensive enough.

31. The duties refer only to the role of the health care system as a provider of patient care. The proposed duties on inequalities ignore the vast potential the NHS has to affect public health, the wider determinants and inequalities through the intelligent and directed use of its economic power in local communities.

32. There is no matching duty in the Bill for local authorities to tackle inequalities in health.

33. The PHOF includes a domain for the wider determinants of health which is consistent with the emphasis on wider determinants from the Marmot Review. The government could strengthen its response to the review and signal its commitment to reducing inequalities reduction by including the “Marmot indicators” (London Health Observatory 2011) in the PHOF.

- The government should widen the duty on inequalities to include the contribution of the NHS to broader health outcomes beyond inequalities in access to care and outcomes from that care as currently in the Bill.
- The government needs to be more explicit in the Bill about the role and expectations of local authorities around tackling inequalities in health and align them with the expanded duties we suggest for the NHS Commissioning Board and GP consortia.
- The Department of Health should include the Marmot inequality indicators developed by the London Health Observatory in the PHOF, or be explicit why it is not doing so.

June 2011

Annex

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Written evidence from Staffordshire County Council (PH 29)

1. INTRODUCTION

We strongly welcome the drive to embed public health into the work of the wider public sector. Local government, with the diverse and everyday nature of public services has an important contribution to make, particularly in terms of prevention and early intervention.

Staffordshire is taking a whole system approach, across local government tiers as well as the voluntary, community and business sectors. We believe our holistic approach utilises more opportunities for long term general health improvement and a very local needs led approach rather than working as individual bodies in a segmented or dislocated way.

We believe this approach is forward-thinking and already seeing improvements to outcomes. This is evidenced in the information provided below, which we have aligned with the Committee's key lines of Inquiry.

2. EVIDENCE

2.1 *The creation of Public Health England within the Department of Health*

As our response will demonstrate, we believe that local authorities, in partnership with other public sector, community, voluntary and private organisations have a pivotal role to play in achieving positive public health outcomes. The diverse nature of local government services means that local needs can be met with local solutions.

The move from a centralised and prescriptive approach brings a tremendous opportunity for clear accountability and will enable a locally tailored approach to the identified needs of local communities which accounts for the diversity of a county this size.

In light of this, it is essential that Public Health England (PHE) has a complimentary and effective relationship with all key local bodies—and not just traditionally “health focussed” organisations eg the NHS. We would be concerned if PHE exercised an over-zealous central control which limited the ability to determine appropriate local actions and innovative local solutions.

2.2 *The future role of local government in public health*

The greater role of local government in public health provides a strategic platform to raise the profile and aspirations of improving public health within the local authority and with the wider, non health, public sector. This will enable a more integrated and holistic approach across social care, health and other organisations that traditionally may not have seen public health to be part of their core remit, but who can have a positive impact on the wider determinants of health.

Responsibility for public health improvement sitting with local authorities will allow it to be embedded within our local leadership and place-shaping role and aligned with our duty to promote community wellbeing. This is the right strategic leadership context to see improved public health and provides greater local accountability within the political and democratic framework to local people.

The substantive work of local government impacts directly on the wider determinants of public health. For example, our work around education, employment, economic prosperity, culture, leisure and transport can all influence positive public health outcomes. The shift in perception away from public health being only within the NHS domain encourages more focus on the public health implications of wider public sector activity. The following examples evidence how we are moving the shared public health agenda forward locally within the public sector, how we are taking valuable steps to ensuring effective prevention and early interventions and how we are using the good partnership frameworks we already have in place to genuinely embed public health into our work as a local authority.

2.2.1 Prevention and Early Intervention

We believe that local government and the wider public sector has an important role to play in public health, particularly in terms of prevention and early intervention. Part of the role as a local authority is in preventing people from needing to access costly acute and long-term health care by ensuring that the appropriate effective preventions and early interventions are in place. Three key examples of our work regarding prevention and early intervention are:

- *Staffordshire Cares*

Our “Staffordshire Cares” programme demonstrates commitment to developing a fuller, wider and more accessible range of community and preventative services to meet the needs of vulnerable adults and older people. We know that our residents want to live independently for longer and have more choice and control over the information, advice and help they receive. Staffordshire Cares is our radical initiative to help people live as normal a life as possible, whether coping with disability, other health challenges or simply getting that bit older. It provides a set of tools to help people take personal responsibility to design a life and achieve their aspirations. Through groundbreaking web-based interactive information, advice and signposting system and trained advisors available by telephone and face-to-face, Staffordshire Cares will give people control to maintain their independence and to live more fulfilling lives.

- *A people approach*

In Staffordshire we are moving significantly towards a whole of life approach. The County Council structure has been radically changed in order to see individuals and families in the round rather than “pigeon holing” into segments through age or other identifiers. This holistic approach results in a more joined up strategy.

— *Families First*

“Families First” is a Staffordshire County Council project which will transform our services for children, young people and families. The focus is on early intervention and is about delivering the right help at the right time to ensure children, young people and families the best possible outcomes in life. Through Local Support Teams, Staffordshire will move towards a consistent focus on family involvement, family services and family outcomes. For example, Local Support Teams will be closely aligned with school nurses and health visitors. As a result of effective early intervention, many children will not require higher level specialist services as agencies will intervene at an earlier stage to prevent problems from escalating.

2.2.2 Joint Director of Public Health

We have already taken significant steps towards an integrated model of working. For example, the appointment of a Joint Director of PH is part of our collaborative approach between the local authority and Staffordshire’s health organisations.

2.2.3 Embedding Public Health Outcomes into Strategic Planning

Our Strategic Plan (2011–16) sets out our vision and plans for the next five years and contains the nine key priority outcomes which give more detail to our vision. We have a specific outcome which helps to define our ambition for public health in Staffordshire:

“Staffordshire is a place where people live longer, healthier and fulfilling lives.”

This outcome is underpinned by several strategic priorities, which demonstrate the cross-cutting nature of public health and how it is intrinsic to much of our work as a local authority. Strategic priorities linked to this outcome are:

- Improve the health of children and young people.
- Improve mental health and wellbeing.
- Improve the health and wellbeing of older people.
- Reduce the harm caused by alcohol misuse.
- Reduce the harm caused by smoking.
- Improve housing, local areas and communities.
- Assess the impact of policy and planning decisions on health.
- Listen to our local communities’ needs and how to meet these needs.

We are already undertaking work to support this outcome, and with our enhanced role and new powers we will use our resources to address local problems with local solutions.

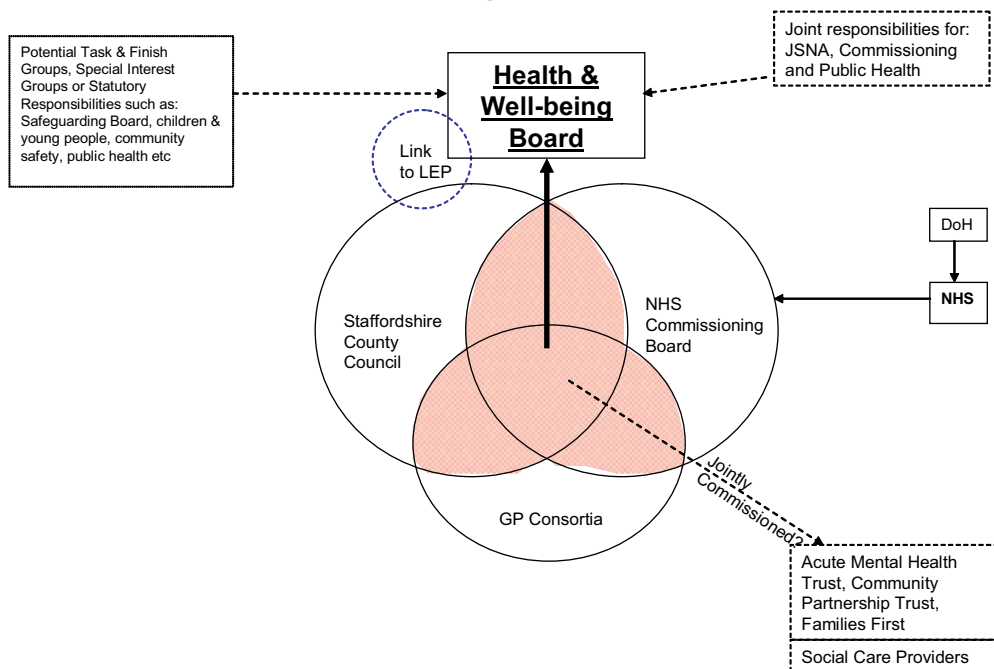
2.2.4 Health and Wellbeing Board (H&WB).

The county council are leading on the development of the proposed H&WB, which will give greater local control over services to local communities. We have been successful in securing a £40,000 place-based leadership bid for 2011, for the development of the Board.

In line with our current thinking on effective partnership working, we are keen that the Board does not have unnecessary layers of bureaucracy, does not duplicate existing activity and is focussed on delivering outcomes.

Rather than setting up an entirely new “stand-alone” Board, we have recognised that the NHS Commissioning Board and GP Consortia will have remits which cross-over with County Council remits. It is at this “cross-over” point that the H&WB will be created, to ensure the delivery of shared priorities, to manage our formal relationship with Health partners and to govern public health activities in Staffordshire (see Figure 1).

Figure 1



The work of the H&WB will be based on a strong, broad outcomes focussed Joint Strategic Needs Assessment, which will encompass a wide spectrum of information including health, safer communities and children’s services information.

2.2.5 Health & Wellbeing Strategy

A three year Joint Health & Wellbeing Strategy for Staffordshire has been produced, adopting a collaborative approach with the County Council, the PCT’s and District Councils and other stakeholders. The Strategy was agreed by Cabinet and PCT Boards in September 2010.

The Strategy is intended to add value to existing local initiatives, particularly with regard to those issues where it is important to have a single Staffordshire approach.

2.2.6 Local Initiatives to Promote Public Health

We are well placed as a local authority to use our influence to promote public health. The following examples describe schemes which are designed to promote public health and to foster shared responsibility and accountability for achieving positive public health outcomes:

— *Staffordshire Caring for Health Award Programme*

Caring for Health is a unique, multi-disciplinary award scheme designed to improve standards of care and the lives of people in residential care homes. The scheme focuses on improving four areas of care:

- (1) Food, Nutrition and Hydration.
- (2) Oral Health.
- (3) Falls awareness and prevention.
- (4) Physical and social activity.

Through these four areas the award places strong emphasis on the importance and support of personalisation and social inclusion in care.

The award was conceived by the Health Development Team and the initial development was carried out with support from The “Live Well Be Well in Staffordshire” partnership. The partnership included NHS, local authority, private sector and voluntary sector representatives.

— *Nurturing Health Early Years Award Scheme*

The “Nurturing Health” early years award scheme is a novel pan-county, multi-agency partnership award, which sets high quality standards for food and drink provision, the mealtime environment, physical activity and oral health for 0–5 year olds in private, voluntary and children’s centre nurseries.

— *Workplace Health Award*

This work illustrates the locally led link across communities and government, seeing health and wellbeing as integral to civic and social responsibility. It will also further develop the link between local government and the private sector across Staffordshire.

At a local level we will be supporting the private sector to engage in corporate social responsibility and positively impact on the health and wellbeing of the local community.

This is a key strand of our workplace health award programme; one which contributes to building the “Big Society” and will provide Staffordshire’s working age population with links to programmes such as Staffordshire Volunteering.

It has produced some early successes and engagement and involvement has been secured with private sector businesses in Staffordshire. The Chamber of Commerce has agreed to fully endorse the health and wellbeing agenda and work with us to further engage with Staffordshire businesses and support this priority as it develops.

Through this programme we will continue to support Staffordshire businesses/employers to provide opportunities for employee health and wellbeing and to enable our business communities to positively impact on the health of Staffordshire residents within their local communities.

— *Community Wellbeing Fund*

Our £1 million Community Wellbeing Fund is intended to enable small, local, grass roots community groups to provide local services to improve the health, independence and wellbeing of vulnerable adults and older people in their community. To date 120 community organisations have been supported to develop preventative health, wellbeing and independence services for older people and at least 1792 older people have been direct beneficiaries of the scheme.

2.2.7 Involving Community and Voluntary Sector in Public Health

We are aware that responsibility for public health does not rest with the public sector alone. We believe that public health is a shared responsibility and we are embedding this approach within our wider partnership arrangements. Public Health needs to be embraced by all organisations working with and for our communities, many of whom have a key role to play in addressing the wider determinants of health.

Three examples of recent work demonstrates how we are taking an innovative approach in Staffordshire to involve organisations who typically may not have considered themselves to have significant roles to play in achieving positive public health outcomes.

— *Benefits Advice*

In the north of the county, outreach services have been commissioned from Citizens Advice Bureau providers, to address the practical, financial and legal issues which can adversely impact on an individual’s health, through the provision of a holistic client-centred advice service. In particular, it allows clients to access financial, debt and benefits advice through their GP surgeries or via a dedicated telephone line and caseworker.

The approach is based on evidence that the targeted communities are more likely to have mental health problems which can be exacerbated by financial issues. The schemes have shown significant benefits for the clients in terms of financial status and concomitant mental and social health benefits. This has been evidenced by case studies of clients and from feedback from GP’s and other referring healthcare professionals.

— *Healthy Walks*

It is recognised that walking has many health benefits, including disease prevention, weight management, the prevention of illnesses related to being inactive and mental wellbeing.

As part of a partnership approach, NHS North Staffordshire have provided funding to enable a local CVS to facilitate healthy walks with trained volunteer walk leaders. The aim is to increase the local community’s awareness of the health benefits of physical activity, to motivate and encourage sedentary people to be active and to provide local communities with opportunities for activity.

The take-up rate by local people within the target ward areas has been high with stretch outcome targets for recruitment and participation in the walks achieved.

— *Wild Steps Programme*

Staffordshire Wildlife Trust have developed a “Wild Steps Programme” to provide opportunities for activity which combine physical exercise and access to the natural environment. The initiative is based on research that highlights the health benefits of engaging in outdoor activities on local green spaces.

Sessions are provided across priority wards to promote health and fitness and offer opportunities for a range of activities from walking through to involvement in practical conservation work. In addition to learning new skills, participants have been able to achieve the recommended 30 minutes of moderate activity.

2.2.8 Engaging Communities in Public Health

Engaging Communities Staffordshire is an innovative project that is making good progress to ensure we are working better together on how we engage and involve people across the County in health and social care matters.

The vision is to establish a social enterprise for the benefit of the people of Staffordshire that will ultimately bring public engagement, consultation, complaints and consumer advice services together in a central organisation and provide local Healthwatch too. It will be community led, utilizing agencies that already do things well. By coordinating things centrally it will become a hub of information, an intelligent organisation, to enable us to see the “bigger picture” in a way that has not been possible before.

The transcripts from the public inquiry into Mid Staffordshire NHS FT are beginning to provide evidence that there are areas of overlap and disconnection and that the idea for this new organisation was well founded. Work has been on-going on this project since May 2010 and following a development and testing of concept phase sponsored by Staffordshire County Council in partnership with South Staffs PCT, Mid Staffs and DH, the Council has been funding the next phase of its development from September 2010.

It is intended that Engaging Communities Staffordshire will add value to what is currently in place such as Community Groups, Support Groups, GP practice groups etc and to ensure trends and themes can be spotted across organisations so that prompt responses can be put in place as soon as they become apparent.

3. Arrangements for commissioning public health services

As GPs will have an increasingly important role in terms of local commissioning arrangements, we have made significant progress in forging strong effective relationships with them.

We have held an initial GP Project Steering Group event in January 2011, which was followed by a successful GP engagement event, “Collaborating to benefit patients across Staffordshire”. Speakers at this event included Elizabeth Buggins, Chair of the Strategic Health Authority, Graham Urwin, Chief Executive of the PCT Cluster and Dr. David Hughes, Executive Chair of the shadow GP Commissioning Consortia (GPCC) Board in North Staffordshire.

Seventy five people were in attendance at the event, including 40 GP’s, contributing to a positive atmosphere of engagement and collaboration. There has been a request from the North Staffordshire GPCC for a repeat of this event in their area.

Our Joint Commissioning Unit (JCU), which was set up in a partnership arrangement between the county council and the local PCT’s, is leading the way in forging close working relationships with local GP Commissioning Consortia. Professor David Colin-Thomé, previously Government Advisor on Primary Care, is working with our JCU and has visited all six GPCC in the Staffordshire area. This work is paying off and the JCU have been invited back to visit the GPCC to present aspects of social care to increase collaboration and they are now working with GP representatives to convene several “Task & Finish” Groups to further develop key aspects of integrated commissioning.

4. The future of Public Health Observatories

Regional Public Health Observatories provide a useful service for local authorities in the provision of regional intelligence to understand health inequalities. Staffordshire regularly uses a number of products/data made available by the Regional Public Health Observatories including local health profiles and alcohol profiles. Staffordshire is currently working to develop its customer insight to better target resources and services. We would welcome any national support that would aid opening up access to local, low-level data on health inequalities to public services. This will truly allow public services to understand the underlying health needs of its residents and put in place suitable services and support to tackle inequalities and change behaviours.

June 2011

Written evidence from the Medical Research Council and Economic and Social Research Council (PH 30)

BACKGROUND

1. The Medical Research Council (MRC) is one of the main agencies through which the UK Government supports medical and clinical research. The MRC is dedicated to improving human health through the best scientific research. The MRC’s work ranges from molecular level science to public health medicine and has led to pioneering discoveries in our understanding of the human body and the diseases which affect us all.

2. The Economic and Social Research Council (ESRC) is the UK’s largest organisation for funding research on economic and social issues. ESRC supports independent, high quality research which has impact on business, the Public Sector and the Voluntary Sector. At any one time, the ESRC supports more than 4,000 researchers and postgraduate students in academic institutions and independent research institutes.

3. The MRC and ESRC are funded by the Department for Business, Innovation and Skills (BIS) and together invest around £908 million per annum (£700 million from MRC and £208 million from ESRC) in research, training and knowledge exchange across a broad spectrum of research areas.

4. This evidence is submitted by the MRC and ESRC and represents the independent views of these two research councils. It does not include or necessarily reflect the views of Research Councils UK or the Department for Business, Innovation and Skills. It aims to address only those areas within the terms of reference of the Committee's Inquiry which are directly related to the work of the research councils and draws upon the views of research council funded researchers and networks, a list of sources is available in Annex 1.

MAIN RESPONSE

The creation of Public Health England within the Department of Health

5. The ESRC and the MRC welcome the creation of Public Health England and the National Institute for Health (NIHR) School of Public Health, and emphasise the importance of establishing structures that integrate research into services by supporting closer engagement among policymakers, practitioners and researchers.

6. Research is crucial to generating evidence and informing effective policy, and Government needs to embrace and embed research throughout its culture and structures.

7. The implementation of health policies should always be accompanied by a rigorous evaluation of their impact rather than the current approach where evaluation is the exception. In situating Public Health England within the Department of Health it will be important to ensure that the objective evaluation of health policies is not compromised. Public Health England is strongly encouraged to develop guidance which will enable robust evaluation in order to ensure that policies or interventions are effective and cost-effective. Excellent forward planning for evaluation was evident with the introduction of legislation to prohibit smoking at work and in enclosed public places in both England¹⁰ and Scotland (Box 1).

Box 1

Legislation to ban smoking in enclosed public places was implemented in Scotland in March 2006. Evidence from previous research about the harm associated with environmental tobacco smoke, and the success of smoke-free legislation in the Republic of Ireland, were used to make the case in Scotland. Researchers worked closely with policy makers to plan the evaluation plan and ensure that the evidence was used to good effect. Multiple outcomes across several domains were agreed. The evaluation strategy was based on a model¹¹ linking the ban to short-term, intermediate and long-term outcomes. The evaluation found evidence of changes in smoking culture and behaviour plus measurable improvements in health. At one year the cohort of bar workers reported fewer respiratory and sensory symptoms.¹² A prospective study of admissions to hospital for acute coronary syndrome found a 17% reduction in a ten month period post-legislation, compared with a 4% reduction in acute myocardial infarction (AMI) admissions in England over the same period and a mean annual reduction of 3% in AMIs in Scotland in the 10 years prior to the legislation.¹³ A time series analysis of routine admission data found a reduction in asthma hospitalizations in children of 18.2% per year. Prior to the legislation, admissions for asthma among children aged 0–14 had been increasing at a mean rate of 5.2% per year.¹⁴

Note: The text in Box 1 is taken from the final draft of a forthcoming publication, based on work of the MRC Population Health Sciences Research Network.

8. The creation of the NIHR School of Public Health is a welcome addition to increasing the evidence base in public health and has the potential to improve the collation of evidence and increase its translation into health policy and practice. It will be important to ensure that the School complements, and communicates with, existing centres of excellence in public health research which have considerable strength and expertise in the field (eg UK Clinical Research Collaboration Public Health Centres of Excellence).

9. A better understanding by practitioners of how research can be applied in practice would be welcomed. This could be achieved through greater integration between academic researchers and service providers and practitioners. Public Health England and the NIHR School of Public Health will need to work closely with the Faculty of Public Health to bridge this divide.

10. Routes for the input of independent evidence to Public Health England are essential, and transparency around those routes is necessary.

¹⁰ Bauld, L. (2011). Impact of smokefree legislation: evidence review. Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124961

¹¹ Haw S J, Gruer L, Amos A, Currie C E, Fischbacher C, Fong G T, et al Legislation on smoking in enclosed public places in Scotland: how will we evaluate the impact?. *Journal of Public Health* 2006;28(1):24–30.

¹² Ayres J, Semple S, MacCalman L, et al Bar workers' Health and Environmental Tobacco Smoke Exposure (BHETSE): Symptomatic improvement in bar staff following smoke-free legislation in Scotland. *Occupational & Environmental Medicine* 2009; 66:339–46.

¹³ Pell J, Haw S J, Cobbe S, Newby D E, Pell A C, Fischbacher C, et al Smokefree legislation and hospitalisations for acute coronary syndrome. *Journal of the American Medical Association* 2008; 359:482–91.

¹⁴ Mackay D, Haw S, Ayres J G, Fischbacher C and Pell J. Smoke-free legislation and hospitalizations for childhood asthma. *New England Journal of Medicine* 2010; 1139–1145.

11. The MRC and ESRC support the use of standards for the collection and storage of health and other public sector data (eg education or housing) in secure and well curated repositories. Public Health England will need to ensure that there are structures in place to collect, maintain and safeguard high-quality data which is accessible for both administrative and research purposes.

12. The burden of research governance is heavy, especially for large-scale population studies, and Public Health England should be closely involved in the process of streamlining research governance, and developing procedures proportional to the risks incurred by research participants, as recommended by the recent Academy of Medical Sciences report on regulation and governance.¹⁵

13. The Department of Health is not the only department developing and implementing policy which impacts upon public health. A significant role is played by other departments (eg Department for Transport, Department for Environment, Food and Rural Affairs, Department for Culture, Media and Sport) which should use evidence in public health to inform their strategies and priorities. These departments need to be active participants in developing and evaluating policies and interventions which may affect health, in areas such as taxation (eg on alcohol and tobacco), the environment, environmental health, leisure, transport, planning, children's services, housing and social care. Appropriate structures and active channels of communication are required across Government to ensure join-up across departments whose activities may impact public health.

14. The proposal, formalised within the recent Department of Health strategy for public health in England *Healthy Lives, Healthy People*, to provide resources which support interventions undergoing research outside the NHS, must not be lost by a potential focus within the Department on the NHS setting or the clinical environment.

The abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse

15. The Health Protection Agency (HPA) is widely recognised for excellent research and should maintain its independent status and research capability in order to best protect the health of the public. If the HPA becomes embedded in Public Health England it will be difficult to demonstrate and maintain its crucial independent role. The HPA has received strategic funds from the MRC, ESRC and others to carry out collaborative research in priority areas. By transferring HPA to Public Health England, HPA researchers would become ineligible for funding by the research councils, thereby impacting upon opportunities to conduct collaborative research in areas of major public health concern.

16. Likewise, it is vital that the work of the National Treatment Agency for Substance Misuse is continued. Effective alternatives would need to be implemented to replace the functions of the Agency if it were abolished. Such provision should be led by professionals in substance misuse treatment, and be guided by the latest research findings in this field.

The public health role of the Secretary of State

17. The increased commitment to Public Health by the Secretary of State is welcomed. There is some concern from the research community that there may be over reliance in the Department of Health Strategy for Public Health on individual behavioural change and local initiatives delivering services.

The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)

18. Strengthening the role of local authorities recognises that health is influenced by a wide and diverse range factors beyond health services (eg urban design, transport or housing) and is a positive step. However, to ensure that the health impacts of policies are fully considered, each Director of Public Health must sit on a Local Authority Executive Board alongside colleagues representing others interests (eg urban design, transport or housing).

19. Directors of Public Health should have an understanding of research and evidence based practice. Ideally Directors should be accredited Public Health consultants. They should be adequately resourced to fulfil public health functions including advising GP commissioning.

20. Local government and local communities are central to the Department of Health's public health strategy yet they have limited experience in commissioning and running health services and adopting research outcomes. As they take on their commissioning role, local authorities will need to develop a research-aware culture to ensure services and policies are evidence based where possible, and can be robustly evaluated.

21. For services to be effectively integrated it will be important that GP consortia have a defined population within an area that aligns with the local authority boundaries.

22. Joint Strategic Needs Assessments are a welcome development but they must be seen to inform GP commissioning as well as local authorities.

¹⁵ A new pathway for the regulation and governance of health research (2011). Academy of Medical Sciences. <http://www.acmedsci.ac.uk/index.php?pid=47&prid=88>

23. The proposed role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies in bringing health and care provision together within their local areas to support vulnerable members of the community is to be commended. However, it is important that these bodies are equipped to take full advantage of research findings across both disciplines.

The arrangements for public health involvement in the commissioning of NHS services

24. Primary care professionals can play a critical role in primary and secondary prevention by providing guidance, brief interventions and referral to, or commissioning of, targeted services (eg weight management). It is important therefore that GPs and GP practices, and also pharmacies, understand and employ the best mechanisms to address prevention in their populations.

25. Some health professionals making commissioning decisions for NHS services may have limited understanding of public health. Arrangements for public health involvement in the commissioning of NHS services are necessary as they are a key part of public health alongside health protection and improvement. It is essential that the views of the Directors of Public Health and other champions of population health are fully considered in commissioning decisions.

26. Government will need to ensure the means by which patient data from GP practices is accessible to other GPs and to the research community, in order to monitor ill health and provide the basis for research evidence to underpin policy.

27. The UK has a number of clinical networks including the MRC General Practice Research Framework (GPRF), UK Clinical Research Network (UKCRN), NIHR Primary Care Research Network (PCRN), regional networks in England and counterparts in Scotland, Wales and Northern Ireland. The MRC GPRF is a UK-wide network of general practices that, over the last three decades, has been involved in clinical trials, epidemiology and health services research. An example of high-impact research involving primary care professionals, facilitated and supported by the GPRF, is indicated in Box 2.

Box 2

FLUWATCH is a community study of behavioural and biological determinants of transmission to inform seasonal and pandemic planning. Funded by the MRC, FLUWATCH has been a very successful collaboration between the General Practice Research Framework (GPRF) and University College London, the Health Protection Agency and MRC Human Immunology Unit at Oxford. The study was funded in response to the MRC pre-pandemic call for influenza research in 2006 and recruited a cohort of over 2,000 individuals. The study has informed our understanding of the epidemiology and transmission dynamics of seasonal influenza as well as the role of prior T cell immunity in development of infection.

Key FLUWATCH findings demonstrate the value of an existing community cohort in studying influenza. In order to provide prompt answers in a pandemic, however, much larger populations must be examined, with “real time” processing of specimens, so that sufficient cases accrue and are analysed in the early phase of the pandemic to inform action in later phases. In June/July 2009, three to four months after the WHO reported the emergence of a new A/H1N1 strain of influenza, the GPRF facilitated collaboration of the existing FLUWATCH research group and the MRC Centre for Outbreaks Analysis and Modelling. As a result, a new FLUWATCH Pandemic Consortium was created with £2.1 million from MRC and Wellcome Trust to undertake a prospective cohort study designed to recruit 10,000 people in general practice. This cohort has described the clinical course of infection and the effectiveness of clinical counter measures and the epidemiological characteristics of the A/H1N1 pandemic. It has monitored changes in population behaviour through the pandemic, providing a greater understanding of immunity to infection (particular T cell), and informed the ongoing vaccination policy.

28. The National Institute for Clinical Excellence (NICE) makes a major contribution to public health intelligence through its reports on specific topics such as preventing heart disease and encouraging physical activity, by providing more general guidance on research methods, and by identifying research priorities. It is critical that NICE retains its central role in providing impartial, independent, expert appraisals of the public health evidence base. How this role will dovetail with that of the annual evidence reviews, proposed in the recent Department of Health strategy for public health, requires careful consideration to ensure transparency and independence is maintained in the provision of evidence.

The future of the Public Health Observatories

29. The MRC and ESRC support the collection and storage of high quality health and other public sector data in well maintained repositories accessible for administrative and research purposes. The Public Health Observatories play an important role in the provision of information and data on people’s health and health care for practitioners, policy makers and the wider community. It is vital that data standards for the collection, storage and security of health and other public sector data are maintained if functions of the Observatories are transferred.

The arrangements for funding public health services (including the Health Premium)

30. The ESRC supports the principle of targeting specific funding for public health to the poorest areas with the worst health outcomes, so long as this is not detrimental to other, slightly less poor areas whose health outcomes are only marginally better. We support the recommendations outlined in Chapters 4 and 5 of the Marmot Review *Fair Society, Healthy Lives*, which call for an inclusive approach which reduces the gradient in health inequalities across society.

The future of the public health workforce (including the regulation of public health professionals)

31. The Department of Health strategy for public health does not adequately address public health training or public health as a profession. It remains unclear how training and regulation will work with the Directors of Public Health in local authorities, for communicable disease and environmental health in Public Health England and for others involved in commissioning. This lack of clarity is causing anxiety among the profession and will inevitably lead to staff losses.

How the Government is responding to the Marmot Review on health inequalities

32. The Marmot Review is acknowledged in the Department of Health strategy for public health. The strategy highlights the need to reduce health inequalities through a life course approach as advocated by the Marmot Review. The MRC and ESRC commend this focus and emphasize the importance of research in generating evidence to inform and evaluate policies underpinning this goal.

33. However, the practical challenges of reducing health inequalities and implementing research evidence into policy and practice are not insignificant. Various measures designed to improve the integration of research with policy and practice have been highlighted above and should be taken into account in the new Public Health England structures.

34. A key message from the Marmot Review is that health inequalities result from social inequalities. The ESRC notes that if this point is accepted, it follows that, in our unequal society, a narrow focus on attempts to change the health behaviours of individuals without taking adequate account of their differing social circumstances is unlikely to be successful.

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Annex 1

SOURCES OF EVIDENCE FOR THE RESPONSE

1. Wellcome Trust/MRC/ESRC workshop “Healthy Lives, Healthy People” (1/03/11).
2. MRC Population Health Sciences Group (PHSG), which includes individuals from the following organisations:
 - University of Glasgow;
 - University of Oxford;
 - University of East Anglia;
 - University College London;
 - London School of Hygiene & Tropical Medicine;
 - University of York;
 - Erasmus MC, The Netherlands;
 - INSERM, France;
 - MRC/CSO Scottish Collaboration for Public Health Research and Policy;
 - MRC Lifecourse Epidemiology Unit;
 - MRC Epidemiology Unit; and
 - MRC/CSO Social and Public Health Sciences Unit.
3. MRC Population Health Sciences Research Network (PHSRN), which includes individuals from the following organisations.
 - MRC Biostatistics Unit;
 - MRC Centre for Causal Analyses in Translational Epidemiology;
 - MRC Centre for Cognitive Ageing and Cognitive Epidemiology;
 - MRC Centre of Epidemiology for Child Health;
 - MRC Centre for Nutritional Epidemiology in Cancer Prevention and Survival;
 - MRC Clinical Trials Service Unit and Epidemiological Studies Unit;
 - MRC Clinical Trials Unit;
 - MRC Lifecourse Epidemiology Unit;

- MRC Epidemiology Unit;
- MRC General Practice Research Framework;
- MRC Human Nutrition Research;
- MRC/CSO Social and Public Health Sciences Unit; and
- MRC Unit for Lifelong Health and Ageing.

Written evidence from Nuffield Trust (PH 31)

1. Nuffield Trust is an authoritative and independent source of evidence-based health service research and policy analysis. Our aims include promoting informed debate on UK healthcare policy. We are also a national training centre for public health specialists and four members of our senior staff, including our Director and our Head of Research, practise public health at consultant level.

2. We have concentrated on three specific topics in this memorandum: the future role of local government in public health; arrangements for public health involvement in the commissioning of NHS services; and arrangements for commissioning public health services.

EXECUTIVE SUMMARY

3. *The future role of local government in public health*—The NHS and local government both have important roles to play in public health. But to ensure that health services meet the needs of local populations, the Department of Health should consider strengthening the accountability of commissioning consortia to their local populations.

Arrangements for public health involvement in the commissioning of NHS services—Public Health skills are required for high quality commissioning. Under the current proposals there is a danger that the specialist public health workforce will be lost from the NHS. The Department of Health needs to consider making public health capacity part of the authorisation process for commissioning consortia. It should also clarify how public health skills will be secured by commissioning consortia and the NHS Commissioning Board.

Arrangements for commissioning public health services—Under the current proposals, public health services will be commissioned by a wide range of commissioning organisations. In order to prevent fragmentation, strategic oversight should be clarified and efforts should be made to devolve commissioning to the local level where appropriate. Overall, we believe it is vital that public health services be commissioned and provided for defined geographical populations. This is to ensure the health needs of vulnerable populations are met, especially for people who are not registered with a GP practice.

The future role of local government in public health

4. The Public Health White Paper states that local government will have a significant role in public health, with roles including health improvement, commissioning services jointly with GP consortia, and tackling health inequalities (Department of Health, 2010a). The Health and Social Care Bill gives all upper-tier local authorities a statutory duty to establish Health and Wellbeing Boards (HWBs) and to encourage integrated work between the NHS commissioners, public health specialists, and social care. HWBs will be required to produce Joint Strategic Needs Assessments (JSNAs) and joint health and wellbeing strategies with each of their partner commissioning consortia (Department of Health, 2011). As local authorities take on this new role, they will require public health capacity with sufficient authority and expertise to assure the quality of these commissioning plans.

5. The Nuffield Trust recognises that the proposal to create HWBs provides an opportunity to create a representative local body that helps shape local decisions about which services to commission and decommission (Nuffield Trust, 2010). However, we believe there are several weaknesses in the planned arrangements for local accountability. If left unchanged, these weaknesses may result in a failure to secure local legitimacy for health care and public health commissioning decisions—despite the government’s stated intentions. HWBs need to be given additional powers to scrutinise and guide commissioning decisions made by GP consortia. This could be achieved by placing a stronger requirement on commissioners to take into account the JSNA and by requiring consortia’s commissioning plans to be approved by their local HWBs.

6. In order to avoid major disputes between HWBs and commissioners it will be important to ensure there is clarity about roles and responsibilities at a local level. Where irresolvable disagreements arise between a HWB and a consortium, the White Paper proposes that a letter be written to the NHS Commissioning Board (NHSCB) which, in turn, will have extensive powers to direct consortia. However, it is difficult to see how this process will work in practice. We suggest that the Department of Health should consider the use of alternative resolution mechanisms that promote more cooperation at a local level. These could include simple measures such as ensuring that there are formal terms of reference in place together with clear governance arrangements and procedures for managing conflict. Another way to avoid escalating conflict may be to devolve

the performance management for contracts held by the NHSCB and Public Health England (PHE) to a more local level.

7. The Department of Health is proposing to allocate ring-fenced budgets directly to upper-tier and unitary local authorities (Department of Health, 2010a). In order to ensure that this funding is used wisely, we suggest that appropriate governance arrangements are put in place. For example, all contracts for services funded from public health budgets should require the signature of the local director of public health.

Arrangements for public health involvement in the commissioning of NHS services

8. The 2010 Health Select Committee report on commissioning concluded that a lack of skills was one of the key reasons for weak commissioning by Primary Care Trusts (PCTs) (House of Commons Health Select Committee, 2010). The commissioning of health care is complex and requires a high level of technical and managerial skills (Ham, 2008). Public health expertise is required for many commissioning functions, including: understanding local population needs, strategic service planning, evaluating the evidence for the quality and cost-effectiveness of care, and holding providers to account (The Information Centre, 2011). Yet, the Public Health White Paper does not acknowledge sufficiently the importance of these public health skills to the commissioning process.

9. The abolition of PCTs and Strategic Health Authorities (SHAs) will result in the loss of vast majority of the public health workforce from the NHS. In particular, those public health professionals who specialise in health services (including public health experts with a clinical background), will diminish relative to the other two areas of public health (health improvement specialists will move to local authorities; and health protection specialists will move to PHE). Such experts are a crucial resource for the NHS, especially when challenging the quality and cost-effectiveness of clinical care in providers. Previous research into GP fund-holding and primary care led commissioning concluded that primary care-led commissioners typically pay insufficient attention to the role of public health in commissioning (Smith and Goodwin, 2006). This proposed change in workforce would run counter to the strategy set out by Sir Donald Acheson in his landmark report *Public Health in England*, which has guided the development of public health and training in the UK since 1991 (Acheson, 1988).

10. Options for securing public health support for commissioners include:

- bringing public health specialists into consortia. This would help embed public health specialists into the commissioning cycle but it may lead to public health specialists' being isolated in small organizations;
- concentrating public health expertise (in health services) at the "PCT cluster" or NHSCB "outpost" level; and
- alternatively, the Department of Health could encourage the development of a market for public health advice comprised of a variety of providers (akin to commissioning support agencies). This might include local authorities, consultancies or independent specialists. The evidence suggests that if done well, external support can improve commissioning (Naylor and Goodwin, 2010). However, commissioners' ability and proclivity to purchase such support will depend on the budgets they are allocated, and on their recognition of the public health skills they need.

11. The NHSCB will need to collect evidence that consortia have taken and acted upon appropriate public health advice. This should include evidence that commissioning decisions have been: aligned to population needs; influenced by consideration of health care inequalities; informed by the best evidence; based on health service and treatment priorities; and that the quality and cost effectiveness of commissioned care has been adequately assessed. This collection of evidence could form part of the authorisation process for consortia and assessed annually by the local HWBs. Clear sanctions should be in place for consortia that fail to demonstrate that they have obtained and acted upon public health advice—including, as a last resort, the revocation of their authorised status.

12. Clearly, the NHSCB will have a pivotal role in the proposed new NHS structure, and the Public Health White Paper states that officials at PHE will be expected to work closely with the national leadership of the NHSCB. However, clauses 1–5 of the Health and Social Care Bill are silent on the roles, routes and accountabilities for the public health input into national commissioning decisions (Department of Health, 2011). We believe it would be important to clarify how these functions will work together, and what expertise in PHE will be available at which level for commissioners. Moreover, if "PCT clusters" are to remain, then it would seem prudent to align PHE staff with the clusters in order to ensure that public health skills are available and streamlined at this level.

Arrangements for commissioning public health services

13. The Department of Health is proposing multiple commissioning routes for public health services. Under the proposals, local authorities, NHSCB and PHE will all be commissioning public health services from ring-fenced public health funds (Department of Health, 2010a, Department of Health, 2010b). This complexity will have implications for commissioning across care pathways and could have a negative impact on the integration

of public health and health care services. For example, cancer screening will be commissioned by the NHSCB through the GP contract, but it will be quality-assured and monitored by PHE; whilst cancer treatment services will be commissioned and monitored by GP consortia (Department of Health, 2010b). Given these complex arrangements, it will be difficult to ensure that services are tailored to local needs.

14. Public health commissioning decisions and performance management should be devolved to the most local level appropriate. Such devolution should help ensure that services are kept responsive to local needs and priorities. Devolution should apply both to services commissioned by PHE through the NHSCB, and to those elements of the GP contract pertaining to public health. In addition, there should be some flexibility at a local level for tailoring contracts to ensure that services address specific concerns and populations. At times, a system manager may need to be appointed at local or regional level to provide strategic oversight, for example to integrate or reconfigure services. This could be a local authority, PCT cluster, NHSCB outpost or GP consortium.

15. The proposed changes are likely to result in a loss of co-terminosity between NHS commissioners and local authorities in some parts of England. This has potential negative implications both for the collection and analysis of information and for the joint commissioning of public health services. It is vital, therefore, that robust arrangements be put in place for commissioning public health services for particularly vulnerable populations. Such vulnerable groups include homeless people, temporary residents, people who are not registered with a GP and people who live between geographical boundaries. We believe that consortia should be obliged to consider joint commissioning arrangements where appropriate to ensure that public health services are commissioned for the entire population.

June 2011

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Written evidence from Centre for Mental Health (PH 32)

Centre for Mental Health is an independent charity working to improve the life chances of people with mental health problems in the UK. We are pleased to have the opportunity to submit evidence to the Health Committee Inquiry into Public Health. Our submission focuses on areas where we have specific knowledge and expertise based on our research and development work.

SUMMARY

- We welcome the focus and priority to be given to improving public health under the new arrangements for health, public health and social care.

- The creation of Public Health England (PHE) could provide the opportunity to ensure that mental ill health is a priority for the new public health system. The public health White Paper, taken together with the cross-government mental health strategy *No health without mental health*, symbolise a clear commitment to improving the nation's mental health and improving the life chances of people with mental health problems.
- Transferring public health responsibilities largely to local authorities could provide important opportunities for taking a life course and integrated approach to addressing the needs of individuals and families. PHE must support local communities to deliver strong local leadership and joint working, and ensure that good quality evidence is available to inform commissioning decisions.
- We support the creation of health and wellbeing boards, which have great potential to improve the health and wellbeing of people in local communities. This is particularly so for those who are the most vulnerable and disadvantaged, who often require support across a range of services.
- The Health and Social Care Bill should be amended to ensure broad representation on health and wellbeing boards not just across health, public health and social care, but also other relevant agencies such as housing services and the police, and including all local GP consortia. It should also be obligatory for local authorities to consider the role of services other than health and social care services when planning Joint Health and Wellbeing Strategies so that all the main factors which influence health and wellbeing are brought into local strategies from the outset.
- It is crucial that Joint Strategic Needs Assessments (JSNAs) accurately capture the needs in their locality, across all groups in their local population, and that delivering on them is a requirement of both local authorities and GP consortia. This will require proper support and advice in areas where expertise may be limited.
- Reducing crime should be a priority for the new public health system. We would welcome clear guidance on the commissioning routes for prison public health and drug and alcohol treatment in order to improve the coordination of support across the community and the criminal justice system.
- The transfer of the responsibilities of the National Treatment Agency for Substance Misuse (NTA) to PHE could provide the opportunity to address the current lack of equivalence between alcohol and drug service commissioning. But without specific ring-fenced budgeting for these services there is a risk of disinvestment in alcohol and drug interventions. We therefore think that there should be a mandatory responsibility for local authorities to commission specialist alcohol and drug services.
- It is crucial that the public health outcomes framework provides clear lines of accountability for achieving progress between relevant local and national bodies. Wherever possible, the outcomes framework should create joint outcomes across health, public health and social care, and ensure that where appropriate there are equivalent outcomes for mental health as for physical health.

1. *Public Health England*

1.1 We welcome the creation of PHE which could allow for a new focus on prevention and early intervention. This provides an important opportunity to tackle the range of factors that influence wellbeing, and to develop integrated and holistic services.

1.2 PHE should put mental health and wellbeing at the heart of the new public health system. At least one in four people will experience a mental health problem at some point in their life, and half of those with lifetime mental health problems first experience symptoms by the age of 14. Our estimates show that the aggregate cost of mental health problems in England is now some £105.6 billion.

1.3 PHE must support local communities to deliver strong local leadership and joint working, and ensure that good quality evidence is available to inform commissioning decisions. There must be concerted action to raise awareness of mental health among all public services and Directors of Public Health (DsPH) must be given adequate support to understand the importance of mental health to achieving public health improvements.

1.4 PHE must also ensure that high priority is given to addressing the needs of children with early starting behavioural difficulties, in a way that minimises stigma to their families and engages them in seeking support. Behavioural difficulties that start early are the most common mental health problem in childhood, affecting 6% of children at a level of severity sufficient to merit a clinical diagnosis of conduct disorder. Children who develop behavioural difficulties early have some of the poorest long-term outcomes, including not only continuing mental health difficulties but also poor educational and labour market performance, disrupted personal relationships, criminality, substance misuse and increased risk of suicide and premature death.

1.5 We welcome the commitments to increase the number of health visitors and the number of families reached through the Family Nurse Partnership Programme. Such early interventions with vulnerable families have shown to be effective in promoting resilience and protective factors in children, and have been successful in engaging those most in need with evidence based support promoting multiple improved outcomes for children. However, there are a number of significant challenges which impede the effective delivery of parenting programmes for those with early starting behavioural difficulties. One of the greatest challenges to providing effective support has been the difficulty in ensuring that what is available both reaches those most

in need and avoids stigmatising or labelling children and families. PHE must work towards ensuring that evidence-based programmes are well coordinated and are targeted at those who need them the most.

1.6 Reducing crime should also be a key priority for public health. Offending, poverty and poor mental health often have the same causes and DsPH will be well placed to reduce the risks of each within their communities, taking positive action to improve mental health within families to reduce the risk of future reoffending, as well as supporting ex-offenders to get their lives back on track.

1.7 Much more needs to be done to address the lack of equivalence between alcohol and drug service commissioning. Alcohol misuse is a major public health issue across England, costing around £23 billion a year, more than half of this in the costs of crime. Yet support for offenders who misuse alcohol is very limited: both PCTs and the NTA have restricted the range of services available to this group at all levels, from basic screening and advice to specialist treatment and support. Transferring the responsibilities of the NTA to PHE could provide an opportunity to tackle this lack of support. There needs to be adequate support available across the community and the criminal justice system to address a wide range of alcohol problems including alcohol dependency and binge drinking.

1.8 The transfer of responsibility for public health to PHE and local authorities could facilitate innovative local approaches, allow for a focus on prevention and early intervention, and lead to a better integration of alcohol and drug service commissioning. However, this will depend on whether DsPH are able to work with a range of health and other local services such as housing, employment and the police.

2. *The role of local government*

2.1 Partnership and joint working will be crucial to the success of PHE. A partnership approach is particularly important for people with complex needs where support on a number of health and other related issues is needed. Transferring public health responsibilities largely to local authorities has the potential to facilitate joint working and the development of an integrated, holistic and life course approach to addressing the needs of individuals and families. Local authorities are in a good position to improve the coordination and integration of services that have a role to play in improving health, and to promote a coherent approach to different stages of life and key transitions.

2.2 However, for this to be achieved there need to be clear mechanisms in place to secure commitment from local agencies and services to joint working. Health and wellbeing boards may provide a means to achieve this.

2.3 Health and wellbeing boards will only be effective, however, if working together is seen as a “must-do” for all. This would be supported by shared outcomes across relevant agencies as well as incentives on all agencies to work together and pool resources. The scope for promoting integration and partnership exists well beyond the NHS, public health and social care, and we would recommend that this is emphasised clearly in the creation of the new boards.

2.4 We would therefore encourage broad membership for these boards. For example, the Health and Social Care Bill as originally drafted proposed that as a minimum boards should include representatives from, among others, children’s and adults’ social services and GP consortia. We would urge that housing services and the police should also be a minimum requirement for membership of the boards. Housing and law enforcement have a significant impact on health and wellbeing, and including representatives from these services will help to bring them together with health and social services to identify areas for cooperation.

2.5 Health and wellbeing boards should also help to ensure that GPs can play a key role in areas for which PHE will take responsibility. The requirement for GP consortia to work with local authorities in relation to health and wellbeing supports this involvement, but consortia should also be encouraged to work with a range of other local bodies such as criminal justice agencies, welfare and employment services, as well as voluntary and community organisations, to ensure that GPs still play an active role in advancing the wellbeing of their local communities. Further, all GP consortia should be required to participate in health and wellbeing boards. We do not think that one person should be allowed to represent more than one commissioning consortium on a health and wellbeing board. Each commissioning consortium in a local authority area should contribute fully to promoting health and wellbeing. Having a presence at the health and wellbeing board is one way of securing the commitment required to do this.

2.6 JSNAs could also help to facilitate local partnerships. However, the NHS Commissioning Board must publish guidance for commissioning consortia on ensuring that JSNAs capture the current and future needs of consortia populations in their entirety. Sufficient expertise must also be available to consortia to ensure that JSNAs are to a high standard. It should be a duty of both local authorities and GP consortia to deliver on the core goals of the JSNA and to account locally for what has been achieved.

2.7 Joint Health and Wellbeing Strategies will also be crucial in delivering an integrated and holistic approach to improving public health. The Health and Social Care Bill enables local authorities to consider the role of services other than health and social care in drawing up these strategies. We believe that this provision should be strengthened so as to make it obligatory. This would help to ensure that all the main factors which can influence health and wellbeing are brought into local strategies from the outset. Without this requirement, key opportunities to engage services outside health and social care will be missed.

3. Commissioning and funding

3.1 It is important that good quality advice is available to inform commissioning decisions. This is particularly important in relation to mental health, an area in which commissioning bodies, such as GP consortia, may currently lack expertise. Where PHE transfers commissioning responsibility for public health services to the NHS Commissioning Board and the Board then transfers this to GP consortia, it is crucial that consortia have sufficient access to public health expertise.

3.2 Joint commissioning routes and clear lines of accountability for achieving progress on outcome measures will be crucial in bringing together a wide range of agencies to improve the health and wellbeing of local communities. Different outcomes frameworks and payment by results systems are emerging in a range of public services and these need to be brought together as far as possible to ensure that a range of services all work together towards common goals. Joint commissioning routes could be encouraged through the use of community or place-based budgets, and there must be sufficient encouragement, guidance and expertise available to support this.

3.3 Commissioning structures must also be able to provide for stable and secure funding for voluntary organisations so that they can support health improvement plans. For example, funding should be available for periods of longer than a year at a time. In addition, voluntary organisations, service users and carers and organisations representing them, should be involved from the outset in local and national decision-making forums.

3.4 The new health premium could provide a mechanism for diverting additional funding to more disadvantaged areas and incentivise action to reduce inequalities. This premium could be an opportunity to focus on what the Marmot Review identified as the social determinants of health, which is crucial for tackling health inequalities. The premium could relate to measures of these social and economic risk factors for later ill health, including risk factors for poor mental health and wellbeing. It could also be targeted at actual rates of mental and physical ill health. Whatever measurements are used, there needs to be parity of esteem between mental and physical health.

3.5 We would welcome clear guidance on the role of GP consortia in alcohol and drug commissioning. According to the White Paper, public health will be responsible for the funding of drug and alcohol misuse services, prevention and treatment. We believe that it should be mandatory for local authorities to commission a full range of drug and alcohol services to meet local needs.

3.6 While we welcome a new ring-fenced budget for public health, we are concerned that the absence of a specific ring-fenced fund for specialist alcohol and drug services could result in disinvestment in these services, particularly at a time when public funding is under pressure. To counteract this, there needs to be strong local leadership to ensure that decision-makers are aware of the benefits of investing in alcohol and drug services in terms of meeting their public health objectives. It is crucial that the public health outcomes framework reflects the responsibility of PHE and DsPH to commission specialist alcohol and drug services, and that there are clear lines of accountability for achieving good outcomes.

3.7 It is also vital to ensure that the new commissioning and funding arrangements do not result in unintended gaps in services for people with complex needs, such as those with a dual diagnosis of mental health and substance misuse problems. Although the new arrangements could provide the opportunity to improve integration between mental health and substance misuse services, greater consideration needs to be given to how NHS commissioning for mental health services but public health commissioning for alcohol and drug misuse will affect people with dual diagnosis, for whom integrated treatment is essential yet seldom delivered in practice.

3.8 We would also welcome clear guidance on the commissioning routes for prison alcohol and drug services. If the NHS Commissioning Board is to take overall responsibility for prison health care, as is currently proposed, we assume that this will include alcohol and drug treatment and interventions. This could hinder joint working and coordinated support across the community and criminal justice system. There is a strong case for health, public health, criminal justice and other agencies working collaboratively to commission a range of support as well as prevention and early intervention. Aligning funding streams on drug and alcohol treatment services across the community and in criminal justice settings could improve continuity of treatment for offenders and those leaving prison.

4. Outcomes

4.1 It is vital that outcome measures are shared jointly across public services and that services are encouraged to work with others to achieve key shared goals. This will not just bring about improvements in care and support but should secure good value for public money. We welcome the integration of the public health outcomes framework with the outcomes frameworks for the NHS and for adult social care. This will need to be developed further over time, however, to create genuine parity between physical and mental health in all domains and to extend to the full range of services for children and young people.

4.2 It is crucial that the outcomes framework provides clear lines of accountability for achieving progress between relevant local and national bodies. Wherever possible, the outcomes framework should create joint outcomes across health, public health and social care, and ensure that where appropriate there are equivalent

outcomes for mental health as for physical health. Overlaps between health, public health and social care outcomes must be clearly set out and accountability for achieving progress on those measures must be shared between the relevant bodies locally.

4.3 We support the overall framework and domains but believe that it is vital that outcome measures for mental health are fully captured within these domains, where necessary by translating some of the ideas to the specific needs of mental health service users and people with common mental health problems. We believe that there should be a duty on health and wellbeing boards to ensure that outcome measures for public mental health are given equal weight to those for physical health.

June 2011

Written evidence from Weight Watchers UK Ltd (PH 33)

SUMMARY

- Government’s public health proposals have strengths—but implications need to be thought through.
- Weight Watchers has public health expertise and experience to comment on government proposals.
- Obesity ignored within government proposals.
- Weight management services for adults an essential part of obesity solution—to “nudge” alone is not enough.
- Confusion over commissioning weight management services .
- Strategic gap between public health and GP consortia in planning weight management services.
- Funding flows complicated and boundaries unclear.
- Public Health England or NHS Commissioning Board should commission or control commissioning of lifestyle modification based weight management services.
- Lack of expertise in commissioning weight management services exacerbated.
- Weight Watchers recommends a “qualified providers” list of weight management services to the public sector.

1. *Government’s public health proposals have strengths—but implications need to be thought through*

Weight Watchers welcomes many aspects of the government’s public health proposals. They have many strengths, particularly local authority involvement, which promises to bring health back into the centre of communities and de-medicalise the notion of wellbeing. They represent an opportunity to re-fashion the commissioning processes for public health services which are woefully inadequate in relation to obesity. Generally, there are not enough service options available for those who are overweight or obese, and the commissioning of these services is often not an evidence-based process. Weight Watchers appreciates the focus on outcomes, especially when applied to weight management services for NHS patients. Providers of these services should know and be able to demonstrate the weight loss outcomes their interventions can achieve.

However, the proposals within the public health white paper represent massive change, especially in how public health will be organised. Weight Watchers has concerns over the proposed speed of change as many of the organisational implications, particularly related to access to services to help people control their weight , do not appear to have been thought through.

2. *Weight Watchers has public health expertise and experience to comment on government proposals*

Weight Watchers has submitted previous evidence to your Committee demonstrating its expertise, experience and effectiveness as a provider of lifestyle modification based weight management services to the NHS. It runs 6,500 weekly meetings in the UK facilitated by 1,700 leaders trained in simple behavioural change techniques with an evidence based holistic approach to weight management (healthy eating, physical activity, changing behaviours all in supportive environment). To date, 65,000 patients have been referred to a 12 session course of Weight Watchers meetings by 1437 GP practices across the country with favourable results (Ahern et al 2011). There is additional good quality evidence demonstrating the efficacy of Weight Watchers methodology (Heshka et al 2003, Jebb et al 2010) and the programme meets NICE best practice standards (NICE 2006).

Two thirds of Primary Care Organisations (PCOs) have worked in partnership with Weight Watchers to make Weight Watchers meetings available free of charge to their patients. Some PCOs have targeted lower socioeconomic localities, and there is some evidence to suggest that the rates of completion and weight loss in low income groups are comparable to those from higher income groups (Lloyd and Khan 2011). Indeed in an evaluation of their scheme within North Somerset NHS trust, 40% of referrals to Weight Watchers were from the most deprived quintile, yet attendance and rates of weight loss were similar to those found within a national audit (Dixon et al 2011, Ahern et al 2011). The authors concluded that NHS referral to personalised weight management services, such as Weight Watchers, was a successful way of reaching the most deprived populations. The inverse socioeconomic gradient of obesity prevalence is a clear indication that deprived communities need access to weight management services—yet the government’s proposals contain no detail

on how this will be achieved. In Weight Watchers' view the Government's response to the Marmot review on health inequalities could be far more assertive.

3. Obesity ignored within government proposals

Weight Watchers has consistently argued that obesity should be the number one public health priority. 61% of adults are overweight or obese (HSE, 2009) and this has serious implications for individuals' health and well being. Your Committee's own estimates in 2004 of direct health care costs for the treatment of obesity and its consequences totalled £991m-£1,124m, equating to 2.3%-2.6% of NHS expenditure (House of Commons Health Select Committee, 2004). These estimates were based on 2002 data, and the Government Office for Science Foresight report projected a seven-fold increase in direct health costs of overweight and obesity by 2050 (Foresight, 2007).

Despite obesity's pivotal role in public health, it is largely ignored within the public health white paper and its detailed daughter consultation on funding and commissioning routes. Weight Watchers acknowledges the intention of DoH to issue a specific framework on obesity (and has been part of a team of experts asked to consult on its development); but this signals a "bolt on" plan rather than a recognised "cross government" priority within the legislative process to reorganise public health in this country.

4. Weight management services for adults an essential part of obesity solution—to "nudge" alone is not enough

Through Weight Watchers' 50 years' experience of supporting people to manage their weight, it understands that obesity is a complex and multi-factored disease. It endorses Foresight's conclusions that tackling obesity requires an equally complex response, encompassing environmental and regulatory measures alongside lifestyle modification interventions, which seek to change an individual's behaviours associated with their diet and physical activity. All Weight Watchers' experience and research indicates that to "nudge" alone, is not enough to change health behaviours in the long term. In order to help those who are already overweight or obese requires intensive treatment and follow up. For many people the journey to control their weight requires significant effort sustained over a lifetime. They need regular support from others (peers and people trained in behavioural change techniques) plus an environment which encourages healthy lifestyle habits. Weight Watchers is encouraged that the Nuffield ladder of interventions is the government's strategic blueprint for public health, because this reinforces the important point that behavioural change interventions (such as Weight Watchers) are a crucial part of the solution. Actions are also required from other players including the food industry, catering sector, local planning, schools, nurseries, the leisure industry, government and the NHS, consumer organisations, transport agencies, and higher and further education providers.

5. Confusion over commissioning weight management services

The public health white paper focuses on prevention and protection. It makes limited mention of the health service domain of public health practice. Whilst the detailed consultation on funding and commissioning fills in some of these gaps (ie it is now clear that weight loss surgery and drug treatment will be the responsibility of the NHS), there are still significant uncertainties as to how lifestyle modification based weight management services, which are needed by an estimated 26 million adults in England, will be commissioned. Whilst these services have traditionally been seen in a "obesity treatment" context, they also have a preventive function in:

- Preventing overweight adults becoming obese and moving up the BMI continuum, thus limiting progression towards more costly and invasive treatment such as anti-obesity medications or bariatric surgery
- Reaching "at risk" children by helping overweight/obese parents inculcate healthy lifestyle habits within the home.

For these reasons, it is vital that there is absolute clarity over who will commission these services, for both overweight and obese adults, particularly for individuals on low incomes and in deprived communities.

6. Strategic gap between public health and gp consortia in planning weight management services

Weight Watchers agrees that changing, redesigning and re-configuring publicly funded weight management services is badly needed. Currently huge amounts of taxpayers' money are wasted by using expensive health professionals to deliver simple behavioural change interventions that can be more cost effectively provided by behavioural change agents (such as Weight Watchers). Results from a randomised controlled trial indicated that weight loss outcomes at one year were significantly greater in overweight and obese patients referred to Weight Watchers compared to those who received standard care delivered by GP practices (Jebb et al 2010). These results were recently corroborated by an independent study which assessed the effectiveness of a range of weight management programmes provided by the NHS and other service providers. The patient group referred for a 12 session course of Weight Watchers achieved a medically significant weight loss at programme end and sustained this medically significant weight loss at the one year follow up. Out of all the interventions evaluated in the trial only Weight Watchers patients achieved significantly greater sustained weight loss at the 1 year follow up, compared with those who "went at it alone", simply being offered 12 weeks of vouchers to attend a local leisure facility (Lewis et al 2011).

Given the lack of clarity within the Government's proposals on who is responsible for commissioning services to help people change their habits to reach and maintain a healthy weight, there will be a strategic gap in service planning between GP consortia and public health. Additionally few GPs have the management strength or appetite to effectively plan service provision for populations across localities—especially services which impact on public health. It is hard to see how the public health proposals and NHS reforms will promote joined up planning, commissioning and provision of weight management services in a way which will meet the wants and needs of local communities.

7. Funding flows complicated and boundaries unclear

Having studied the detailed consultation on funding and commissioning routes for public health, Weight Watchers found the proposed funding arrangements over-complicated and the boundaries unclear. There is a lack of clarity of what services are covered by different budget segments linked to public health. Specifically there is a danger that a ring-fenced budget for public health will be expected to cover all public health interventions; when many will continue to be the responsibility of other organisations. For example, GPs may perceive that “tier one” lifestyle modification weight management interventions should be funded by ring-fenced public health budgets held by local authorities; whereas public health directors may perceive that these services should be covered by NHS budgets. Without clear and directive guidance on where weight management sits and what patient groups sit where; there is a real risk that obesity treatment (for those with a BMI>30kg/m²) is seen as the responsibility of GPs, whilst those patients who are overweight are lost in the middle with no clear services or support strategy. The uses to which the ring-fenced budget is to be put must be identified and the size of this budget estimated from a realistic baseline that reflects local needs.

8. Public Health England or NHS Commissioning Board should commission or control commissioning of lifestyle modification based weight loss services

The government's proposals for public health and NHS reforms suggest that GP consortia will commission lifestyle modification based weight management services for their patients. This will result in a conflict of interest. GPs have a vested interest in providing these services themselves, when in reality there is evidence that other providers are equally or more effective (Ahern et al 2011; Jebb et al 2010; Lewis et al 2011) and cost the tax payers less (Curtis et al 2009). The Health and Social Care Bill proposed that GPs will have more autonomy over the services they commission for their patients and it seems that public health directors, who have the strategic insights in planning services for populations, will merely act in an advisory role. In this scenario it only seems fair and transparent that either Public Health England or the NHS Commissioning Board should control the commissioning of these types of public health services for patients.

9. Lack of expertise in commissioning weight management services exacerbated

Current proposals within the public health white paper are likely to exacerbate the current lack of expertise in commissioning lifestyle modification based weight management services. In Weight Watchers' experience of tendering to provide services for NHS patients, many commissioners lack knowledge of the weight management research literature and achievable outcomes and this is exacerbated by poor understanding of the realities of trying to manage weight. In the future GPs will be at the centre of the commissioning process. However, too few are weight management specialists. Indeed the Quality and Outcomes Framework has not encouraged the development of weight management skills and knowledge amongst GPs, whilst there is more expertise within public health directorates; this is likely to become disengaged from the commissioning process under current proposals.

10. Weight Watchers recommends a “qualified providers” list of weight management services to the public sector

Having now studied the detail within the consultation on commissioning and funding routes for public health, Weight Watchers will continue to argue for a nationally maintained list of qualified providers of effective weight management services to the public sector. In the chaos and confusion which will follow the implementation of new public health legislation it is vital that people are offered safe and high quality interventions.

The weight management arena is diverse. Interventions and services are available from a wide range of agencies in the public and private sectors. These services vary in lots of different ways—but perhaps most pertinently in the level of data which has been collected on their effectiveness and their compliance with NICE best practice standards. However many commissioners lack the specific expertise and interest in differentiating between effective and ineffective services, often relying solely on NICE best practice standards as a tick box exercise rather than taking outcomes, cost effectiveness, equality of access and scalability into account.

A list of qualified providers would save significant time and money so that commissioners can focus on getting the best services to the most deserving people faster. Inclusion within this list would depend on:

- Outcomes of service/intervention—ability to demonstrate efficacy
- Savings—versus alternative services or doing nothing.
- Cost effectiveness to the NHS.

- Safety, including compliance with NICE guidelines.
- Referral criteria, ensuring equality of access.

June 2011

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Written evidence from Association of Convenience Stores (PH 35)

1. ACS (Association of Convenience Stores—Annex 1) welcomes the opportunity to respond to the Health Select Committee Inquiry into Public Health. The restructuring of the NHS and the devolution of public health decision-making to a local level creates both opportunity and challenges for the retail sector.

2. This response covers the following issues:

- ACS’ current public health initiatives and how they will be affected by the reforms;
- the impact of the public health reforms on the business sector;and
- the need for greater ownership of policy relating to the illicit tobacco and alcohol trade as part of the public health agenda.

PUBLIC HEALTH INITIATIVES

3. ACS has worked with Government and other industry bodies to create voluntary partnership schemes which aim to tackle public health issues. Below is a summary of Community Alcohol Partnerships (CAPs) and the Change4Life convenience store project. These schemes are designed to be introduced at a local level in response to specific local problems and rely on strong relationships being created between local businesses, communities and other authorities. The devolution of public health responsibility should encourage the creation of these local partnerships. However there remains a role for national Government and industry representatives to make the case for partnership working and to provide support and encouragement where necessary.

Community Alcohol Partnerships

4. The Community Alcohol Partnership model was developed by the Retail of Alcohol Standards Group (RASG) and aims to tackle public underage drinking through co-operation between alcohol retailers and local stakeholders.¹⁶ CAP addresses both the demand and supply side of underage drinking through enforcement, education and public perception.

¹⁶ Such as Trading Standards, police, local authority licensing teams, schools and health networks.

5. The key component in CAPs success is that it is based on partnership approach which sees retailers as part of the solution to underage drinking, not just part of the problem. All parties share information to ensure that issues relating to underage drinking, whether concern surrounding a retailer, proxy purchaser or certain underage drinking area, are tackled. This work goes hand in hand with joint confiscation operations between police and trading standards and educational sessions for pupils and parents in local colleges and schools highlighting the legal issues in attempting to purchase alcohol and raising awareness of proxy purchasing.

6. The impact of CAPs has been independently evaluated.¹⁷ In the trial area of St. Neots, Cambridgeshire evaluation showed:

- a 42% decrease in anti-social behaviour incidents in the St Neots area from August 2007 (pre-project) to February 2008 (post-project);
- a 94% decrease in under-age people found in possession of alcohol; and
- a 92% decrease in alcohol-related litter at key hotspot area.

7. Kent County Council was the first area to introduce a CAP county wide and they had the scheme independently evaluated by Kent University. Overall results showed criminal damage down by 28% and total recorded crime was down by 16%.

Change4Life Convenience Stores Project

8. ACS has also been involved with the Change4Life convenience stores project, which encourages convenience store retailers to improve their offer of fresh fruit and veg and creates invaluable links between schools, health workers and retailers. The project has three aims:

- increase access to and availability of fresh fruit and vegetables in convenience stores;
- increase sales of fruit and vegetables by focussing on improving range, merchandising, quality and communication in stores; and
- drive awareness of fruit and vegetables to the consumer through good sign posting within retail stores using the Change4Life brand.

9. Over 200 stores have taken part throughout England over a period of three years and have seen on average sales growth for fresh fruit and veg of 35%. This is particularly important for tackling health inequalities as many of these stores are in deprived communities and offer the only source of fresh and health food.

10. Retailers have to commit to reviewing their range of fresh fruit and vegetables, appointing a fresh food champion, introduce a fruit and veg marketing plan and using the Change4Life branding only on fresh fruit and vegetables. ACS is continuing our commitment with the project under the Responsibility Deal.¹⁸

IMPACT OF THE PUBLIC HEALTH REFORMS ON THE BUSINESS SECTOR

11. While the shift towards localised public health decision making will facilitate the operation of localised schemes, it could also create significant problems for businesses, especially those operating on a national level. It has to be recognised that in many instances these problems will result in extra cost and burdens and a balance must be struck between localisation and business certainty.

12. There are clearly some public health policy areas which require a lead from national Government, either due to the complex nature of the evidence base or the associated legal complexities. For example any activities restricting price, promotions and siting clearly needs to be taken at a national level, due to the complexities surrounding European competition law.

PUBLIC HEALTH ROLE OF THE SECRETARY OF STATE

13. Despite the devolution of power, the Secretary of State needs to retain leadership for the direction of public health policy. In particular the Department of Health needs greater ownership for policies relating to the reduction of the illicit tobacco and alcohol trade. The illicit trade, particularly in tobacco products, is a threat to Government public health policies, especially those targeted at reducing health inequalities. A significant proportion of lower income smokers buy tobacco from illicit sources within the UK¹⁹ and young smokers are also likely to be at greater risk.²⁰ It is clear that further efforts to control smuggling are probably the most important tobacco control measures that Government can adopt, particularly with a view to reduce underage smoking.

¹⁷ See <http://www.wsta.co.uk/social-responsibility/133-info/392>

¹⁸ For further information please see http://www.acs.org.uk/en/lobbying/issues/food_policy/

¹⁹ The *Smoking Toolkit Survey* compiled by ASH has found that 22% of those in C and D socio-economic groups buy tobacco from illicit sources within the UK, compared to 12% A and B.

²⁰ A more recent survey for Trading Standards North West of 14–17 years old found that nearly one in five (19%) bought from street sellers, vans, neighbours or private houses, 60% had bought packs of cigarettes with health warnings in a foreign language and up to 50% said they had bought fake cigarettes.

14. Yet current responsibility for this policy resides with HMRC at both a national and a local enforcement level, while for other associated legislation responsibility lies with the Department of Health.²¹ The Secretary of State needs to take responsibility for this issue, heading a regular cross-Government illicit trade policy meeting with representatives from HMRC and the Home Office.

15. With the Department of Health taking the lead, there could be a devolution of responsibilities relating to local inland enforcement to the Police and Trading Standards. Understandably HMRC focus their enforcement on preventing large cross-border shipments. However the inland illicit trade, which allows products to be accessed from tab houses, white vans and car boots, is not tackled with the same resource.²² Trading Standards and Police, who currently enforce other aspects of tobacco and alcohol legislation on the ground, have the networks with retailers and communities to more effectively tackle the issue.

16. Tackling the illicit trade for tobacco alone would significantly benefit the health service, leading to 4,000 fewer deaths caused by smoking-related illnesses²³ and creating an increased tax revenue of £1.3 billion.²⁴ It is clear and the responsibility for this issue must be transferred to the Secretary of State for Health as a crucial aspect of the Public Health remit.

Annex 1

THE ASSOCIATION OF CONVENIENCE STORES

ACS is the trade body representing the interests of over 33,000 convenience stores operating in city centres as well as rural and suburban areas. Members include familiar names such as The Co-operative Group, Spar and Costcutter, as well as independent stores operating under their own fascia. Our members operate small grocers, off-licence or petrol forecourt shops with between 500 and 3,000 square feet of selling space.

June 2011

Written evidence from the Royal College of Midwives (PH 36)

1. The Royal College of Midwives (RCM) is the trade union and professional organisation that represents the vast majority of practising midwives in the United Kingdom. It is the only such organisation run by midwives and for midwives. The RCM is the voice of midwifery, providing excellence in representation, professional leadership, education and influence for and on behalf of midwives. We actively support and campaign for improvements to maternity services and we also provide professional leadership for one of the most established of all clinical disciplines.

2. The RCM welcomes the opportunity to contribute to the Health Committee's examination of public health. Our response is based on the views and opinions of RCM members, lay representatives and officers.

3. Maternity care is very important in delivering improvements in public health. As the Public Health White Paper, *Healthy Lives, Healthy People*, states, "*The health and wellbeing of women before, during and after pregnancy is a critical factor in giving children a healthy start in life and laying the groundwork for good health and wellbeing in later life.*"

4. Indeed, midwife-led care can make an important contribution to the wellbeing of childbearing women. Women who access midwife-led care tend to report high levels of satisfaction with the service they receive, because they are made to feel empowered. The sense of wellbeing that this engenders is known to be important in contributing to the future health of the newborn child. Midwifery-led care also leads to higher rates of breastfeeding—a critical public health intervention.

5. We would also like to state specifically that we welcome the Government's commitment to narrowing health inequalities through improving the health of the poorest, fastest. We support also the adoption in the White Paper by the Government of the Marmot Review's advocacy of proportionate universalism.

6. The RCM supports an explicit public health role for the Secretary of State. We welcome the proposal that public health will be embedded in the Secretary of State's mandate for the NHS Commissioning Board. We would go further and recommend that the mandate also recognises the crucial public health role played by midwifery services and ensures that this public health function is effectively delivered through adequate antenatal and postnatal provision. This can also be enhanced by mandating for schemes that are midwife-led and which enhance continuity.

7. We note the reference to the announcement in the Coalition agreement that the Department of Health (DH) will strengthen the role and incentives for GPs and GP practices on preventive services. We would not wish to dispute the critical role that GPs play in both primary and secondary care prevention. We would simply point out that when it comes to the preventive aspects of maternity care, that midwives are as important

²¹ Such as Tobacco Banning Orders and the Tobacco Display Ban.

²² Inland enforcement represents just 180 million of seized product by far the lowest level for seizures. *Tackling Tobacco Smuggling Together* HMRC 2011.

²³ British Medical Journal *Why combating tobacco smuggling is a priority* 2008.

²⁴ See http://www.ash.org.uk/files/documents/ASH_720.pdf

to mothers and babies as GPs are. Could the DH therefore look at strengthening the role and incentives for midwives?

8. We welcome too the establishment of a new public health budget, ring-fenced within the overall NHS budget. We criticised the previous Government for raiding public health budgets when the NHS faced cost pressures in the past, so we view this as a welcome development. However, we also note the stated hope that the DH will “*work to ensure that funding for public health is not squeezed by other pressures*”, which strikes us as falling somewhat short of being a copper-bottomed guarantee that the budget will in fact be ring-fenced.

9. Indeed, an early sign of this risk has been the removal of government funding for National Breastfeeding Week (19–25 June). It is widely acknowledged that breastfeeding offers babies the best possible start in life, and this withdrawal of funding can only really be seen from the perspective of cost-cutting. This is a bad sign, and we look to the Committee to highlight this example.

10. Since public health is as much a function of maternity services, health visiting and GP services as it is a specialist function in itself, the question will arise what is covered by ring-fencing and what sits outside the public health budget? While recognising that further work is needed in order to properly cost the public health budget this only reinforces the importance of clarifying how public health functions are defined and where responsibility rests for commissioning, funding and providing those functions.

11. The RCM supports the recognition of the vital role that local government can have in leading on public health. We recognise the logic of giving lead responsibility to local government, since many of the functions it oversees—such as education, housing, planning and transport—have a significant impact on the health and wellbeing of local communities. Indeed, we support, in principle, the establishment of Health and Wellbeing Boards and recognise the potentially valuable role they can fulfil in bringing together local government, the NHS and public health to take a rounded view of the needs of local populations. Accordingly we agree that Health and Wellbeing Boards are the appropriate body for bringing together ring-fenced public health and other budgets.

12. Whilst we agree with the proposal to embed public health within local government, we are concerned that the Government intends to “*keep to a minimum*” the constraints as to how local government decides to fulfil its public health role and spend its public health budget. Our anxiety stems from the fact that determination of these issues will now be in the hands of elected representatives, the majority of whom will have been elected on a manifesto that may or may not include public health issues. This could lead to considerable variation in the availability and quality of public health services if prioritisation is left to local politicians. It may also lead to instability in local authorities where political power regularly changes hands or in councils where no one party is in overall control.

13. If left to the vagaries of local government politics there is a real danger of a public health postcode lottery developing—when what is needed is for public health to be a priority in every area. Directors of Public Health (DsPH) will be an important check to preventing public health slipping down a local authority’s list of priorities and we welcome the proposal that they act as the strategic lead of public health in local communities and that they will be responsible for the health improvement functions of local authorities. We think however that further safeguards are needed in order to maintain the professional independence of DsPH.

14. The RCM supports in principle the allocation, by Public Health England (PHE), of ring-fenced public health budgets to local authorities, as stated above. We do however have some reservations relating to our other concerns about the political priorities and knowledge and understanding of public health issues of local politicians.

15. Another important consideration is the extent to which Health and Wellbeing Boards are able to access appropriate clinical advice and expertise. However, we are not clear how the new boards will access professional midwifery advice; given the importance of maternity care, as acknowledged by the Public Health White Paper, we see this as a significant omission. The White Paper proposes that membership of local boards should be expanded to include local clinicians and the RCM would therefore recommend that Heads of Midwifery (HOMs) should be represented on all Health and Wellbeing Boards. Similarly, professional midwifery advice will also be crucial for the effective operation of Joint Strategic Needs Assessments (JSNAs) and the joint health and wellbeing strategies.

16. On commissioning, the RCM has some concerns regarding the services listed as coming under the aegis of PHE for the purposes of funding and commissioning. Our chief concern is that there are clear funding and commissioning routes and that, as with GP-led commissioning, there is input from midwifery services for those services—such as smoking cessation and obesity—that require input from midwives. There also needs to be greater clarity around how certain services are defined, in order to ensure that the right organisations are funding and commissioning those services. For example, the RCM is as yet unclear how screening services are defined and what, if any, distinction will be drawn between routine scanning services and national screening programmes. It is vitally important that these definitions and distinctions are quickly established in order to ensure that there is clarity as to those elements that form part of national tariffs and those services that fall within the remit of PHE.

17. In terms of commissioning public health services from the voluntary and independent sectors, we would question whether this is inherently beneficial to health improvement programmes. That is not to say that

voluntary and independent providers don't have an important contribution to make in providing some health and wellbeing services. But it is important to ensure that the provision of health and wellbeing services is commissioned and organised not on the basis of a competitive free-for-all but rather so as to maximise opportunities for integration and cooperation between NHS, local authority, public health, voluntary and independent providers. Our starting point would therefore be to identify, via the JSNA and health and wellbeing strategy, where there are gaps in service provision or where existing providers have demonstrably failed to deliver services of an acceptable standard and quality; it would then be possible to consider whether there is a role for voluntary and independent providers to provide the capacity to deliver in these areas and to contract accordingly.

18. For primary care services it will be important for the NHS Commissioning Board to ensure that commissioning decisions are underpinned by a combination of recommendations contained in relevant NICE quality standards, by research evidence produced by the public health observatories that will come under the control of PHE and by the recommendations of relevant professional organisations, such as the Association of Directors of Public Health.

19. In terms of ensuring that public health expertise informs NHS services commissioned by GP consortia, the most effective source of advice will be from local DsPH. These people however themselves need to have mechanisms in place for hearing the advice of experts.

20. The RCM supports the creation of a Public Health Outcomes Framework as an accountable, transparent framework for measuring the effectiveness and impact of public health activity. We believe that the framework should also promote joint working where local organisations share common goals. For the framework to do this effectively, it is important that all partner organisations are able to access comprehensive and rigorous health, demographic, social and economic data. In this respect it is important that PHE has the requisite funding to resource and support the public health observatories that it will be managing.

21. The RCM would in principle support linking a proportion of health improvement funding to progress on elements of the Public Health Outcomes Framework, so long as the agreed performance measures were stretching but also measurable, realistic and achievable.

22. The RCM supports the ring-fencing of public health funding, nationally and locally. Furthermore, we support in principle the proposal to develop a health premium as a means of incentivising local authorities to make progress on health improvement priorities and reduce health inequalities. The RCM believes that the overriding factor in designing the health premium is the extent to which interventions offer the greatest long-term benefits. We also believe that the premium should incentivise reductions in inequalities. We would therefore recommend that health premiums are developed that focus on early intervention as the most effective means of ensuring every child gets the best start in life and of reducing health inequalities. Accordingly health premiums could be used to incentivise progress on outcomes such as breastfeeding or smoking cessation.

23. On the question of the regulation of public health specialists, it is relevant to say that the Nursing and Midwifery Council (NMC) currently regulates midwives, health visitors, children's nurses and occupational health nurses, all of whom undertake roles with a strong public health component. The RCM would therefore strongly recommend that the NMC is best suited to provide a system of voluntary regulation for public health specialists.

June 2011

Written evidence from the School Food Trust (PH 37)

SUMMARY

The food that children eat has a direct impact on their health. Improving the diet of children and young people, at school, at home and in the community is important because:

- Habits that are developed as children are carried into adult life and impact on their future reliance on health services.
- Poor nutrition is at the heart of the health inequalities faced by many children.
- Healthy school food improves children's health—and their behaviour and performance at school.²⁵
- Healthy children are able to reach their full potential—when children eat well, they do well.

As a result, we suggest that the proposed minimum membership of the statutory Health and Wellbeing boards should include a children's food specialist.

EVIDENCE

1. The School Food Trust is the Government's leading expert advisor on children's food. We work in schools to transform school food and run the largest network of cooking clubs in England which gives adults and

²⁵ <http://www.schoolfoodtrust.org.uk/documents/slab2>

children the confidence, skills and knowledge to make healthy food choices and cook good food themselves. We welcome the opportunity to submit evidence to this committee, and to contribute to the Government's plans to tackle public health challenges.

Why is children's food so important?

2. Experts predict that, left unchecked, overweight and obesity will cost the UK economy £50 billion a year by 2050—with devastating social and health consequences.²⁶ Clearly, the food that children eat has a direct impact on their health. Improving the diet of children and young people, at school, at home and in the community is important because:

- Habits that are developed as children are carried into adult life and impact on their future reliance on health services.
- Poor nutrition is at the heart of the health inequalities faced by many children.
- Healthy school food improves children's health—and their behaviour and performance at school.²⁷
- Healthy children are able to reach their full potential—when children eat well, they do well.

3. We continue to see a significant increase in diet related illnesses amongst children. The Advisory Panel on Food and Nutrition in the Early Years, February 2011, highlighted that children eat too little carbohydrate and essential minerals such as iron and zinc, and too much salt and sugar. Type 2 diabetes is appearing at earlier and earlier ages, and dental health in young children is deteriorating.

4. The National Child Measurement Programme 2009–10 reported that in Reception, nearly a quarter (23.1%) of the children measured were either overweight or obese. In Year 6, this rate was one in three (33.4%). The percentage of obese children in Year 6 (18.7%) was nearly double that of Reception (9.8%), whilst the percentage of overweight children was higher in Year 6 (14.6%) than in Reception (13.3%).

5. The health and life chances of too many children, particularly those from disadvantaged backgrounds, are being undermined by obesity and diet related diseases and conditions. But health is not just about the presence of disease or illness—it is about being able to take advantage of the opportunities offered—being able to flourish. The personal and social impacts of the food children choose, or are offered, often determine their future and have life-long consequences. Undernourished children are less likely to reach their full potential.

A children's food specialist on all Health and Wellbeing boards

6. There is a range of complex factors which affect a child's diet. Detailed understanding and expert advice on these are fundamental to enabling Directors of Public Health to shape local services and deliver their vision for public health. We suggest that the proposed minimum membership of the statutory Health and Wellbeing boards should include a children's food specialist. Such a person would provide the expert overview of the composite picture linking food and improved health. Their advice would also help councils to adopt a holistic approach to food—and to join up policies to make the maximum impact and secure cost savings.

7. Ensuring that the Health and Wellbeing boards include a children's food specialist will support the targeted and rapid development work that is needed. Their presence would encourage councils to review and influence the food provision across local community services, and support changes to the environment so that healthy choices are easier to make.

8. The opportunities are varied and compelling. For example, standards in the food that is served to children in hospitals are currently variable—many hospitals serve meals that have high levels of salt and fat which are linked to an increased risk of children developing high blood pressure and diet related disease such as obesity.²⁸ And the average calorie content of the snacks most often found in vending machines in leisure centres is 203. An average seven year old would need to swim for 88 minutes to use up these calories.²⁹

9. A children's food specialist would help councils understand the impact of a balanced diet on the full range of public health outcomes, including obesity. Only when the impact is understood can an action plan be developed to bring about the changes necessary. Food for children—in school and outside—and cooking education should be clearly linked into the public health planning process.

A change worth making—the School Food Trust experience

10. The Trust was established on the principle of helping people to help themselves. We agree that everyone needs to take responsibility for their own health, but people need to be properly informed and to be given the skills they need to make healthy choices. We have increased—rather than decreased—the food choices available at schools. This has introduced children and young people to unfamiliar food and helped them to make healthy choices in an increasingly commercial environment. We have helped children and adults to improve their own

²⁶ Foresight Report, 2007.

²⁷ <http://www.schoolfoodtrust.org.uk/documents/slab2>

²⁸ Consensus Action on Salt and Health, October 2010.

²⁹ British Heart Foundation, Food for Thought.

cooking and food skills and seen them develop a real enjoyment of good food. Our interventions, based on nudging people in the right direction, are bringing about real changes:

- The 30 year decline in the number of school meals eaten has been reversed—the number of school meals eaten every day continues to rise.
- The quality of school food has risen. School meals are more nutritious than packed lunches. More fruit and vegetables are being eaten for school lunch.
- Learning related behaviours in the classroom (concentration and attention) improve after children have eaten a school lunch.
- Over 4,000 Let's Get Cooking clubs are in operation across England, improving the cooking and food skills of 900,000 adults and children.
- 58% of Let's Get Cooking club members report eating more healthily.
- 90% of Let's Get Cooking club members report they use their new skills at home.

11. The School Food Trust is ideally placed to provide support to the children's food specialists on Health and Wellbeing boards.

12. The food children eat today make them the adults they become tomorrow Good quality food improves children's health, behaviour and performance. It helps children develop good eating habits—which are shared with their families—and plays a significant role in assisting them to maintain a healthy weight. Food and cooking is an important part of culture, and plays vital non-nutritive roles. Recognising and engaging with diverse foods enriches people's lives, and provides a basis for sharing experiences and connecting with others. Improving the food children eat and giving them food skills is a common sense way to improve their health. A public health system that recognises the importance of children's food is one that gives all children a healthy start and the opportunity to flourish.

13. The School Food Trust has separately offered contributions to the forthcoming Department of Health Obesity Document.

June 2011

Written evidence from the Yorkshire and Humber Health Trainer Hub Team (PH 38)

SUMMARY

- The transfer of health improvement into Local Authorities is positive in principle but we have a number of concerns about what the transfer will mean in practice for health trainer services and for health improvement provision more generally.
- The fragmentation of both commissioning and provision across a number of agencies poses dangers in terms of lack of health improvement (and specifically health trainer) expertise being available where it is needed.
- There is a real danger than funding for health improvement will be reduced to what is left after Public Health England and health protection has been funded.
- Health trainers and community health champions have the potential to enable organisations to engage more effectively with communities, both as lay people themselves and through their reach out to other members of the public.
- Health trainers now have a strong evidence base and the potential to save a lot of public sector money if programmes are effectively commissioned and scaled up.
- For health trainers (and other practitioner level public health staff) there is a lack of consistency around training and continual professional development and an absence of clear career pathways that needs addressing.
- The effectiveness of health trainers (and community health champions and social prescribing) depends on there being community based activities to improve health which they can signpost people to. Many of such activities (both in voluntary and statutory sectors) are being cut which in the long term will increase ill health, health inequalities and demands on health care.
- Health trainers are part of a wide range of health improvement activities which engage lay people in their delivery and which are achieving results but which need more recognition, support and mainstreaming if we are to develop a health and social care system which enables people to achieve not just great life expectancy, but greater healthy life expectancy.

SUBMISSION

1. The Health Trainer Programme has been developed over the last five years in a unique collaboration between the National Team at the Department of Health, regional teams and local services. An enormous amount has been learnt about how to recruit, train and support a lay workforce to effect behaviour change in some of the country's poorest communities. This submission is being made by the Yorkshire and Humber Health Trainer Hub Team which is responsible for rolling out the Health Trainer Programme across the region.

2. We welcome the transfer of health improvement functions to local authorities. Health trainers are the only public health workforce specifically focussed on addressing health inequalities. They are about promoting health and engaging with disadvantaged communities to do this—an approach that sits well with local authorities. However we have a number of concerns about what the transfer will mean for health trainer services and for health improvement provision more generally.

3. The remit of public health and of DPHs is huge and we are concerned that the focus of activity tends to be on health protection, health care delivery and information gathering/analysis rather than on commissioning/delivering health improvement and addressing inequalities in disadvantaged populations and we are concerned about a potential loss of focus on health improvement for the reasons we set out below.

4. There was some real fragmentation of health improvement services following the commissioner/provider split in PCTs and more recently the running down of PCTs ahead of reorganisation. Many, including health trainer services, previously managed in public health directorates, have gone into providers in other NHS bodies, the voluntary sector or local authorities or have become social enterprises. Whilst in some instances this is working well, overall there has been a reduction in the involvement of senior public health managers with understanding of health improvement in commissioning and running programmes. This process is being exacerbated by ongoing management reductions and reorganisation.

5. The fragmented nature of services and the continual churn in commissioners and managers means that the lessons learnt from rolling out innovative programmes like health trainers are in danger of being lost. It is commonplace for health improvement services to be commissioned and managed at higher levels in statutory organisations by people with no understanding of these services.

6. We welcome the principles behind Health and Well Being Boards and endorse the need for a more strategic approach to health improvement, but are concerned that they could just become talking shops which make little difference on the ground, and that it will be difficult for them to implement a strategic approach when services are increasingly fragmented in different provider organisations. We are concerned that sufficient attention must be paid to building relationships and shared understanding between members of health and well being boards in order to be effective.

7. Where commissioners are interested in health trainers we have concerns about where they will get the information from to commission effectively. The National Health Trainer Team at DH which has steered the roll out of the programme has gone as has the National Support Unit for Health Inequalities which supported the implementation of health trainers in spearhead districts. Some regional health trainer teams have now gone, others have stretched their funding to continue until March 2012, after that it is unclear where the knowledge and learning accrued over the last few years will go, although various possibilities are being investigated.

8. We have reservations about ring fencing public health monies as health trainers are already involved in areas like leisure services and social care and if they are just seen as a service to be commissioned through public health we think that could limit their potential to work across many departments within local authorities. We also have concerns about the amount of funding that will be left for health improvement once money has been allocated to set up Public Health England and for health protection.

9. In Yorkshire and the Humber there is a very varied picture re the level of funding for health trainers (and for health improvement services generally) and it seems uncertain whether they will be commissioned through local authorities or GP commissioners in the future, or possibly both, in the future. Many health trainers work closely with GP practices, and some are based in them, but many also work in community settings with some of the most disadvantaged groups. There is a danger of GP consortia just seeing commissioning health improvement as the local authority's role and the local authority not having the resource or expertise to do this effectively. With tightening finances the danger is that commissioners see health improvement as someone else's responsibility and health trainers could fall between them.

10. As currently described we think that health premiums would be unworkable and will exclude some local authorities which do not meet the criteria through no fault of their own, whilst penalising others who might for example get worse because of population movements rather than anything to do with the local authorities activities. Incentivising health improvement is complex and the health premium needs to be carefully designed so that it does not have the effect of disproportionately rewarding improvement in those populations which are easier to reach and change, rather than those that are harder to reach and slowest to change.

11. Health trainers are lay people, drawn from the communities they serve and therefore have a lot of knowledge of those communities. Their expertise, along with that of other non clinical staff in the public sector could be an important aspect of public involvement in commissioning which is currently undeveloped. Many public sector staff are low paid, live in the areas they work in and are members of 'the public' who so far, the public sector has been very poor at engaging with.

12. In principle we agree with having outcomes, but think they need to be carefully framed so as not to create perverse incentives. So for example they need to encourage evidenced based interventions which specifically address the inequalities gap or there is a real danger than health improvement programmes will be designed to "get the numbers in" but will increase the gap. Health trainers are one such evidence based intervention.

13. Health inequalities outcomes are more likely to be addressed if some indicators reflect different levels of attainment i.e. using a physical activity example, an indicator could be about encouraging people to moving on from where they are now to an improved position for example a positive behaviour change from being sedentary (inactive) to being more active (ie moving from being active on zero days per week to one day per week, one to two etc) in order to capture changes in those with the lowest levels of inactivity.

14. Although there are separate Outcome Frameworks for the NHS, public health and for social care, it is positive that, where outcomes depend on integration and alignment, indicators are replicated across the three frameworks, or complementary indicators are included. However we feel there is more scope for integration and that to ensure all sectors work in partnership to achieve outcomes, it is important that there are shared reporting arrangements and that all parties benefit from incentives.

15. In relation to workforce, attention within public health has been focussed on the regulation and development of senior staff, mostly at consultant and DPH level. We think that there should be a shift of focus towards the needs of the public health workforce at lower levels, like health trainers, but also other health improvement practitioners, some of whom have lost their jobs as funding has been scaled back. At the moment there is a lack of consistency around training and continual professional development and an absence of clear career pathways that needs addressing.

16. There are many promising developments in relation to lay engagement in public health, in particular the community health champion role has achieved greater recognition in recent months (one of the Big Society Awards went to the Altogether Better Programme in Yorkshire and Humber which is training and developing champions). Health Trainer Services are increasing recruiting and training health trainer champions who are volunteers from target communities who promote the service and signpost people into it, thereby extending the service's reach into marginalised communities. There needs to be much greater recognition of the role volunteers are playing in promoting health, particularly in some of our most disadvantaged communities, and investment in developing and supporting this form of lay engagement.

17. We support the findings of the Marmot review and have concerns, some of which we have detailed above, that the social determinants of health and health inequalities are not being addressed by current policy, and indeed are getting worse, one example being in relation to housing policy.

18. Health trainers have an important role to play in addressing inequalities, but, despite what is now a strong evidence base, including clear evidence of how they can save money in the short and medium term, programmes have not been scaled up to a level where they can make a real difference to population outcomes.

19. Social prescribing is another approach, which can be combined with health trainers to achieve excellent results for people who are socially isolated or have low level mental health problems, which has not been scaled up.

20. Health trainers and champions are increasingly supporting people living with long term conditions through simple measures like for example helping diabetics to develop new meal plans, shop for appropriate foods and manage on a budget. Both this approach and social prescribing, if scaled up across health economies, could save considerable amounts of money and reduce health inequalities.

21. Health trainers, community health champions and social prescribing all depend on there being community based activities to improve health which they can signpost people to. Many of these activities are run by voluntary and community groups and are disappearing as these groups experience cuts in their funding. Walking groups, cook and eat sessions and weight management support are just some examples of activities that do not need a lot of funding but do need some, and which are vital if those in marginalised groups are going to be able to change their behaviour to improve their health.

22. In conclusion, health trainers are part of a wide range of health improvement activities which engage lay people in their delivery and which are achieving results but which need more recognition, support and mainstreaming if we are to develop a health and social care system which enables people to achieve not just great life expectancy, but greater healthy life expectancy.

June 2011

Written evidence from The Bow Group Health & Education Policy Committee (PH 39)

EXECUTIVE SUMMARY

1. The Bow Group supports the motives and rationale behind the creation of Public Health England, which if properly implemented will help support people in maintaining and improving their health, mainly at a community level through local councils, whilst keeping a firm national grip on public health issues such as flu pandemics at a national level.

2. However, we would particularly like to bring to the Committee's attention our view that it would be the wrong decision to abolish the Health Protection Agency, and we call for the Government to think again and reverse this policy.

3. The Government's plan to give Local Authorities more power and responsibility for their population's health can be seen as a positive step and consistent with the wider vision to devolve healthcare decision-making to the local level. However, more detail is needed to explain how these plans will be implemented and how responsibilities will be allocated. At this point, the Government has only postulated a broad framework for implementation and important detail is missing.

4. We support the proposed framework of Health and Wellbeing Boards and hope they will go some way to bring together those local bodies responsible for the improvement of local population health.

5. The Bow Group welcomes the rationale behind the Public Health Outcomes Framework and would urge the Government to build on this by developing a national standard for public health interventions.

6. We would like to see a greater focus from the Government so that all healthcare professionals, from the student to the consultant, from the nurse to the dietician, are trained, skilled and motivated to practice preventative medicine.

INTRODUCTION

7. The Bow Group exists to develop policy, publish research and stimulate debate within the Conservative Party. It has no corporate view, but represents all strands of Conservative opinion.

8. The Bow Group are delighted that the Health Committee has chosen to undertake an inquiry into public health. In recent years, the Bow Group has taken a great interest in developments around public health and we have previously published a considered response to the Government's White Paper on public health, 'Healthy Lives, Healthy People: Our Strategy for Public Health in England' which can be downloaded by accessing the following link:

http://www.bowgroup.org/files/bowgroup/Bow_Group_Public_Health_White_Paper_Response_FINAL%2029%2003%2011.pdf

9. We are grateful for the opportunity to provide this response to a number of the Committee's questions.

Creation of Public Health England

10. A central part of the White Paper concerns the creation of a new public health service called Public Health England. Operating within the Department of Health (DH), Public Health England will oversee national public health programmes in areas such as vaccination, screening, health visitors and family nurses.

11. The Bow Group supports the motives and rationale behind the creation of Public Health England, which if properly implemented will help support people in maintaining their health, mainly at a community level through local councils, whilst keeping a firm grip on national public health issues such as flu pandemics at a national level. In principle, it should help to provide a focal point for prioritising an overall improvement in public health. Public Health England should also provide an excellent opportunity to coordinate health, social and other services, which currently often work in isolation. The critical challenge will be implementation and explaining to people within the NHS and outside how exactly this new part of the healthcare system will function and operate; a significant challenge the Government is already confronting with its wider NHS reform programme.

12. The White Paper confirms that a ring-fenced funding pot of at least £4 billion will be provided for tackling public health issues. Part of this money will be spent by local councils and the rest by Public Health England. The Bow Group is pleased with this development and believes this will go some way to ensure that public health budget will no longer be "raided" by the NHS to cover deficits. However, in future it will be essential that Public Health England is funded adequately to undertake its important role. This cannot be a one-shot measure or an easy target for spending cuts when the going gets tough. The White Paper is less convincing and reassuring in this regard.

13. It is also concerning that there is increasing evidence already that the £4 billion expected to be allocated to Public Health England might lead to an underfunded system in the future. For example, Health England data from 2009 showed a £3.7 billion spend on public health and health improvement in 2006–07, increasing to £5 billion if some categories of medication were included. The same report identified a further £1.3 billion when environmental health services, food safety measures and health visiting services were factored in.¹ A new public health service will only work with proper funding, and there is an immediate worry that the finances have not been fully thought through.

14. There is a real need to challenge conventional thinking in this regard. Otherwise, there is a real danger that the important work of Public Health England could be undermined from the start due to a lack of financial backing and sustainable funding. We urge the Government to set out at the earliest opportunity how the funding structure for public health will precisely work and how this will be sustained over time.

Abolition of the Health Protection Agency (HPA)

15. In addition, we have some concerns about reports that the two QUANGOs being pulled into Public Health England, the National Treatment Agency and the HPA, risk losing around 15–20% funding over the

next year adding more pressure to the proposed budget.² In the case of the HPA, a breakdown of its accounts shows the agency to be largely self-sufficient in many areas of its *modus operandi* due to international research grants and other external funding—something that does not cost the beleaguered taxpayer a single penny. This is primarily due to the HPA's strong international reputation—arguably an “asset” rather than a “liability” in financial terms.

16. With this in mind and given the Government's rationale for cutting the size of the QUANGO state, ie to reduce costs and deliver economic efficiencies, the abolition of the HPA and its integration into a new Public Health Service would seem odd and counter-intuitive. We feel it is the wrong decision to get rid of the HPA, and we call for the Government to think again. One other viable option is to make the HPA an “executive agency”, which would be politically acceptable but ensure critical functions are not jettisoned or messily merged into the DH itself.

Structure of Public Health England

17. There is also a clear need for more detail on how exactly Public Health England will be configured, organised and structured. This is particularly important given that the new Public Health Service will be assuming critical roles and responsibilities.

18. As discussed above, one such example is health protection where the functions of the soon to be abolished HPA will soon be transferred to Public Health England. The HPA's current responsibilities are by no means trivial, covering highly skilled and intricate areas such as preparedness and protection against health hazards, infectious disease, and hazardous chemical, poisons and radiation. In the extreme sense, the HPA has responsibility for advising the Ministry of Defence (MoD) on issues to do with chemical and biological warfare. How will Public Health England subsume such critical, and in extreme cases “life and death”, responsibilities without undermining current arrangements and ongoing research work?

19. With all such functions, there is a big question mark as to how these responsibilities will be effectively transferred ensuring that independence in assessment is retained (per the original “arms length body” rationale)—something seminal to the credibility of health protection both domestically and internationally—without undue political interference and/or Whitehall obstruction. The Government needs to urgently provide clarity on the practical details of its proposed new structure, not least given that these reforms are all directly tied up with the larger reorganisation of the NHS.

Local Government

20. A critical part of the White Paper concerns the involvement of local government and ringfenced budgets to advance the Government's key policy proposals. The desire to devolve responsibility for public health to local government is a positive step and consistent with the wider vision to devolve healthcare decision-making to the local level. However, more detail is needed to explain how the plans will be implemented and how responsibilities will be allocated. At this point, the Government has only postulated a broad framework for implementation, which in isolation is not really sufficient.

21. The White Paper sets out the framework for how the new Public Health service will operate through Public Health England in the DH down to GP consortia and Directors of Public Health (DPH) at the local level. It is the implementation of this framework that will decide whether this is a radical success or a demonstration in good intentions not translating into practice.

22. Importantly, this new framework will be locally driven and therefore has a greater potential to be in line with local needs. Arguably the most controversial aspect of this new policy approach concerns the amount of power being handed to local authorities (LAs). It is stated very clearly that the Government intends to “keep to a minimum the constraints” on how LAs will fulfil the public health role and spend budgets.

Directors of Public Health (DPH)

23. The White Paper outlines an increased role for DPH. This can be considered a sound decision that should help to ensure that there is a visible figure directly responsible for the improvement of local public health. Furthermore, since DPH are accountable to the Chief Medical Officer (CMO) and will be jointly appointed by the LAs and Public Health England the issue of accountability should not be a problem as some have precipitously suggested. This should foster a certain level of ‘quality-control’ between different areas, and avoid too much potential for DPH to go too far in one direction without proper checks and balances as to whether this aligns with national imperatives.

Health and Wellbeing Boards (HWBs)

24. The creation of HWBs is a philosophical shift that bravely challenges the previous ethos of centralisation. This is true even when considering the minutiae of policy implementation. It allows those in local government to demonstrate their talents and makes decisions in accordance with local needs. Although we are supportive of more local and therefore responsive decision-making, any such philosophical shift does confer potential problems. There is no guarantee that each LA will be capable of taking on and successfully carrying out the

vast range of responsibilities. It is therefore imperative the DH is not an idle spectator on the touchlines, but rather a leader and promoter of good practice where needed.

25. The Government's proposed framework of HWBs should help to bring together those local bodies responsible for the improvement of local population health. The weaving together of these different bodies into a statutory body ought to result in effective joint working. These boards will bring together GP consortia, DPH, Social Care, Children Services, and make them all accountable for the public health needs of the local population. These boards will, like DPH, provide a visible body to ensure accountability. We strongly advise that local HealthWatch, as part of minimum membership requirements, guarantee the involvement of local charity and patient groups in HWBs. This would help to ensure that local people who are not directly involved in public health have an opportunity to be represented and engaged in the process from the outset.

26. In line with the more general theme of "centralisation doesn't work", this proposed structure puts responsibility for success squarely in the hands of local bodies. This is what has been called for by local health representatives for many years if not decades. It remains to be seen whether those at a local level with the responsibility to promote public health will be as able and as willing as historical rhetoric implies. Again, this is an area the DH must keep a close eye on as the reforms progress and early performance indicators come through.

Public Health Budgets

27. Ring-fenced budgets are low-hanging fruit in the world of quick political wins; translating the policy into a funding reality is much harder. At a time when LAs are facing cuts to their budgets across the board, a ring-fenced budget for public health is good and should be supported. It should mean the public's health is not secondary to other financial pressures, and keeping the public healthy is of course a long-term financial saving.

28. It is short-term pressures that will make this ring-fenced pledge something of a financial challenge. Just as important, what is the mechanism to stop any attempt by a LA to use the budget for something other than public health using loose justification via the classic "wider determinants of health" argument? Moreover, at a time when local facilities are being cut and reduced how easy will it be to justify keeping this budget ring-fenced? Given that public health is about many different local services working together (including social services and mental health services), what can be done to ensure the funds are used to support all these public health services and are not siphoned into politically advantageous schemes for individual authorities? The Government needs to answer these important questions as part of its consultation.

29. The White Paper describes the health premium as policy to improve the health of the poorest, fastest. Through a simple formula, LAs will be rewarded for improvements to the local populations' health based on the public health outcomes framework. Those areas with the worst health outcomes will receive an "incentive" payment. It is not clear whether those LAs deemed to have good public health when measured against the public health outcomes framework will receive any incentive to make additional improvements.

30. It is difficult to argue with the principle of improving the health of the poorest with priority, but the devil is in the detail. This could potentially leave the Government open to accusations that LAs who already have a good level of local public health or do not make any progress in improving their public health will face cuts. The latter is actually recognised in the White Paper, "Potentially an area that makes no progress might receive no growth in funding for these services." The key to this are the words "potentially" and "might". This formula is being developed with unidentified "key partners" and so we do not yet know how this premium will function in practice.

31. There is no timescale for when the detailed model will be available as it is clearly stated "we will only set out a detailed model when we have established the baseline and potential scale of the premium clearly, and have agreement about the outcomes we will use." This is somewhat frustrating given it was first raised in *Equity and Excellence* in July 2010. If the health premium is successfully delivered, it will be a truly progressive reform. It will ensure that those areas facing the greatest challenges achieving real outcomes in improving health (rather than hitting targets) will be rewarded. Until we can assess how this premium will be formulated, it is only possible at this stage to speculate on its potential rather than comment on detail on its likely success.

Public Health Workforce

32. In the White Paper, the Government rightly acknowledges the importance of maintaining a well-trained and highly motivated public health workforce that utilises an evidence-based approach to clinical practice. Importantly, it is recognised that clinicians and other professionals have an essential role to play in improving and protecting population health.

33. This is undoubtedly an area that has been undervalued by previous Governments of all persuasions, but nonetheless constitutes a critical piece of the public health jigsaw. If the Government's ambitious public health reforms are to have a chance of success, it is essential that all healthcare professionals, from the student to the consultant, from the nurse to the dietician, are trained, skilled and motivated to practice preventative medicine. There is a long way to go.

34. Unfortunately, the White Paper makes no mention of undergraduate medical and dental education, and similarly undergraduate health education. At present, medical training and education around public health and the management of conditions like obesity, drug and alcohol addiction receives little if, in some cases, any attention at all. This has to change and change quickly—a massive piece of the jigsaw missing from the public health White Paper.

35. It is from this perspective that the Bow Group calls on the Government to overhaul public health education across the healthcare sector particularly at the undergraduate level.

36. Innovative, engaging teaching styles are needed to educate our future healthcare professionals in a vitally important area of medicine. This is one of the key determinants in securing the future health of our nation. After all, if our healthcare professionals are not properly skilled and equipped to tackle head on the public health challenges of today and tomorrow, what chance have the rest of us got?

Health Inequalities

37. The White Paper set out plans for Public Health England to work with NICE and the DH to set indicators for the Quality and Outcomes Framework (QOF). Public Health England and the new NHS commissioning board will also be charged with working collaboratively to ensure GP consortia “maximise their impact on improving population health and reducing health inequalities”.

38. The Bow Group sees this as a positive step and will aid developments towards a QOF which will do more to encourage GPs to help patients to achieve key public health targets, such as weight loss, smoking cessation and reduced alcohol consumption.

39. Alongside this development, the Bow Group is pleased that the White Paper confirmed plans for at least 15% of all QOF funding will be assigned to public health and primary prevention indicators from 2013. This idea was originally mooted by the DH after the Lord Darzi Review. As a report published by the Bow Group in 2010 proposed, a greater proportion of the framework dedicated to public health “would help to potentially shape a culture that is more consciously focused on prevention rather than the traditional and prevailing model of reactive/curative healthcare”.³

40. Following on the seminal work of the Marmot Review, it is promising that the Coalition Government are committed to reducing health inequalities, noting that these have got worse over recent years. The White Paper rightly identifies that health inequalities are determined by a plethora of factors, ranging from early years care to social policies. In order for the proposals to reduce health inequalities to work, it will require departments across government to implement effective social policies which foster a focus on equity right from the outset. Despite the fiscal constraints and the reality of Government departments facing significant cuts, it will be crucial that the Government invest in making this a reality.

41. The role of GPs in tackling health inequalities should not be underestimated. GPs are normally the first point of medical contact within the NHS and they play a vital role in preventive care, which typically involves diagnostic screening and providing advice on how to lead a healthy lifestyle. The Bow Group has previously argued that in its current form the QOF has not been designed effectively enough to address health inequalities. The Coalition Government should urgently look into the possibility of introducing new incentives for GPs in deprived areas with a view to improving services for patients in those areas.

Public Health Outcomes Framework

42. The Bow Group welcomes the rationale behind the Public Health Outcomes Framework. This should help provide clarity and focus on the key issues of importance in public health for those involved in the provision and commissioning of public health interventions. GPs can play a vital role in achieving good outcomes against all of the proposed domains within the Public Health Outcomes Framework, and therefore the amended QOF should be indexed to the Public Health Outcomes Framework to ensure coherence.

43. The Bow Group welcomes the Government’s aim to promote confluence where possible between the NHS Outcomes Framework and the Public Health Outcomes Framework. This will promote a more joined up approach to commissioning, and will likely lead to a situation where public health is seen as a top priority by local GP commissioning consortia.

44. Finally, we call for enforcement of a national standard for public health interventions. Whilst NICE guidelines are extremely useful, they are exactly that—only guidelines and, regardless of the reality, most providers tend to claim they are compliant. By linking a national standard for public health services providers with the NHS Outcomes Framework and the Public Health Outcomes Framework, greater scrutiny on intervention quality would be possible and in turn lead to better outcomes and value for money. This is a current area of weakness in the White Paper and something the Government should think about further as part of its consultation.

REFERENCES

¹ Health England, Health England Report No. 4: Public Health and Prevention Expenditure in England, Health England, 2009.

² Graham Burgess, Local Government Chronicle 9th December 2010, Accessed 22nd January 2011.

³ Page 14, The Quality and Outcomes Framework—What Type of Quality and Which Outcomes? Gary Jones, Stuart Carroll & Jennifer White (BG Health Committee) February 2010.

Written evidence from the Wellcome Trust (PH 40)

SUMMARY

1. Our key messages are:

- research plays a vital role in informing the evidence base for public health interventions. It is essential that **research, evaluation and the use of evidence are embedded** in the public health system;
- Public Health England (PHE) must be established in a form that enables it to provide **independent advice** to ministers, the Department of Health and the National Health Service (NHS). The proposed loss of independence of key functions currently undertaken by the Health Protection Agency (HPA) will seriously compromise the provision and use of scientific evidence for policy and practice;
- the fragmentation of public health services across local authorities may make it more difficult to deliver evidence-based services. A **coordinated national approach** to public health is required;
- reforms to the public health system need to be considered within the **context** of the proposed reforms in health and social care services, including the reorganisation of the NHS. The public health functions of the Department of Health, the NHS and the National Institute of Health Research need to be clarified and must be coordinated with PHE and local authorities; and
- we support the proposal that PHE will act as a **central repository for public health data** in England. In order to maximise the use of this resource it will be important that this is supported by appropriate mechanisms to facilitate access to these data for research.

INTRODUCTION

2. Reform of the public health system in England provides an important opportunity to establish a new vision for public health, fit to respond to the challenges of the 21st century, including: an ageing population; the increasing burden of non-communicable diseases; and the threat posed by global infectious diseases. Realisation of this long-term vision for the provision of public health in England needs to be reflected in the structural reform of public health services.

3. Given the Trust's remit, our comments focus primarily on research and the use of evidence in informing public health policy and practice. We are pleased to have the opportunity to submit evidence to the Health Committee's inquiry and we welcome scrutiny of the Government's proposals to reform public health service provision, as part of the wider reforms outlined in the Health and Social Care Bill. We look forward to the publication of the Government's response to the consultation on the strategy for public health in England and note that this is likely to lead to significant changes to the Health and Social Care Bill.

4. The Wellcome Trust, the Medical Research Council and the Economic and Social Research Council held a joint workshop in March 2011 that brought together public health practitioners and researchers. The aims of the workshop were to discuss the implications of the White Paper "Healthy Lives, Healthy People" and to discuss how evidence can be effectively translated into policy and practice in the new system. The discussions at the workshop and the report summarising the day's discussions have informed our response and is attached as Annex 1³⁰ to this paper. Our vision is that a reformed public health service for England must be able to:

- commission, undertake and adopt the results of high quality research;
- provide independent advice to Ministers;
- take a nationally co-ordinated view, with clear lines of accountability;
- draw on suitably trained professionals;
- make effective use of data from surveillance, patient records and research; and
- have the capacity to utilise a range of technologies.

³⁰ Workshop hosted by the Wellcome Trust in partnership with the Medical Research Council and the Economic and Social Research Council, Public Health Workshop Report, Department of Health White Paper: *Healthy Lives, Healthy People*, March 2011 (not printed here).

RESEARCH AND EVIDENCE IN PUBLIC HEALTH

5. Although the White Paper “Healthy Lives, Healthy People” emphasised the importance of an evidence-based approach to public health policy and practice, both the White Paper and the Health and Social Care Bill fail to set out mechanisms to achieve this.

6. A public health research framework is needed to ensure that the full range of research that could inform public health policy is supported. This will include epidemiological research; natural experiments; social science research; health service research; bioethics research; and environmental health research. In turn, mechanisms must be in place to facilitate uptake of these findings into practice and to ensure that information is made available for all stakeholders in public health service provision to inform their policy and practice. Implementation of this approach can be promoted through improvements in education and training, and the development of incentives that reward adoption and ongoing evaluation of practice.

7. Robust methods to evaluate the success of public health interventions are required. The proposed Public Health Outcomes Framework and Health Premium, outlined in the White Paper, must be underpinned by the best available evidence and should be refined as evidence is gathered over time.

8. Research and evidence-based evaluation of public health policy and practice should be embedded in the new system for public health. One possible mechanism would be to create public health research networks, based on clinical research networks, that can coordinate research and act as the interface between researchers and health practitioners. A culture of research and the use of evidence must be fostered in all components of the public health system, notably PHE and the local authorities. This should be supported by legislative duties on these bodies to promote research and the use of evidence in public health services.

INDEPENDENCE OF PUBLIC HEALTH FUNCTIONS

9. The HPA undertakes research and is responsible for providing independent advice on health protection issues. However, the Health and Social Care Bill would abolish the HPA and transfer its key functions to PHE within the Department of Health. This will undermine the actual or perceived independence of the advice provided. Public trust in Government advice was undermined during the BSE crisis due to a perception that Government scientists lacked independence, and this contributed to the establishment of an independent HPA in 2003.

10. Another potentially damaging consequence of moving the functions of the HPA to within the Department of Health is that it may compromise the ability to obtain external funding and carry out independent research, which is important in retaining expertise. The eligibility criteria of external funders, including the Wellcome Trust, will often not be met if the work is to be carried out within a Government department, and this would therefore limit the availability of resources to carry out research. The retention of expertise is fundamental to the role of providing advice; for example, the experts leading the UK response to the recent Fukushima nuclear accident were supported by external research funding.

11. It is essential that the public health system can provide Government with independent advice on health protection issues. We therefore propose that the functions of the HPA are retained at arm’s-length from the Department of Health, for example within a Special Health Authority or Executive Agency.

COORDINATION AND NATIONAL OVERSIGHT ARE CRITICAL TO AVOID FRAGMENTATION

12. We are concerned that commissioning of public health services by local authorities will lead to fragmentation in public health service provision and increase social inequalities. Devolution to a local level is likely to make it more difficult to communicate and implement successful evidence-based initiatives consistently. Local authorities do not have experience of managing public health services or commissioning research at a local level and it is vital that some level of national oversight and coordination is maintained to ensure public health policy and practice can be refined over time. The White Paper proposes to abolish Public Health Observatories, removing a regional tier that could have provided advice to local authorities if they became responsible for public health commissioning.

13. Reform of public health must be considered alongside, and be compatible with, reform of the NHS and social care systems. The health reforms attempt to draw a distinction between prevention and treatment, as responsibilities of PHE and the NHS, respectively. However, this distinction is somewhat arbitrary. Prevention and treatment lie along a continuum with overlap between the two spheres; for example, public health practice spans health promotion, health protection and improvement of health services. The reforms should take a holistic view of public health within health and social care and the Government should outline how the responsibilities of the National Institute of Health Research, the Department of Health, the NHS, local authorities and PHE will be coordinated.

14. The commissioning arrangements outlined in the Health and Social Care Bill are confusing and lack detail. As outlined in paragraph 12, it will be necessary to coordinate public health services commissioned through the NHS, PHE and local authorities, as well as commissioning social care and research. We welcome the Health Committee’s proposals that local Directors of Public Health should be represented on the proposed

commissioning consortia; and that co-terminosity of these consortia with social care structures should be encouraged to facilitate integration.³¹

15. We believe that the local commissioning consortia, alongside local authorities and PHE, should support and foster public health research. We welcome the creation of the NIHR “School for Public Health Research” and the “Policy Research Unit of Behaviour and Health” to promote the role of research and its adoption into practice, as outlined in the White Paper. However, we would welcome further clarification on the roles of these organisations.

16. The Government should clarify the functions of organisations involved in public health research and the mechanisms for their coordination.

EMBRACING NEW TECHNOLOGY AND THE USE OF PATIENT DATA

17. It is essential that the public health system is responsive, and can adapt to emerging technologies, such as genomics and informatics, and it is therefore critical that research is embedded in the public health and healthcare systems. It is essential that the single repository for population health data, research and surveillance, as outlined in the White Paper, is created. This will require a specialist workforce for analysis and development of the web-based system, as well as training at a local level in public health and primary healthcare settings to maximise its potential. Concurrently, mechanisms must be developed to ensure that this valuable resource is available for public health research while safeguarding individuals’ data.³² These issues must be taken into account in the upcoming “Information Revolution” strategy.³³

The Wellcome Trust is a global charitable foundation dedicated to achieving extraordinary improvements in human and animal health. We support the brightest minds in biomedical research and the medical humanities. Our breadth of support includes public engagement, education and the application of research to improve health. We are independent of both political and commercial interests.

June 2011

Written evidence from Dr Ann Hoskins (PH 41)

SUMMARY

- We support the commitment to the recommendations of Sir Michael Marmot’s review on health inequalities and welcome the opportunity to provide written evidence on the work undertaken by the North West, including “Living Well”, an Asset-based approach, the Well-Being Survey and Wellness Services.
- We welcome the opportunity to comment on the Select Committee’s new Public Health Inquiry.
- The creation of Public Health England would require clear lines of accountability as well as independence.
- We welcome the transfer of responsibility for health and wellbeing to local government to ensure a holistic and integrated service and will help address the wider social determinants of health.
- The role of Director of Public Health needs to be clearly defined, independence retained and lines of accountability agreed to ensure the role is effectively serving the public.
- As part of their statutory powers Health and Wellbeing Boards must be able to bring all those partners responsible for NHS commissioning and tackling wider social determinants to the table and to be held accountable.
- It must be recognised that a whole pathway approach is needed for commissioning of NHS services.
- The variety of commissioning routes may lead to fragmented commissioning for a number of public health services, it is therefore vital that public health expertise is provided to all the different commissioning routes.
- Public health intelligence functions must to be retained at local and intermediate as well as at national levels of organisation.
- We welcome the well-structured and robust outcomes framework, however decisions for improving population health should be made as locally as possible, informed by evidence of what works.
- A local budgeting approach to the health of the public has shown to promote a more joined up approach. The health premium needs to be incentivised by allowing local flexibility as to which outcomes will count towards the premium.
- We welcome the Government’s emphasis on the need to build on the achievements and skills of the current public health workforce, but it supports statutory regulation for all public health specialists.

³¹ <http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/796/79612.htm>

³² http://www.wellcome.ac.uk/stellent/groups/corporatesite/@policy_communications/documents/web_document/wtvm049559.pdf

³³ http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120080

INTRODUCTION

1. We welcome the opportunity to submit evidence to the Select Committee's Public Health Inquiry. The following memorandum sets our view on some of the key issues covered by the Select Committee, although these are addressed in more detail in the NH NW response to the public health white paper. In particular we believe we have developed an important body of knowledge for tackling Health Inequalities and we welcome the opportunity to set them out here in more detail, the evidence base for the approach the North West is taking in its response to the Marmot review and improving the health of the population.

The Creation of Public Health England within the Department of Health

2. There are a number of issues resulting from the division of the public health function between Public Health England and public health teams working within local authorities and other organisations including commissioning consortia. The relationship of the director of public health with Public Health England (PHE) is unclear. With the functions of the HPA and PHOs located within PHE, the health protection function would no longer be an independent one. The workforce will become fragmented, employed by different organisations on different terms and conditions. This fragmentation could lead to the loss of substantial expertise resulting in some local public health services being inadequately resourced to function effectively and safely. Although cross-local authority pooling of resources may be possible, arrangements will be vulnerable to local changes within separate local authorities and will add to the blurring of accountability.

3. We view the Public health functions within Public Health England and the NHS Commissioning Board to be generally the responsibility of public health specialists, and PHE should become an a Special Health Authority or Executive Agency in order to ensure its' independence.

The Future Role of Local Government in Public Health

4. The transfer of responsibility for the health and wellbeing of local populations to local authorities brings opportunities to align resources and activity to reduce inequalities and to improve health outcomes by addressing some of the wider determinants of health in a more coordinated and holistic manner than has previously been possible.

5. Local Authorities are ideally placed to commission integrated Wellness Services and align expertise on smoking cessation, alcohol brief interventions, weight management, stress management and relaxation with the support on finding work, managing debt, occupational health, family welfare, housing, mediation and befriending. There will be a good opportunity for skills and knowledge to be shared across existing public health and local authority staff, supported by training and development.

The Appointment of Directors of Public Health

6. The Director of Public Health (DPH) is the only defined role at local authority level when the NHS public health function moves to the local authority and the local authority becomes responsible for population health improvement. The role of the DPH should be defined as a public health adviser to the Local Authority Health and Wellbeing Board, responsible for providing advice and developing, implementing, performance managing and reporting on the population health of the area and the integration of health, care and wellbeing delivery through the Joint Strategic Needs Assessment, the Joint Health and Wellbeing Strategy and the Public Health Annual Report on behalf of the Board.

7. In order to carry out this role effectively the DPH should be invested with statutory powers to ensure control of resources and accountability to and from other public functions. The DPH must be positioned at Executive Director level in the local authority, directly accountable to the Chief Executive and with strategic overview of all local authority functions rather than restriction to health and social care. Lines of accountability need to be nationally agreed. Finally the DPH must retain the independence of the public health function, able to speak at all times on behalf of the health and wellbeing of the local population rather than from a political or administrative position.

The role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

8. The creation of Health and Wellbeing Boards (HWBs) in every council area with statutory powers will ensure all partners are delivering their organisation's contribution to health and wellbeing. They will become the focal point of health policy and health service delivery ensuring that clinical services are commissioned in a way that is efficient and levers maximum health gain out of investment to support local priorities.

9. HWBs must have sufficient powers to deliver on its responsibility to co-ordinate health and well-being commissioning with power to sign off the (JSNA based) commissioning plans of the GP Consortia and councils for investment in health, care and wellbeing outcomes. It is essential that as part of these statutory powers the Health and Wellbeing Boards is able to bring all partners to the table that can contribute to both NHS commissioning and tackling the wider health determinants and hold them to account. There needs to be clarity on the proposals for partnership responsibilities and accountability and considerable developmental work

around building common understanding and capacity to enable effective future working between HWBs and GP Consortia.

Arrangements for Public Health Involvement in the Commissioning of NHS Services

10. The population health perspective for designing, commissioning and delivering health services is vital to avoid wider health inequalities and poorer health outcomes. It must be recognised that for many services a whole pathway approach to commissioning is vital to ensuring efficiency savings are met eg tackling increasing alcohol admissions needs to be addressed through interventions along the entire pathway from prevention to treatment.

Arrangements for Commissioning Public Health Services

11. The variety of commissioning routes may lead to fragmented commissioning for a number of public health functions and priorities (eg screening, sexual health, immunisation), which will impact adversely on the meeting of local needs, compromise the quality of service provision and reduce individual commissioner accountability. We would wish to see public health expertise and input provided to all the different commissioning routes for the identified public health priorities/functions and the delivery of health care. Public health expertise in evidence based decision-making and prioritisation is key to ensuring services are cost effective and commissioned according to need.

12. GP Consortia should commission Public Health input from the local authority based Public Health team particularly for population interventions such as screening programmes. The expertise for commissioning and monitoring screening programmes currently rests within the director of public health and this should be retained. GP consortia and the NHS Commissioning Board need to participate in an agreed series of local operational commissioning commitments and strategies—through the medium of the Health and Wellbeing Boards, which they agree to be bound by, and publicly accountable for.

13. NHS NW has already raised concerns in its response to the public health white paper around the fragmented commissioning of children’s services and programmes, particularly the proposal that children’s services for five to 19 years are to be commissioned by local authorities while those for the under five years are to be commissioned by the NHS Commissioning Board and at some time transferred to local authorities. There is a strong evidence base that the healthy child programme will improve health and wellbeing. Local authorities need to be in a position to commission children’s services for the under five years once Public Health England is established rather than waiting until it is devolved from the NHS Commissioning Board, thus making local authorities the sole commissioners of the complete healthy child programme from 0 to 19 years. This would also encourage a whole life-course approach, with potential impacts on positive outcomes, as well as take a whole family approach. We are also of the view that these changes would significantly strengthen safeguarding systems and practice across health, social care and education, which has been a persistent area of concern from many Serious Case Reviews.

14. Like the Marmot review, the North West Region gives a high priority to children, particularly early years. The NHS NW has developed a Guide to support GP, PCT and local government commissioners to improve health and wellbeing outcomes for children, young people and expectant mothers. The Guide identifies child and maternal health priorities for improvement and evidence base for these priorities, describes key features of effective commissioning for child health and provides each local area with a child and maternal health profile to assist with prioritisation. A central aspect of the Guide is the focus on the life course of a child to the age of 18, and to the importance for commissioners to focus on intervention in early years. Many of the critical child health issues have their origin public health in its widest sense; the emerging Health and Wellbeing Boards will therefore be critical to the successful commissioning and provision of services.

Future of the Public Health Observatories (PHOs)

15. The experience of the Regional Public Health Observatories shows that national analyses tend to be better undertaken by regional or local bodies and academic communities that have specific expertise in the domain in question, rather than through the central consolidation of analytical work. Local areas and “supra-local” areas with particular expertise should be commissioned to undertake national public health intelligence work on behalf of the wider public health community.

16. In the North West the public health observatory fulfils a regional public health information and intelligence function, supporting public health professionals working in the NHS, local authorities and other services to improve the health of the North West population. To enable this it has provided some valuable tools including bespoke reports using a wide range of health-related datasets, for example annual alcohol profiles. (See <http://www.nwph.net/nwpho>)

The Structure and Purpose of the Public Health Outcomes Framework

17. We welcome the well-structured and robust outcomes framework and the proposal for data to be collected nationally, as far as possible, to allow for comparison and transparency as well as reducing the burden on local areas. However, the national function needs to support the principle that decisions for improving population

health should be made as locally as possible, informed by evidence of what works and as such local areas must have the flexibility to identify and agree local priorities, informed by the Joint Strategic Needs Assessment.

18. The Public Health Outcomes Framework should not “second guess” what local communities will co-produce as local public health priorities. Local areas should be rewarded for tackling locally agreed priorities, not for delivering a standard set of nationally defined outcomes—in some cases standing still might be a success in terms of public health.

Arrangements for Funding Public Health Services (including the Health Premium)

19. Some local authorities have expressed concern that they may not receive sufficient funding to commission and deliver health improvement services because the national formula for public health resource allocation will not be sensitive enough to identify current variation in Primary Care Trust investment. A local budgeting approach to the health of the public has been shown to promote innovative, joined-up and whole-systems approaches to improving health. Therefore, where appropriate the public health budget needs to be aligned and/or pooled with other budgets to maximise overall public health impact in local areas.

20. The health premium needs to be incentivised by allowing local flexibility as to which outcomes will count towards the premium. In general, public health action towards delivering locally defined priorities is likely to deliver more benefit in terms of reducing inequalities than will public health action towards delivering national priorities.

The Government’s Response to the Marmot Review

21. Health is determined by wider socio-economic influences most of which sit outside the NHS, that have an effect from pre-birth and throughout life and that public health is everyone’s responsibility. We welcome the life-course approach to improving public health, particularly the focus on early intervention and prevention. However, more emphasis is needed on the transition within children’s services and between services for children and adults.

22. Despite massive investment and enormous effort by dedicated people and innovative organisations, patterns of inequality in health, income and aspiration persist across the North West—and there are newer challenges on the horizon, which have the potential to undermine existing gains. In 2010 the North West produced “*Living Well: Across local communities- prioritising wellbeing to reduce inequalities*”:

(<http://www.nwph.net/hawa/writedir/a862Living%20Well.pdf.pdf>) It builds on the recommendations and evidence of the Strategic Review of Health Inequalities in England post- 2010, and describes a way of working to remove entrenched inequalities. “Living Well” is not a framework with solutions as these are for local partners and communities to work through, but a long term approach that promotes a way of working locally to bring about improvements in health and wellbeing.

23. Important concepts that support local delivery of Living Well include: Investment for Health and Social Value—where the aim is to help decision makers create more health and wellbeing from their investment/disinvestment activity; and Social Value—designed to maximise the value of the money spent during commissioning.

24. Health Outcomes should reflect the presence of health and wellbeing in a population. This should include health assets and protective factors and not merely deficits in the population’s health or risk factors for ill health. Supporting wellbeing and enabling people to live well is our approach to achieving lasting reductions in inequalities. This new approach needs different outcomes measures which are evidence-based and measure changes in status as a result of an intervention.

25. To support this approach the North West developed an “Asset-based approach”: (<http://www.nwph.net/hawa/writedir/2fa6The%20Asset%20Approach%20to%20Living%20Well.pdf>). The approach values assets and identifies skills, strengths, capacity, and knowledge of individuals and the social capital of communities. It provides a positive and outcome focused picture that values what works well and where health is thriving. Community pride and spirit is therefore high and people are engaged in solutions that are more sustainable for that community, with use of outside support where it is needed most.

26. The asset approach could therefore make a significant contribution to:

- Tackling the social determinants of health and reducing health inequalities.
- Strengthening health protection resilience.
- Focusing on health and wellbeing outcomes.
- Strengthening Joint Strategic Needs Assessments.
- Fostering co-production of health and the provision of health and social care.
- Building the *Big Society* vision of empowered communities.
- Supporting the systematic engagement of communities in partnership.
- Maximising the role of the voluntary sector.
- Enabling greater condition management, self care and care closer to home.

- Improving individual and community resilience in challenging times.
- Improving demand management and service efficiency.

27. Improving positive mental health has been a growing priority over the last decade. *The North West Mental Wellbeing Survey* was undertaken in 2009 in response to a growing need to understand more about the positive mental wellbeing of people in the region. With a total sample of 18,500 people across Cumbria, Lancashire, Greater Manchester, Cheshire and Merseyside, the North West Mental Wellbeing Survey was the largest survey of its type ever conducted in the UK. It found stark differences in mental wellbeing across the North West; and that those living in disadvantaged circumstances have, in general, much lower levels of wellbeing. It found that an individual's connection and interaction with their community is critical; in particular having a sense of belonging to the neighbourhood and feeling one can influence decisions about the local area, make a big difference to mental wellbeing.

28. The groundbreaking research is of national importance given the relative lack of data on population mental wellbeing in the UK. The information gathered gives a better understanding of mental wellbeing, highlighting what it is to be well and stay well across a series of determinants in relation to physical health, social capital and health inequalities. It will also help inform Joint Strategic Needs Assessments and targeted commissioning and have the potential to provide baseline data for evaluation of interventions to inform outcome-based commissioning. The *North West Mental Wellbeing Survey* is the most significant and detailed investigation of the region's mental health and wellbeing ever undertaken and should inform service provision for years to come.

29. There is increasing evidence and emerging policy of the need to address both mental (and psychological) well-being AND physical health. Individuals with poor levels of mental well-being are much less likely to be able to make sustainable lifestyle changes, be in good physical health or to manage and recover from illness than those with high levels of mental well-being. In turn, people with poor physical health will have poorer mental health.

30. Wellness services provide a holistic and seamless service to support people in improving their health and well-being. Traditional lifestyle services have often been provided separately, making it difficult for patients to navigate between. This is especially so for those with complex needs where support on a number of health issues is needed. Such models have potential therefore to cause inefficiencies in patient pathways and commissioning.

31. Work in the North West is supporting the development of Wellness Services across localities (see Annex A). The Transforming Community Services programme is a lever to enable this, alongside developing the new Public Health Service.

32. Local Authorities are ideal partners in the provision of Wellness Services. Alongside expertise on smoking cessation, alcohol brief interventions, weight management, stress management and relaxation is the support on finding work, managing debt, occupational health, family welfare etc.

CONCLUSION

33. We recognise that the Government's call for a public health system that can deliver world-class outcomes raises huge opportunities for public health. We support and welcome the increased focus on population health and in particular the commitment to the recommendations of Sir Michael Marmot's review on health inequalities. We see the transfer of responsibility for the health and wellbeing of local populations to local authorities, together with the transfer of directors of public health as an opportunity to align resources and activity to reduce inequalities and to improve health outcomes by addressing some of the wider determinants of health in a more coordinated and holistic manner than has previously been possible.

June 2011

Annex A

LIVING WELL WITH WELLNESS SERVICES

Proposed new approaches to public health provide a rare opportunity to create a sea change in the way we view health—from illness to wellness. Are we really aware of what could be achieved in this new world in terms of a truly people centred approach that focuses on wellbeing? It's possible that many colleagues, who are understandably focused on the change process, may not have had the opportunity to consider its full potential.

In the North West, we have been exploring what the wellness approach would look like as part of a new wave of public health.¹ We took up the challenge, working alongside the Marmot review team, with publishing a call to action document—Living Well: prioritising well-being to reduce inequalities. The regional well-being survey clearly showed that those with high levels of well-being are much more likely to be able to make sustainable lifestyle changes, be in good health, manage and recover from illness sooner and use health services better than those with poor levels of well-being.

The creation of a new Public Health Service with Local Authorities and the reconfiguration of community health services are providing an opportunity to develop integrated and holistic wellness services. The time is

right for a new approach to support people in “living well” that goes beyond the traditional availability of single-issue healthy lifestyle services and a focus on illness, rather than wellness.

The new strategy for public health in England, *Healthy Lives, Healthy People*,ⁱⁱ places increased emphasis on tackling both physical and mental health as part of healthy lifestyles. Factors of self-esteem, confidence, resilience, social networks and sense of control are all seen as key to decision-making and the ability to lead healthy lives and maintain well-being.

Increasing control is also a priority within the Marmot Reviewⁱⁱⁱ which holds a vision of “creating the conditions for individuals to take control of their own lives” and puts prevention in the context of the social determinants of health. Thus, individual responsibility for health is achieved through individual *and* community empowerment and proportionate availability of prevention services.

The North West Living Well document^{iv} is a regional response to Marmot and a call to action to prioritise well-being in order to reduce inequalities. The *Living Well* concept focuses on creating the conditions that support well-being and enable people to live well. It calls for new approaches to address the background causes of good health and a focus on how people feel and function (well-being) as key to individual change.

Research in the North West^v also shows that individuals with high levels of well-being are much more likely to be able to make sustainable lifestyle changes, be in good health, manage and recover from illness sooner and use health services better than those with poor levels of well-being.

Traditional lifestyle services have often been provided separately, making it difficult for patients to navigate between. This is especially so for those with complex needs where support on a number of health issues is needed. Wellness services have potential therefore to provide a holistic and seamless service—to create easier and consistent pathways for patient and referrer rather than going between different services for different aspects of their health.

A broader well-being focus to a wellness service might provide holistic assessment at the point of access and generic interventions that address psycho-social determinants. There is a clear need to have a stronger focus on enhancing sense of control, coherence, self-efficacy, motivation, self determination and social skills. A good level of well-being is needed before any individual can start to make healthy choices and changes.

Specific interventions would focus on a whole range of factors that influence a person’s ability to live healthy and well (see figure 1): healthy lifestyle, self care and independent living, family support, work & learning, personal health protection & safety, welfare and community development & leisure.

A partnership approach is therefore needed if wellness services are to be effective in providing quality services and in addressing inequalities. The Health & Well-being Board is ideally placed to support joint and integrated approaches for this across the Local Authority, Commissioning Consortia, NHS Trusts, voluntary and independent providers and local communities. The Public Health White Paper emphasis on health as a positive sense of well-being and not merely the absence of illness will be demonstrated through the Board’s Joint Health & Well-being Strategy and the type of services available locally.

The role of community members in contributing to providing such services is fundamental to a new *Living Well* approach of empowerment and building community assets and resilience. The *Big Society* approach can involve more appropriate forms of support being available at a neighbourhood level, people coming together to provide their own services and people more involved in what services are needed. Understanding and building on the health assets of individuals and communities is fundamental to the new approach of focusing on health as wellness rather than illness and deficits. Likewise the development of Community-oriented Primary Care and Health Promoting Organisations are the key shifts needed within the delivery system to implement the White Paper and support the wellness approach and make every contact with the public an opportunity to address health and well-being.

Building momentum for change also involves increasing the significance of personal health to people’s lives and the ability to sustain good health. For many people this remains a challenge and the availability of good information and appropriate support will enable us all, and the most challenged, to look after our own health, participate in improving our community’s wellbeing and removing the barriers to living well.

Many localities have already started to shape a new wellness service with examples of integration as outlined in Figure 1. The Liverpool Public Health Observatory has recently published a review of wellness services,^{vii} commissioned by the Cheshire & Merseyside Public Health Network to support the development of local models. The report draws on learning from existing holistic services such as Well Women Centres, Jobcentre Plus Condition Management Programmes, Partnerships for Older People Projects, Social Prescribing, Health Trainers, Occupational Therapy and Psychological Well-being interventions.

Specific innovation within the North West region detailed within the report is summarised below. Within Halton and St Helens a partnership between GPs and the Citizen Advice Bureau provides support to patients on issues around debt, employment, benefits and housing. It resulted in 38% of patients having their mental health intervention stepped down. Within the Wirral Health Action Area health trainers, community health development workers and lifestyle advisors provide a range of physical and mental health activities and support. The partnership approach also includes employability programmes that seek to improve health and well-being

alongside employment skills and support. The community programme was cost effective with a cost per client at £32.75 and per QALY of around £16,000.

Within Knowsley the proposed one-stop shop for lifestyle services is based on individuals needing generic behaviour change support (eg assess current status, set goals, set out plans, access support and keep them motivated and informed) and not necessarily needing specialist topic based skills at all stages. The historic target focus on individual behaviours was felt to be a barrier to taking a person centred approach, especially when working in deprived areas where each service potentially targets the same people (eg the person who smokes, drinks heavily and is inactive etc). The Knowsley model also includes social care partnerships through including independent living services such as aids and adaptations.

Well-being Sefton is a pilot programme offering one to one consultations utilising a Life Balance Assessment and provision of support on housing, debt, welfare issues as well as weight management, anxiety and broader social prescribing for mental well-being, bibliotherapy, arts, CAB, exercise, volunteering and green gyms. There is a single telephone number for access and information.

The St Peters Centre in Burnley is a combined leisure and primary care centre providing a holistic one stop shop and quicker direct access to specific services such as exercise on prescription or smoking cessation. This demonstrates a good partnership between sectors to achieving local outcomes.

Salford is working up a radical redesign of its lifestyle services to unify them into a single *way to well-being* service. This will integrate health improvement, work & skills and neighbourhood teams and incorporate community based activities alongside public sector interventions. “The holistic approach will ensure both that people’s health issues are dealt with in the context of the wider social context in which they arise, and also that common approaches and skill sets apparent in the variety of services covered by the work are managed more effectively.”^{vii}

Achieving fully integrated wellness services will be a challenge that requires leadership, vision and an element of risk taking and openness. Sharing learning across localities will be an important task to maintain throughout the reforms, supported by Public Health Networks and other Improvement agencies.

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^{vi} Hennell T, 2010, *The contribution of well-being to health inequalities* presentation Warwick University

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Figure 1



Written evidence from the Family Planning Association (PH 42)

1. EXECUTIVE SUMMARY

1.1 FPA is one of the UK's leading sexual health charities, with over 80 years' experience of providing the UK public with accurate sexual health information, education and advice services.

1.2 FPA represents a national voice on sexual health, working with and advocating for the public and professionals to ensure that high quality information and services are available for all who need them.

1.3 We welcome the inclusion of sexual health services in public health as it recognises the major public health role that sexual health services play in people's health and wellbeing.

1.4 In principle we welcome the proposal that local authorities will commission public health services, but have some concerns around the execution and mechanisms of localised commissioning.

1.5 We welcome the ring-fenced public health budget but have concerns over whether the budget allocation will be sufficient to fund the full range of public health services proposed.

1.6 It is vital that the indicators on under-18 conceptions, rates of Chlamydia diagnosis and late diagnosis of HIV are retained in the Public Health Outcomes Framework. We would also like to see indicators that pay attention to the importance of sexual health throughout people's lives and not just for young people.

2. *Creation of Public Health England*

2.1 FPA welcomes the creation of Public Health England as a body to focus specifically on public health. We think that greater detail needs to be provided about how the functions of Public Health England at a national level will be supported.

2.2 We welcome the inclusion of sexual health services in public health given the important public health role that these services have in treating and preventing the spread of infection and enabling people to maintain their sexual health and wellbeing. We also welcome the inclusion of contraception services, sexually transmitted infection (STI) services, abortion services and health promotion and prevention services in the definition of sexual health services contained in *Healthy Lives, Healthy People*. The commitment that these services will be easy to access and delivered in a confidential and non-judgemental way is also welcomed.

3. *Future role of local government in public health*

3.1 We agree with the principle of local authority commissioning of public health services, including sexual health services, but do have concerns over the execution and commissioning mechanisms.

3.2 We think that there is a risk that certain elements of sexual health service delivery could become politicised given the involvement of locally elected representatives. For example, abortion is often seen as a controversial issue and, although it is clear that delivery of sexual health services must include abortion, some people seeking elected office may wish to make it a political issue. It must be made clear that the role of the public health service is to deliver high quality services, including abortion services, to meet the needs of the local population and that local politicians are not able to prevent service provision on political grounds.

3.3 It will be important that efforts are made to ensure that local knowledge of sexual health need and mechanisms to assess the need successfully are maintained through the transition and into the new structures to ensure that local Joint Strategic Needs Assessments are meaningful and accurately inform commissioning.

3.4 It is not currently clear whether Public Health England will issue guidance to local authorities to support them in commissioning public health services. It can be difficult to assess local need for sexual health services accurately because the stigma and embarrassment that are still associated with sex and sexual health mean many people are reluctant to talk about the services they need. We are concerned that local authorities may not have the expertise needed to assess local need accurately and to understand the services they will need to commission. Clear commissioning guidance from Public Health England may overcome some of these issues.

3.5 FPA welcomes the recognition in *Healthy Lives, Healthy People* that some public health services will need to be co-ordinated and delivered at a national level by Public Health England. We recommend that this includes the commissioning of a comprehensive sexual health information service to ensure that high quality information is available to all those who need it. FPA currently runs the **sexual health direct** service through a contract from the Department of Health. Through this service we deliver a wide variety of information functions including:

- A national telephone helpline and a web enquiry service, Ask WES that respond to 45,000 enquiries a year.
- Development and publication of a range of over 30 booklets on sexually transmitted infections, contraception and pregnancy choices that are based on the latest available scientific evidence, are regularly reviewed and are extensively consumer tested. We distribute around eight million of these booklets to GUM, contraception and general practices across England.

- A website featuring a clinic finder which receives an average of around 23,800 hits a month and an innovative decision-making aid *My contraception tool*, which was viewed almost 10,000 times between the beginning of September and the end of November 2010.
- National awareness raising campaigns on sexual health, recent topics for which have included older people's sexual health, the links between alcohol and sexual health and the range of methods of contraception available.

4. *Commissioning of public health services*

4.1 As mentioned previously FPA warmly welcomes the inclusion of sexual health services in public health. We think that it should be mandatory for local authorities to commission comprehensive, open access sexual health services, including STI testing services, contraception services and abortion services.

4.2 We believe it is vital that integrated, high quality sexual health services continue to be provided under the new system. Strong links between sexual health services delivered through the public health service and those which continue to be delivered by NHS services, including general practice should be maintained. For us the crucial consideration about commissioning sexual health services is continuing to ensure that people have choice about the sexual health services they access and effective integration is key to this.

4.3 We also believe that there needs to be a clearer statement of the importance of ensuring that sexual health services are commissioned for people of all ages. Rates of sexually transmitted infections are higher among younger people and consequently much of the prevention activity is targeted at this age group. However, official statistics show that rates of STIs diagnoses in older people are increasing and, although the numbers remain small, the rate of increase is faster than among younger people. It is crucial that people of all ages are able to access information and services to protect their sexual health and wellbeing.

5. *Public Health Outcomes Framework*

5.1 FPA broadly supports the overall framework for public health outcomes and the proposed domains.

5.2 We warmly welcome the inclusion of indicators on under-18 conceptions, rates of Chlamydia diagnosis and late diagnosis of HIV and believe it is vital that these proposed indicators are all retained for inclusion in the Public Health Outcomes Framework. There is strong evidence that robust national leadership on sexual health outcomes effectively translates into improved services and demonstrable improvements in sexual health.

5.3 FPA believes that the current proposed indicators relating to sexual health ignore the importance of sexual health throughout people's lives. We know that it is not only young people who are sexually active and people need to be able to access information and services to protect their sexual health and avoid unplanned pregnancies and STIs whatever their age.

6. *Funding of public health services*

6.1 FPA warmly welcomes the ring-fenced public health budget, as funding for public health has previously been an easy target for cuts when budgets are squeezed. However, we fear that the funds allocated to local authorities as part of the public health ring-fenced budget will not be sufficient to fund the range of services proposed. Current expenditure on the full range of sexual health services is estimated to be around £700 to £750 million. *Healthy Lives, Healthy People* estimated that current spend on areas likely to be the responsibility of Public Health England is around £4 billion. With sexual health just one part of public health we are concerned that the ring-fenced budget will not be enough to meet the local needs for public health services.

6.2 It is vital that it is made clear that the ring-fenced public health funding is only to be spent on public health services and that it is not acceptable to re-define other services as contributing to public health to get around the ring-fencing. We are aware that local authority budgets are likely to be under significant pressure over the next few years and this must not have an adverse impact on the funding for sexual health services. Cuts to sexual health service provision may appear to be cost-saving in the shorter term but are actually more costly over the medium and long-term as the costs of increased rates of STIs and unplanned pregnancies have to be met. We urge the government to take steps to avoid reductions in services which would lead to a deterioration in sexual health.

7. *Future of the public health workforce*

7.1 FPA welcomes the intention of the Government to develop and consult on a public health workforce development strategy in 2011. Currently, there is not any detail around how clinical training for people delivering public health services will be planned and managed. For example, sexual health services will be part of the new public health structure but many of the skills required to deliver these services are clinically based, such as carrying out STI tests and initiating treatment. It is not clear how strong links will be made between public health workforce planning and healthcare workforce planning to ensure these training needs are identified and met.

7.2 We are concerned that the proposals for the provision of workforce education and training to be made the responsibility of individual providers to fund and organise could see a loss to a co-ordinated approach to

training. There is already a shortage of healthcare professionals trained to provide and fit all forms of contraception, and we are worried that this problem will be exacerbated by the proposed changes to responsibility for training provision.

8. *Abolition of the Health Protection Agency and future of Public Health Observatories*

8.1 FPA believes that publicly available national data on sexual health services are vital to be able to assess sexual health and wellbeing as well as the performance of services. This data will be crucial for local authorities in helping them assess local need, performance of services and address inequalities.

8.2 We would like reassurances that Public Health England will continue and even improve the functions it takes on from the Health Protection Agency (HPA). The data collection and analysis that the HPA currently carries out into STIs, including HIV, is crucial to informing service provision and assessing progress in improving sexual health. A loss of these functions would have a significant negative impact on the evidence base for sexual health service provision, making it more difficult to assess the need for services.

8.3 We think that Public Health Observatories also play a key role in sexual health data collation and publication. For example, the South West Public Health Observatory was commissioned to develop a set of sexual health process and outcomes indicators and created the *Sexual Health Balanced Scorecard* which is widely used. We seek reassurances that access to this data and its regular updating will be retained.

June 2011

Written evidence from Brook (PH 43)

1. EXECUTIVE SUMMARY

1.1 Brook is the UK's leading provider of sexual health services and advice for young people under 25. The charity has over 45 years of experience working with young people and currently has services in England, Scotland, Northern Ireland and Jersey.

1.2 Brook services provide free and confidential sexual health information, contraception, pregnancy testing, advice and counselling, testing and treatment for sexually transmitted infections and outreach and education work, reaching over 260,000 young people every year.

1.3 Brook warmly welcomes the inclusion of sexual health services in public health as it recognises the major public health role that sexual health services play in young people's health and wellbeing.

1.4 In principle we welcome the proposal that local authorities will commission public health services, but have some concerns around the execution and mechanisms of localised commissioning for young people's sexual health services.

1.5 We welcome the ring-fenced public health budget but are concerned over whether the budget allocation will be sufficient to fund the full range of public health services proposed.

1.6 We think that it is important that the indicators on under-18 conceptions, rates of Chlamydia diagnosis for 15 to 24 year olds and late diagnosis of HIV are retained in the Public Health Outcomes Framework.

2. *Creation of Public Health England*

2.1 Brook welcomes the creation of Public Health England as a body to focus specifically on public health.

2.2 We welcome the inclusion of sexual health services in public health as it recognises the important public health role that these services have in treating and preventing the spread of infection and enabling young people to maintain their sexual health and wellbeing. We also welcome the inclusion of contraception services, sexually transmitted infection (STI) services, abortion services and health promotion and prevention services in the definition of sexual health services contained in *Healthy Lives, Healthy People*.

2.3 We welcome the commitment that these services will be easy to access and delivered in a confidential and non-judgemental way as these are important considerations for young people when they access sexual health services.

3. *Future role of local government in public health*

3.1 Brook welcomes the commissioning of public health services by local authorities in principle. However, we are concerned that there is a risk that certain elements of sexual health service delivery could become politicised given the involvement of locally elected representatives. For example, we know that confidentiality for young people when they access sexual health services is one of their key concerns. We fear that some people seeking elected office may wish to make a political issue out of young people accessing sexual health services without their parents' knowledge. It must be clear to local authorities that the public health services they commission must meet the needs of the local population including young people.

3.2 We are concerned that local authorities may not have the knowledge or expertise to commission appropriate sexual health services for young people. Furthermore, the stigma associated with accessing these services may mean that local young people are reluctant to talk about the services they need. We think that accurate local Joint Strategic Needs Assessments and clear commissioning guidance and support from Public Health England will help ensure that local sexual health services meet the needs of young people.

4. *Commissioning of public health services*

4.1 Brook welcomes the inclusion of sexual health services in public health. We think that it should be mandatory for local authorities to commission comprehensive, open access sexual health services for young people, including STI testing services, contraception services and abortion services.

4.2 Key considerations for young people when they access sexual health services are that they must be confidential and free; open at times convenient to them; in locations they can easily reach; provided by friendly, non-judgemental staff; and well publicised. It is vital that local commissioning of sexual health services ensure that these needs are met for young people.

4.3 Brook believes that it is vital that local commissioning arrangements continue to ensure choice of services for young people. We know that some young people access sexual health services through central locations such as Brook Centres; and some young people access them through community venues that they feel confident using. It is crucial that this choice is retained and services are offered in a variety of locations to make them more accessible to young people.

4.4 We also think that horizontal integration across all public health services delivered for young people will lead to a creation of a holistic public health service for young people and enable them to make healthy and informed choices throughout their lives.

4.5 We believe that all sexual health services commissioned for young people should follow the Department of Health's *You're Welcome* criteria for making health services young people friendly. We also think that young people should be involved in development of sexual health services and feedback on sexual health services. We would be keen to see mechanisms to ensure that young peoples' voices are represented on bodies such as local Health and Wellbeing Boards.

5. *Public Health Outcomes Framework*

5.1 Brook broadly welcomes the overall framework for public health outcomes and the proposed domains. We particularly welcome the inclusion of indicators specific to young peoples' sexual health issues.

5.2 We warmly welcome the inclusion of indicators on under-18 conceptions, rates of Chlamydia diagnosis for 15 to 24 year olds and late diagnosis of HIV and believe it is vital that these proposed indicators are all retained in the Public Health Outcomes Framework. There is strong evidence that national leadership and robust data collection on sexual health outcomes leads to improved services and demonstrable improvements in sexual health for young people.

6. *Funding of public health services*

6.1 Brook welcomes the ring-fenced public health budget, as funding for public health has previously been an easy target for cuts when budgets are squeezed. However, we fear that the funds allocated to local authorities as part of the public health ring-fenced budget will not be sufficient to fund the range of services proposed. Current expenditure on the full range of sexual health services is estimated to be around £700 to £750 million. *Healthy Lives, Healthy People* estimated that current spend on areas likely to be the responsibility of Public Health England is around £4 billion. With sexual health just one part of public health we are concerned that the ring-fenced budget will not be enough to meet the local needs for public health services.

6.2 It should be made clear that the ring-fenced public health funding is only to be spent on public health services and that it is not acceptable to re-define other services as contributing to public health to get around the ring-fencing. We are aware that local authority budgets are likely to be under significant pressure over the next few years and this must not have an adverse impact on the funding for sexual health services. Cuts to young people's sexual health services may appear to be cost-saving in the shorter term but are actually more costly over the medium and long-term as the costs of increased rates of STIs and unplanned pregnancies have to be met. We urge the government to take steps to avoid reductions in services which would lead to a deterioration in young people's sexual health.

7. *Future of the public health workforce*

7.1 Brook welcomes the intention of the Government to develop and consult on a public health workforce development strategy in 2011. We believe that a workforce development strategy for public health must recognise the role that non-health professionals like teachers and youth workers have in supporting young people's public health.

7.2 We would like to see a strategy that proposes a training and education framework that enables all professionals that work with young people to deal with all young people's issues including sexual health.

8. *Abolition of the Health Protection Agency and future of Public Health Observatories*

8.1 Brook believes that national data on sexual health services is vital in assessing the sexual health and wellbeing of young people as well as access that young people have to sexual health services.

8.2 We think that Public Health England should, at the very least, continue to deliver the functions that it will take on from the Health Protection Agency (HPA). The data collection and analysis that the HPA currently carries out into STIs is crucial to informing service provision and assessing progress in improving young people's sexual health. We also believe that access to the sexual health data collected by Public Health Observatories and its regular updating should be retained.

June 2011

Written evidence from NHS Ashton, Leigh and Wigan (PH 44)

1. *Creation of Public Health England within the DH*

With major public health challenges such as demographic change, climate change, sustainability, impact of globalization, socio-economic determinants of health, health inequalities and lifestyle factors, there is huge potential for strengthening the role and influence of public health, and establishing a strong coordinated national (and international) evidence base to underpin and address the major challenges of today. The preferred model would be for Public Health England to be an organization within the NHS rather than a department within the DH. Public Health England would be the umbrella organization for employing the core Public Health Workforce in its entirety, at national, sub national and local level, across all three domains of public health. This would avoid fragmentation and loss of knowledge and skills within the workforce and public health agendas, as well as ensuring that ring-fencing of the budget was maintained. DPH's would be responsible for the local Public Health budget and accountabilities for certain functions. Local partnership arrangements, joint accountabilities, pooling of resources and "hosting" of Public Health within the Local Authority would strengthen the response to the Marmot Review. This approach would also maintain a level of autonomy and professional independence for Public Health. The role of the CMO would be key at a national level, and DPH's could be accountable to the CMO.

2. *Abolition of the Health Protection Agency and National Treatment Agency for Substance Misuse*

- (a) The Health Protection Agency currently has a level of independence and autonomy that would not exist if Public Health England is part of the DH.
- (b) The current model for the Health Protection Agency is resource intensive, but lacks accountability and does not cover all the functions eg immunisation. Local functions and accountability are still required.
- (c) Local knowledge and networks are key to managing health protection and responding to emergencies. Local emergency planning and local relationships are key to successful operations. There are a variety of local models nationally.
- (d) Consideration should be given to sub-national coordination once the SHA no longer exists.
- (e) It is important that the local health protection function is able to provide expertise and advice as well as operational functions and local capacity to respond in emergencies and disease outbreaks.
- (f) The benefit of Public Health England and extended powers of direction of the Secretary of State to command NHS organisations in national emergencies is key, however this needs to be extended to include service providers as currently there is no legal responsibility for individual practitioners eg GPs to respond as they are not bound by the Civil Contingencies Act. GP Consortia would however have statutory obligations in the future. NHS contracts with providers could possibly include arrangements for emergency situations.
- (g) Lessons learnt from the pandemic flu emergency should be incorporated within new structures to ensure accountabilities and operations in emergency situations are robust and effective.
- (h) Public Health England would need to be designated as a Category 1 responder. There is a need to be clear about the responsibilities of Public Health England and Local Authorities in emergency situations.

3. *Public health role of the Secretary of State*

- (a) It is welcome that public health is being given greater importance within government.
- (b) In order to balance government political agendas and the autonomy and independence of public health priorities, it is important that the Secretary of State is supported with a strong network of public health professional leaders, along with the CMO, to support and advise on the public health functions and influence policy.
- (c) Cross departmental approaches to address the wider determinants of health and health improvement are key at national level as well as local level. Public Health can provide a key coordinating function and a means by which Health Impact Assessments and social policy analysis (eg accumulated impacts

of a range of policy changes on health inequalities) can be conducted during the process of decision making.

- (d) New powers proposed for the Secretary of State during emergency situations is an important development. These powers should be extended to include provider organisations for the NHS/LA.

4. Future role of local government in public health (including arrangements for DPH, role of Health & Wellbeing Boards, JSNA's and Joint Health & Wellbeing Strategies

- (a) Stronger partnership working arrangements between the Local Authority and Public Health is key to the agenda, however there may be tensions with professional independence, clinical governance and accountability (to elected members) with the current proposals.
- (b) Joint clear accountabilities, and the “hosting” (but not “employing”) of an NHS Public Health organisation within the Local Authority may be a model that could overcome this. It would also ensure appropriate ring-fencing of the budget at a time of Local Authority cuts, so the budget is not seen as a substitute to meet service demand, as was the case in the NHS when the budget was not previously ring-fenced.
- (c) The budget should bring additionality and new ways of working to address the wider determinants of health, including the pooling of resources.
- (d) Maintaining a Public Health “core” workforce as a substantial body is important to ensure that public health functions do not become fragmented and weakened. There should be a whole system approach (national, sub-national and local) to ensure strong coherence, coordination and quality in advisory capacities and delivery.
- (e) Setting up organisational structures that embed public health strongly within both the NHS and Local Authorities is key to tackling the major public health challenges of today. (The position and authority of the DPH needs to be much clearer and stronger than “advisory”)
- (f) The JSNA and joint Health and Well-being Strategies are an important overview of health need in the borough, but these also need to be underpinned by more in depth knowledge and understanding of specific areas that individual public health employees have as specialist areas of knowledge. A strong evidence base and community engagement to understand issues on the ground are key.
- (g) Maintaining a community engagement function within the public health workforce is key to the success of partnerships both with local authorities and GP Commissioners. Current public health directorates have staff skilled in community engagement which is gathered through a number of means and workstreams. The intelligence gained through this means is absolutely essential to ensuring that the strategies, policies, JSNA's and themed needs & asset assessments, along with other key documents, are reflective of the needs of the population they serve, include public health outcomes wherever possible and are appropriate in terms of planning and reviewing service delivery.
- (h) Joint Intelligence functions between LA and NHS can play a key coordinating role for intelligence, research and data sharing, and ensure intelligence led commissioning decisions.
- (i) Health and Well-being Boards should have a clear remit and powers and be able to scrutinize and powers to “sign off” commissioning decisions. (Who will regulate processes, and conflict of interest eg robustness of commissioning decisions based on population needs and assets assessments such as JSNA; private business interests of GP Commissioners who are both commissioners and providers?).

It is essential to note that the DPH is not a lone expert but requires dedicated experienced support day to day from Public Health Consultants and Specialist, Public Health practitioners in health improvement, Public health intelligence staff, public health programme managers and administration staff currently employed by PCTs—for the most part, unless a DPH is fortunate to already have a dedicated resource in a Local Authority, these roles cannot be covered by existing Local Authority staff as they are specialist practitioner roles requiring appropriate training and qualifications. The current proposals for Public Health at a local authority level does not appear to recognize this vital local Public Health workforce currently employed by PCTs despite their critical role in the production of JSNAs, public health programme commissioning, public health advice and support to GPCC, health protection surveillance (local outbreaks), planning and response. Recently there were two meningococcal disease outbreaks in separate nurseries in the Borough each requiring prompt action to give antibiotic prophylaxis to 100 children and advise anxious parents. The local HPU provided expert advice but the actual delivery of the public health response was done through PCT Public Health staff.

5. Arrangements for public health involvement in the commissioning of NHS services

- (a) It is important that Public Health is a key player within the commissioning of NHS services. The specialist skills within public health can support data and intelligence gathering, community engagement, analysis and evidence to underpin understanding of population health and service development.
- (b) Strong partnership arrangements with the LA and Third Sector can support integrated joint commissioning models for health & social care, and pooling of resources.

- (c) Commissioning for population health requires specialist knowledge and upstream approaches for primary prevention as well as secondary prevention and self care, primary, secondary and tertiary care.
- (d) Commissioning should be for the whole population, encompassing the diversity of the population and demographic change. Equity Audits, Equality Analysis and Impact Assessments and data collection across all equality strands can strengthen knowledge and understanding of the local population.
- (e) Cost benefit analysis and Social Return on Investment models can support investment decisions.
- (f) Issues surrounding coterminosity of GP Consortia and Local Authority boundaries could be problematic. Understanding population health requires support and development opportunities for GP Commissioners, however the current pace of reform does not enable this to take place adequately.

6. *Arrangements for commissioning public health services*

- (a) There needs to be clarity regarding what “public health services” encompass. For example does this include Health Visiting and School Nursing, or will these universal services be commissioned from the main NHS budget rather than the public health budget. Public Health incorporates a wider role such as that it can play in policy, planning, sustainability etc. which is wider than traditional health remits.
- (b) The ring-fenced budget needs to be clarified and adequately resourced if it is to be effective (4% may be inadequate).
- (c) Details of what percentage of the public health budget will be spent at national level, GP Commissioning and Public Health/LA need to be calculated.
- (d) It is important to maintain flexibility with commissioning to enable effective and innovative ways of working (eg in Wigan Looked After Children Service, Homeless & Vulnerable Persons Service, Public Health Capacity Building Programmes and Health Improvement Initiatives).

7. *Future of Public Health Observatories*

- (a) Public Health Observatories provide a valuable regional focus, but local analysis is still very important, especially sub LA geographical analysis eg neighbourhood level, or by social identity eg older people, ethnicity etc. at local level. Support and development for local analysts who specialize in public health is also important, as well as the benefits afforded by PHO's.
- (b) With a skills shortage, workforce development should consider ways to enhance and develop these skills and knowledge. Analysis requires knowledge and understanding of the public health issues as well as technical data management.
- (c) Nationally PHO's have experienced a reduction in funding, but consideration should be given to finding means to utilise expertise to better support workforce development at a local level, as well as better coordinating the valuable work undertaken by PHO's nationally, rather than risk losing valuable expert knowledge.
- (d) Skills for the core public health workforce should be enhanced to be able to interpret and appraise public health data and intelligence.
- (e) Sub national coordination of all public health functions that lie within the remit of Public Health England would enable the valuable work of PHO's to continue, whilst maintaining a coordinated evidence base nationally.
- (f) Evidence should also be coordinated with NICE.

8. *Structure and purpose of the Public Health Outcomes Framework*

- (a) Outcomes focused Public Health is a welcome approach, and the Outcomes Framework covers key domains within public health, and provides potential for joint accountabilities with the LA.
- (b) Statutory accountability would need to be established for Public Health England NHS and the Local Authority (if this model is adopted).
- (c) However there is a need to consider the range of budgets that these are accountabilities for, as the measures go beyond the immediate ring-fenced public health budget (in particular domain 2). Again the ring fenced budget purpose and amount has not yet been clarified, but the Outcomes Framework clearly represents a range of NHS and LA budgets.
- (d) Outcomes in Public Health can take many years to achieve and may not be measurable immediately in the short term. Progress measures may need to be considered. Outcome measures should also be linked to Quality Standards with joint accountability for Public Health England and Local Authorities.

9. *Arrangements for funding public health services*

- (a) Clarity is needed over the amount and use of the budget, based on more robust assessments.
- (b) There is potential for the health premium to disadvantage some areas with chronic complex issues and high levels of population churn and potentially exacerbate health inequalities.
- (c) There is currently no clarity about what constitutes Public Health Services.

10. *Future of the public health workforce (including regulation of public health professionals)*

- (a) It is important to maintain a coherent workforce, and not just consider “specialists” as the core public health workforce. The public health workforce is diverse and covers a range of skills, knowledge and expertise at different levels, as well as incorporating functions such as business administration and IT. Advisory roles and analysis are important, but a skilled operational/practitioner workforce is also important.
- (b) The public health workforce should remain as employees of NHS Public Health England and “hosted” within the LA to avoid fragmentation and maintain a level of professional independence. Clinical governance issues for medical and clinical staff (eg health protection functions in particular) would also be addressed.
- (c) Establishing a core public health workforce at a range of levels and from a range of disciplines is important in order to avoid a “medical model” and to address the wider determinants of health. Properly assessing the wide range of skills and knowledge required and constructing a Public Health career framework will enable strengthening and development of a core workforce to support the “wider public health workforce”.
- (d) The functions of public health cannot be easily divided, and holistic approaches are needed to improve and protect health.
- (e) A robust means of regulation for senior Public Health Consultants/Specialists/DPH’s is important to ensure quality, safety and robust practice that reflect the level of responsibility for the public’s health, well-being and protection and financial investment.

11. *How the Government is responding to Marmot Review on health inequalities*

- (a) The Public Health White paper adopts a life course approach, however, there is a need to emphasize socio-economic/wider determinants interventions more, in line with Marmot.
- (b) There have been a wide range of major socio-economic policy reforms eg welfare reform, housing etc and an economic downturn. It is recommended that Health Impact Assessments be undertaken before decisions on reform are made in future. The cumulative impact of a wide range of reforms on the most vulnerable in society has yet to be realized, and has the potential to increase health inequalities and add to the burden of ill health.
- (c) The Nuffield Ladder of Intervention highlights a range of intervention levels. It is important that public health policy and practice works across all these levels according to what is most effective, based on a robust evidence base.

Dr Kate Ardern

Executive Director of Public Health, Borough of Wigan

June 2011

Written evidence from Lindley Owen (PH 45)

KEY POINTS

- Protect public health from interference from vested interests.
- Create a cabinet level post for public health, separate from the NHS.
- Make all local DsPH joint appointments.
- Make JSNAs mandatory and include Assets.
- Maintain and strengthen Public Health influence on NHS commissioning.
- Protect Public Health Observatories.
- Implement Marmot’s recommendation of a Minimum Income for Healthy Living.

INTRODUCTION

I am director of, and consultant in, public health for a Primary Care Trust in the South West region, and a fellow and examiner for the Faculty of Public Health. I have 38 prior years’ service in the NHS, as a manager of hospitals, director of a health authority, chief executive of a Primary Care Group, director of a Health Action Zone. I am qualified in health service management and a graduate of the NHS national management scheme.

1. The creation of Public Health England within the Department of Health, the abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse

This proposal brings the risk of public health decisions being too closely influenced by political considerations. While arms-length bodies may currently be out of favour, they do provide a degree of distance, enabling the service to retain a semblance of impartiality. Many major public health issues have longer time scales than the electoral cycle. The health consequences of rising levels of atmospheric carbon dioxide being just one such example.

2. *The public health role of the Secretary of State*

As long as he is also responsible for the NHS, that huge, clamorous organisation will occupy his every waking hour. A separate cabinet post for Public Health is the only way to ensure proper recognition of its importance.

3. *The future role of local government in public health*

In the South West, almost all Directors of Public Health are joint appointees with their co-terminous local authorities. This means a heavy workload for the DsPH, with up to three Boards to report to, but is really important in helping address the cross-cutting influences on the health of populations. This link should be strengthened under any future changes, with careful attention to both ends; a DPH fully integrated in local government, but who loses influence in the NHS, would be weakened.

4. *Arrangements for the appointment of Directors of Public Health*

These should, as at national level, provide for a degree of protection for Public Health against undue political influence locally. The former Medical Officers of Health could only be dismissed on the vote of the whole council, a fact which enabled many in the 19th century to drive through schemes such as underground sewage systems, which were very unpopular to many in their day.

5. *Joint Strategic Needs Assessment*

This is a clumsy and misleading term for a vital process. A safe, healthy future for humanity depends on clean, clear science, and at local level the JSNA is the vehicle. The term misleads because it excludes assets, a fact now recognised as a flaw in the latest guidance. (ID&EA 2011). We need to ask the marketers to come up with a more accurate, accessible title, and make the process mandatory for all local authorities.

6. *Health and well-being Boards*

Many local authorities in the South West have already established these, but unless they are put on a statutory footing, they risk being ignored or sidelined.

The “Joint” in Joint Health and Well-being Strategies should go beyond health and social care, and include planning, transportation, housing, leisure and agriculture.

7. *Public Health involvement in commissioning NHS services*

We seek an NHS which is both comprehensive, universal, effective and efficient. Commissioning which meets these four, often apparently irreconcilable requirements, must be underpinned by dispassionate analysis of intervention and outcome which epidemiology provides. Public health professionals at local level and above implement that science on a daily basis. Strengthening public health in local government should not jeopardise that, but reinforce it. The US healthcare experience, of “provider capture” which has led to over-intervention and high cost for the insured population, and the widest health inequalities in the developed world, are a clear warning of the risks otherwise.

8. *Public Health Observatories*

These organisations, just ten years old, have justified their existence many times over. Not just public health staff, but local government and voluntary organisations turn to the network of PHOs as a vital source of accurate, unbiased, up-to date evidence, presented in a clear and accessible way. Recently their effectiveness has been diminished slightly by budgetary cuts; these should be restored.

9. *The Government response to the Marmot Review*

The Public Health white paper purported to be such a response, and it did indeed recognise many of the themes of that document. However, it was silent on a central recommendation. Marmot’s team had worked closely with the North West Region, and London, and as a result had identified an important distinction between the statutory minimum wage, and what they term a “Minimum Wage for Healthy Living”. The latter is higher than the minimum wage because Marmot’s team discovered that in Britain today, it is not possible to live a healthy life on the minimum wage. Those, including the London Mayor and many major businesses, who back the London Living Wage, recognise this. The government should do so, too.

Written evidence from NHS Sheffield Directorate of Public Health (PH 46)

SUMMARY

- We agree with the Public Health white paper and the Faculty of Public Health that there are three domains of public health: health improvement, health protection, and health services public health.
- We share the same concerns as the Faculty of Public Health, Royal Society for Public Health, and Association of Directors of Public Health (<http://www.fph.org.uk/uploads/Letter%20to%20David%20Cameron.doc>) with regards the proposed changes to Public Health in England and that these concerns have been overshadowed by other issues relating to changes to the NHS.
- We have particular concerns about the proposed reforms in the following main areas:
 - Lack of standard setting and professional regulation of public health specialists if employed by local authorities.
 - One of the three domains, health services public health, is integral to health services commissioning and is not an add-on. It will be very challenging for this to be delivered from a local authority setting, yet separation from the rest of the Public Health workforce may lead to fragmentation of the public health system.
 - We believe that the proposed “health premium” is flawed in principle and will be unworkable in practice.

1.0 Thank you for inviting responses to the Health Committee on Public Health. Please find enclosed a summary of our concerns about the proposed changes to Public Health submitted by NHS Sheffield’s Public Health Directorate. The Directorate includes a Director of Public Health, five qualified public health specialists employed at Consultant level, three additional qualified and registered PH specialists who are not currently Consultants, one Director of Dental Public Health as well as over 50 other public health specialist staff.

2.0 LACK OF STANDARD SETTING AND PROFESSIONAL REGULATION

2.1 Most public health specialists are members or fellows of the Faculty of Public Health, and all are required to be on the Specialist Register. This gives the public reassurance in their professional standing, Continuous Professional Development, qualifications and training and sets the rigorous standards which all members of the profession are required to meet.

2.2 We are concerned that public health specialists in the Local Authority will not, as plans currently stand, be mandated to be above this quality line. Public health is a professional undertaking with defined competencies and standards in order to protect the public’s health. Not mandating that public health specialists require this status in our opinion puts the health of the population at risk.

2.3 There is also a significant risk that failure to require that Directors of Public Health in particular, but also other Public Health specialists are properly trained and registered, will result in significant inequity across the country, as some Local Authorities will wish and be able to recruit properly trained experts, whereas others may not.

3.0 HEALTH CARE/HEALTH SERVICES PUBLIC HEALTH SPECIALISTS

3.1 Health care public health is a vital domain of Public Health activity, and makes a major contribution both to improving the health of the population, as well as reducing health inequalities. Many Public Health consultants who specialise in this area are first qualified doctors, undertaking junior medical jobs before higher specialist training in public health medicine. This is an additional five years training with associated additional professional qualifications and study. This gives them a broad and deep understanding of the NHS and the health needs of the population.

3.2 Healthcare public health specialists’ input into commissioning health services is integral on a day-to-day basis. No-one else has the academic rigour and practical experience of commissioning nor the understanding of the health needs of the population, the evidence base, and is able to balance complex interrelated disease pathways with health economics within the context of finite monies to pay for services.

3.3 A population perspective to health service planning has been integral to the NHS for decades now and has ensured rationing of finite resources in a fair and equitable manner. We have worked alongside GPs, hospital specialists, nurses, other clinicians, social care and NHS managers for years to ensure a multiprofessional clinical input into commissioning.

3.4 It has been suggested during the recent NHS “listening exercise” that GP commissioners would be able to buy health needs assessments from local universities in order to make commissioning decisions. If only it was as simple as that. The reality is that commissioning is a hugely complex juggling act. Health care public health specialists provide leadership and strategic direction as well as managing health service quality improvement projects and programmes.

3.5 Our local GP commissioners do recognise that they do not have the time nor the skills of balancing the needs of a whole population with the evidence base with reducing inequalities with commissioning services which offer value for money, and like all other GP commissioners in the country are keen to have public health support in the future. We believe that it will be extremely challenging to directly influence NHS commissioning from the Local Authority, as is currently planned.

4.0 THE “HEALTH PREMIUM”

4.1 We think it is highly unlikely that a “Health Premium”, as described in the Public Health White Paper and associated consultation document, could possibly be made to work, for three reasons.

4.2 There are no outcome measures that are sufficiently robust as overall measures of population health (and hence health inequality, and reduction in health inequality) that are sufficiently responsive at local level in a relatively short space of time, to be a valid tool for this purpose.

4.3 Even if there were, the mechanism would need to take into account other factors on health and health inequalities at population level. For example, economic changes in an area which health services cannot influence. Another example would be the impact of population change, in particular immigration and emigration, both in and out of a district as well as internally, within a district. If these sort of factors are not taken into account, local areas will end up being penalised, or rewarded, simply because of the impact of population change on local health indicators. At present, the impact of immigration and emigration is completely undefined, though undoubtedly real.

4.4 Even if the above problems were overcome, we cannot conceive of any additional incentive that this proposed mechanism would deliver.

4.5 Further, there is a real danger that if implemented, the “health premium” would end up further disadvantaging already disadvantaged districts, since they are the ones least likely to be able to attract it, through no faults of their own.

June 2011

Written evidence from Royal National Institute of Blind People (PH 47)

KEY POINTS

- We welcome the creation of Public Health England with a stronger role for Local Authorities in the provision of public health services.
- We deplore the fact that eye health is not mentioned as a major public health issue in the Public Health White Paper despite robust evidence that there are already two million people with sight loss in the UK today and that this number could more than double by 2050 unless effective preventative action is taken.
- We believe that the current data on the certification of people as visually impaired or severely visually impaired provides a valid basis for an indicator to measure progress in the prevention of avoidable sight loss under domain four.
- We urge the Health Select Committee to call on the Government to highlight eye health as an area of health inequalities in relevant forthcoming legislative proposals and to include eye health promotion in future Government funded health promotion initiatives.

ABOUT RNIB

RNIB is a membership organisation with over 10,000 members who are blind, partially sighted or the friends and family of people with sight loss. 80% of our Trustees and “UK Forum” Members are blind or partially sighted. We encourage members to be involved in our work and regularly consult with them on Government policy and their ideas for change.

As a campaigning organisation of blind and partially sighted people, we fight for the rights of people with sight loss in each of the UK’s countries.

During the next four years we want to tackle the isolation of sight loss by focusing on three clear priorities:

- (1) Stopping people losing their sight unnecessarily.
- (2) Supporting blind and partially sighted people to live independent lives.
- (3) Creating a society that is inclusive of blind and partially sighted people.

Our response to this consultation is in relation to our first priority of stopping people losing their sight unnecessarily. We will focus on the questions that we feel most qualified to address.

The creation of Public Health England within the Department of Health

1. As signatories of the UK Vision Strategy response to the Public Health White Paper we would like to reiterate that we welcome the plans to create a Public Health Service in England that recognises the importance of health and wellbeing, the prevention of ill health and the need to tackle health inequalities holistically, taking into account the impact of the wider determinants of health and associated policies (in relation to social care, transport, environment, welfare, etc) rather than focusing exclusively on health.

2. The creation of the Public Health Department within the Department of Health appears to signal a desire to ensure strong links between public health and NHS policies. However, the move of accountability for the NHS from the Department of Health to the NHS Commissioning Board could undermine this desire, when integration across the whole patient pathway from prevention to treatment to social care is crucial to optimise outcomes and minimise costs.

3. As an organisation engaged in sight loss prevention as well as in the provision of support for blind and partially sighted people we are keen to ensure that Public Health England takes an active role in safeguarding sight as well as promoting the health and wellbeing of blind and partially sighted people and their access to any proposed initiatives.

4. We would like to highlight our disappointment with the failure of the Public Health White Paper to make any reference to eye health as a public health issue. This is an unfortunate omission given the Government's frequently expressed support for the UK Vision Strategy, the sector-wide initiative to improve the eye health of the UK population, secure full support in all areas of life for people with sight loss and build a more inclusive society that fully embraces what blind and partially sighted people have to offer.

5. In the UK, about a quarter of sight loss in children and over half of all sight loss in adults is avoidable. For the approximately 18,000 children currently growing up with impaired sight, there is lifelong impact on well-being and social and economic prospects.

6. Without concerted efforts to prevent avoidable sight loss the number of adults suffering ill health and a lack of wellbeing due to visual impairment is likely to double from the current 2 million to almost 4 million by 2050. Only preventative action through primary prevention, improved case finding, access to treatment and appropriate support for blind and partially sighted people will help reduce the burden of disease associated with eye disease and visual impairment that has been estimated to have cost the NHS and wider society more than £6 billion in 2008.³⁴

7. The costs relating to sight loss that starts in infancy or childhood have not been widely studied but can be anticipated to be high, given that these are incurred across the whole lifespan and there are additional costs due to loss of economic productivity. Importantly, there is clear evidence of inequalities in eye health, linked to late presentation in adults and children people from deprived backgrounds.³⁵ The current lack of efforts to tackle these health inequalities needs to be addressed.

8. This evidence points to eye health being a public health challenge that needs to be recognised in the forthcoming Public Health Bill as well as in the outcomes and commissioning frameworks. We have long called for the appointment of a National Director for Eye Health to drive this agenda. As a minimum an ophthalmologist should be appointed to the panel advising the National Clinical Director. Now would be a good time for the Government to make this appointment to show that its support for eye health is not merely tokenistic.

The public health role of the Secretary of State

9. We welcome the strong role suggested for the Secretary of State, which signals a shift towards prevention at the highest political level and guarantees accountability to Parliament.

The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)

10. We feel strongly that local authorities, as advised by their public health directors, should take a leading role in ensuring that partnership takes place between the NHS, local government and the voluntary sector to secure the health and wellbeing of local people. The reorganisation of the public health service in England with local public health departments being placed in local authorities gives local government a tremendous opportunity to expand their role to the benefit of local people. Traditionally they have played a very important role as holders of the registers of blind and partially sighted people, as supporters of people already experiencing sight loss and as providers or funders of rehabilitation services. Their understanding of the impact of blindness and partial sight on the lives of affected people puts them in an excellent position to appreciate the need for improved prevention to minimise the number of people requiring social care support and relying

³⁴ Access Economics: Future Sight Loss UK (1): The economic impact of partial sight and blindness in the UK adult population. 2009. http://www.rnib.org.uk/aboutus/Research/reports/2009andearlier/FSUK_Report.pdf

³⁵ Wormald, R et al: Deprivation and late presentation of glaucoma: case control study. *BMJ* 2001; 322 : 639 doi: 10.1136/bmj.322.7287.639 (Published 17 March 2001). <http://www.bmj.com/content/322/7287/639.full>

on informal care with its knock-on effect on carer health and productivity. The new system will allow them to use this knowledge to facilitate steps that blind and partially sighted people may want to take to adopt a healthy lifestyle and avoid preventable diseases that affect the general population such as cancer, heart disease and stroke.

11. We welcome the recognition that Directors of Public Health need to continue to play a key role in the provision of public health services based on strengthened Joint Strategic Needs Assessments. An analysis of JSNAs conducted in 2010 revealed that only 13% of JSNAs in England made reference to the eye health needs of their local population. Given the prevalence of eye disease this is an omission that needs to be addressed, particularly in light of the intention to make it mandatory for Local Authorities to take account of JSNAs when developing their health and wellbeing strategies.

12. In relation to sight loss we would hope that joint working based on clearly identified local needs would lead to a situation where the NHS and Social Services provide joint funding for Eye Clinic Liaison Officers who:

- Support people at the time of sight loss *diagnosis*.
- Ensure those who reach the level of being eligible for registration as blind or partially sighted are certified and referred to Social Services.
- Provide information to patients with sight loss about support services available in their area.

Arrangements for public health involvement in the commissioning of NHS services

13. We believe that provisions in the Health and Social Care Bill relating to joint working between the NHS, Public Health England and Local Authorities needs to be strengthened. Ideally, joint budgets should be made mandatory. Failing that, other mechanisms to foster joint working need to be explored. One way of doing that would be the development of NICE Quality Standards that cover the whole patient pathway. Commissioners should be encouraged to implement existing NICE public health guidance to maximise their chances of achieving the desired outcomes under the public health outcomes frameworks. In addition, concrete steps should be taken to link up all guidance relating to specific patient pathways to ensure that public health, the NHS and Social care services work in conjunction rather than in silos and that NICE Quality Standards in health and social care are complemented by action on prevention.

14. The current Quality Standard development does not seem to allow crossover between these different areas of care. This was illustrated in the development of the glaucoma quality standard. Two additional quality statements that were proposed by stakeholders to cover the whole pathway from case finding to social care support were not included in the final Quality Standard because it was felt that they were not within its remit. With no reference to these important issues in the Quality Standard it is likely that providers aiming to implement the Standard will not focus sufficiently on the areas of overlap between public health, the NHS and Social care.

Arrangements for commissioning public health services

15. In terms of the arrangements for commissioning public health services it will be important to secure the continuation of existing health promotion services (such as smoking cessation services) during the transition phase from the NHS to the new Public Health Service. Future health promotion campaigns should emphasise that smoking cessation, healthy diet and physical exercise are good for eye health. Messages around the link between smoking and blindness should be promoted as an effective way of encouraging smoking cessation as evidenced by experiences in Australia.³⁶

16. Health promotion is particularly important in relation to the screening of children for vision defects at school entry. This is currently funded by PCTs, yet we have evidence that in 2008 11% of 142 PCTs that responded to a Freedom of Information request from RNIB did not fund any children's screening. We believe that given their role in school education Local Authorities are in an excellent position to take on this responsibility and ensure that all children are screened at school entry to prevent avoidable sight loss. This should be enshrined as mandatory in secondary legislation.

The structure and purpose of the Public Health Outcomes Framework

17. The proposed outcomes framework is coherent. The five outcome domains understandably focus on tackling avoidable causes of premature mortality. However, we welcome the inclusion of a domain focusing on the reduction in the number of people living with preventable ill health.

18. Action under this domain should focus on conditions that constitute a major burden on individuals and society as evidenced by epidemiological and public or patient survey data. That should include eye health and sight loss.

³⁶ Carroll T, Rock B: Generating Quitline calls during Australia's National Tobacco Campaign: effects of television advertisement execution and programme placement. *Tob Control*. 2003 Sep;12 Suppl 2:ii40-4
Wilson, NA et al: Smoking and blindness advertisements are effective in stimulating calls to a national quitline. *BMJ* 2003;328(7439)537-538

19. We are keen to work with NICE and the Department of Health in conjunction with the Royal College of Ophthalmologists and other stakeholders on an indicator to measure progress in preventing avoidable sight loss. The certification data collected by Hospital Eye Clinics provides a viable basis for the development of such an indicator (or indicators).

Arrangements for funding public health services (including the Health Premium)

20. We welcome the fact that the Government has decided to earmark funding for the Public Health Service to ensure that the money allocated is not used for different purposes. This is particularly important in times of severe funding cuts to Local Authority budgets. However, the predicted £4 billion to be spent on Public Health can only represent a starting point. Given the huge challenges of addressing health inequalities and improving early detection of a large number of diseases, including eye diseases, there is certainly room for scepticism as to whether the Public Health Service will achieve the change that is required on this limited budget. At a later date it might therefore be prudent for the expenditure to be audited to ascertain whether it has been invested in a cost-effective fashion securing measurable outcomes.

21. Many eye health interventions will either prevent further sight deterioration or will restore a proportion of sight loss. A number of national initiatives are already in existence and they should be recognised under national guidance on commissioning public health and securing better health outcomes. Promotion of these programmes to produce measurable eye health improvements could be rewarded. Even if some or all of these programmes are commissioned by GP consortia, ways need to be found to encourage GPs, eye health specialists, public health specialists and local authorities to co-operate in the interests of local people.

22. For example, the national programme for screening for diabetic retinopathy already helps people with diabetes to be screened for retinopathy and offered treatment in time to prevent more serious sight loss.

23. NICE has produced guidance on glaucoma. If patients recognise symptoms and present early enough their remaining sight can be preserved through daily use of eye drops and sometimes by surgery to relieve intra-ocular pressure. If left too late the sight loss can be irremediable. There is no national programme at present but work is underway to identify effective screening programmes for populations that are at an increased risk of developing the disease (ie those with first degree relatives with the disease and people from African and African/Caribbean background). Improved case finding has the potential to save the sight of tens of thousands of people of all ages.

24. Wet Age-related macular degeneration (AMD) can now be treated successfully in line with NICE guidance. The earlier it is caught the better the chances of retaining and even improving sight. Wet AMD affects 26,000 people each year, mainly but not exclusively of retirement age. It therefore seems appropriate for these eye conditions to be a focus for future public health leadership and action.

25. There is an existing national programme for tackling cataracts for which treatment on a day surgical basis is quick, cost-effective and beneficial to the patient.

26. Refractive error is not sight threatening, but affects a very large number of people of all ages. Prescription of spectacles or contact lenses usually solves the problem and reduces the risk of accidents in the home and on our roads, which add to the pressure on emergency services. When public health specialists participate in public safety campaigns led by local authorities then they could consider these factors for inclusion in campaigns.

27. Public health leaders will be looking for opportunities to integrate NHS, local authority and voluntary services to improve health outcomes. In many places these agencies already co-operate well in the field of eye care but they provide good opportunities for even better integration and financial incentives should be provided to make this co-operation happen.

How the Government is responding to the Marmot Review on health inequalities.

28. We believe that one benefit of moving responsibility for public health to Local Authorities is the ability they have to see the wider picture and the importance of tackling the wider determinants of health. People who lose their sight not only suffer the negative health consequences of their eye disease but they are also more likely to use more health resources because of the risk of developing depression and experiencing unemployment. A disproportionate number of blind and partially sighted people live on a low income, exposing them to additional health risks.

29. In addition, children from all ethnic minorities as well as those from socio-economically deprived backgrounds are at considerably increased risk (up to nine fold in some cases) of blindness³⁷ and at least 10% of blind children die within a year of diagnosis.³⁸

³⁷ Reference: Rahi, JS, Cable, N, for the British Childhood Visual Impairment Study Group. (2003). Severe visual impairment and blindness in children in the UK. *The Lancet* 362(9393), 1359–1365. ISSN: 0140–6736 [DOI link].

³⁸ Rahi, JS, Cable, N, for the British Childhood Visual Impairment Study Group. (2003). Severe visual impairment and blindness in children in the UK. *The Lancet* 362(9393), 1359–1365. ISSN: 0140–6736 [DOI link].

30. Socio-economic deprivation has been strongly linked with late presentation for glaucoma³⁹ and different ethnic minority groups are at a higher risk of sight loss from the main eye conditions. Asians have a greater risk of developing cataracts compared to the black and white populations, Black and Asian populations have a greater risk of developing diabetic eye disease compared to the white population and the relative risk of glaucoma is much higher for the black population compared to the white population.⁴⁰

31. Given the strong evidence for inequalities in eye health both in children and in adults and the importance of early detection local authorities with significant minority ethnic populations from these backgrounds should have an obligation to allocate part of their public health funding to initiatives to tackle these health inequalities as part of their activities to promote early presentation and diagnosis.

June 2011

Written evidence from Mr James Douglas (PH 48)

SUMMARY

- There has been a concerted effort in the professional literature, from a small cabal within the medical fraternity, to argue the case for reinstating non-therapeutic circumcision at the expense of the NHS, frequently using professed concern for the well-being of boys of certain ethnic or religious backgrounds receiving circumcision in non-medical settings, as a pretext.
- Recently, there has been a string of mainstream media items favourable to male circumcision, which amount to nothing less than a marketing campaign to motivate parents to have their sons circumcised. Many of these articles draw upon established marketing concepts (in turn derived from insights of behavioural science), most notably, the use of “experts”. In the context of promoting circumcision to parents, such “experts” generally include medical practitioners who work at private circumcision clinics and religious officials.
- Regardless of whether it is performed in a medical or non-medical setting, a significant number of boys subjected to the practice of circumcision will later fulfill the DSM-IV criteria for a diagnosis of Post-Traumatic Stress Disorder.
- Circumcision removes the most sexually sensitive parts of a boy’s penis, including the foreskin, the frenulum, and the ridged band of nerves. The male foreskin is also designed to protect the glans of the penis throughout a man’s life, ensuring that the internal mucosal tissue remains moist and sensitive (much the same way that a woman’s clitoral hood protects the clitoris). In addition, the foreskin acts as a natural gliding mechanism to reduce chafing and dryness during intercourse.
- The British Medical Association advises against routine male circumcision, and no national medical association in the world recommends that boys be forcefully circumcised for preventive health reasons.
- There has been little incentive for the medical profession to investigate the long-term effects on men’s sexual and psychological health and well-being, but the growth of groups such as NORM-UK (an organisation registered with the Charities Commissioners for England and Wales), suggests that a substantial number of men genuinely resent being circumcised.
- It is imperative that Department of Health and Public Health England mandate that all staff, contractors, agencies, facilities and departments under their auspices, including GPs and GP practices: Must not offer among their services the harmful male genital mutilation known as circumcision; Must not permit on their premises individuals or organisations promoting the harmful male genital mutilation known as circumcision; Must not be refer patients explicitly for the harmful male genital mutilation known as circumcision; Must not be employed or associated with any facility offering the harmful male genital mutilation known as circumcision; Must not allow their facilities to be used for the harmful male genital mutilation known as circumcision.; and Must not stock or allow on their premises literature or other material promoting the harmful male genital mutilation known as circumcision.
- Given the dearth of research in this area, it would be appropriate for the Department of Health and Public Health England to partner with registered charities such as NORM-UK and to create incentives for medical researchers to investigate the long-term effects of circumcision on men’s sexual and psychological health and well-being.

1. There has been a concerted effort in the professional literature, from a small cabal within the medical fraternity, to argue the case for reinstating non-therapeutic circumcision at the expense of the NHS, frequently using professed concern for the well-being of boys of certain ethnic or religious backgrounds receiving circumcision in non-medical settings, as a pretext,¹ a call loudly echoed in sections of the mainstream media.² Regardless of whether it is performed in a medical or non-medical setting, a significant number of boys subjected to the practice of circumcision will later fulfill the DSM-IV criteria for a diagnosis of Post-Traumatic Stress Disorder.³ Further, circumcision removes the most sexually sensitive parts of a boy’s penis, including

³⁹ Wormald, R et al: Deprivation and late presentation of glaucoma: case control study. *BMJ* 2001; 322 : 639 doi: 10.1136/bmj.322.7287.639 (Published 17 March 2001). <http://www.bmj.com/content/322/7287/639.full>

⁴⁰ See reference 1.

the foreskin, the frenulum, and the ridged band of nerves.⁴ The male foreskin is also designed to protect the glans of the penis throughout a man's life, ensuring that the internal mucosal tissue remains moist and sensitive (much the same way that a woman's clitoral hood protects the clitoris). In addition, the foreskin acts as a natural gliding mechanism to reduce chafing and dryness during intercourse.⁵

2. Recently, there has been a string of mainstream media items favourable to male circumcision, which amount to nothing less than a marketing campaign to motivate parents to have their sons circumcised.^{2,6,7,8} Many of these articles draw upon established marketing concepts (in turn derived from insights of behavioural science), most notably, the use of "experts". An "expert", in a marketing context, is an individual who, because of their occupation, or perceived experience, is uniquely placed to lend credence to the product or service that an advertisement promotes.⁹ In the context of promoting circumcision to parents, such "experts" generally include medical practitioners who work at private circumcision clinics^{6,8} and religious officials.⁷ Following complaints from the public, the *Press Complaints Commission* has reached resolutions noting the inappropriate implication in media items that religious officials are qualified to offer medical advice in regard to circumcision, the minimisation of the inherent risks of circumcision as a medical procedure, and the implication that circumcision is of minimal discomfort through the impression that it is legitimate practice to conduct the procedure without anaesthesia.^{10,11} Both the hospital and doctor (who is also a Consultant Urological Surgeon at Royal Liverpool University Hospital NHS Trust) featured in a recent episode of the Channel 4 television series *Embarrassing Bodies*,⁸ linked to the video on the Channel 4 website from their respective web-pages,^{12,13} effectively by-passing the *General Medical Council Guidelines* about how medical practitioners should promote and publish information about their services.¹⁴ It is unsurprising that such symbiotic relationships should form between private doctors seeking to promote their practice and mainstream media outlets who want to appease advertisers by keeping such a high-profile controversial social issue alive, since advertising is the force which has historically sustained all commercial media.¹⁵

3. The British Medical Association advises against routine male circumcision,¹⁶ and no national medical association in the world recommends that boys be forcefully circumcised for preventive health reasons. The Royal Dutch Medical Association's very up-to-date policy on circumcision states that "KNMG is calling upon doctors to actively and insistently inform parents who are considering the procedure of the absence of medical benefits and the danger of complications", and that there is a good case for making it illegal.¹⁷ Female genital mutilation has been illegal for a number of years now.¹⁸ There has been little incentive for the medical profession to investigate the long-term effects on men's sexual and psychological health and well-being, but the growth of groups such as NORM-UK (an organisation registered with the Charities Commissioners for England and Wales), suggests that a substantial number of men genuinely resent being circumcised.¹⁹

4. A recent statement from the British Association of Paediatric Urologists on behalf of the British Association of Paediatric Surgeons and The Association of Paediatric Anaesthetists admitted that some doctor's under its charge "have been willing to provide non therapeutic circumcision without charge rather than risk the procedure being carried out in unhygienic conditions."²⁰ In its statement on the law and ethics of male circumcision, the British Medical Association has concluded that "it is for society to decide what limits should be imposed on parental choices."¹⁶

5. It is therefore imperative that Department of Health and Public Health England mandate that all staff, contractors, agencies, facilities and departments under their auspices, including GPs and GP practices: Must not offer among their services the harmful male genital mutilation known as circumcision; Must not permit on their premises individuals or organisations promoting the harmful male genital mutilation known as circumcision; Must not refer patients explicitly for the harmful male genital mutilation known as circumcision; Must not be employed or associated with any facility offering the harmful male genital mutilation known as circumcision; Must not allow their facilities to be used for the harmful male genital mutilation known as circumcision.; and Must not stock or allow on their premises literature or other material promoting the harmful male genital mutilation known as circumcision.

6. To best develop and enhance the availability, accessibility and utility of public health information and intelligence regarding the harmful male genital mutilation known as circumcision, it is imperative that the Department of Health and Public Health England establish a central information store of the harm caused by male circumcision, which will form the basis for establishing a dictate that staff, contractors, agencies, facilities and departments under its auspices, including GPs and GP practices, will not perform nor refer patients for circumcision; and to make use of the insights of behavioural science to research and implement strategies which discourage parents from subjecting their sons to the harmful male genital mutilation known as circumcision, without lending to its prestige by implying that it is a practice worthy of its own policy statement or the subject of a legitimate "debate".

7. To counteract the mainstream media marketing of circumcision to parents, it is appropriate that the Department of Health and Public Health England mandate that staff, contractors, agencies, facilities and departments under its auspices, including GPs and GP practices, will not perform nor refer patients for circumcision; and should use the insights of behavioural science to research and implement strategies which discourage parents from subjecting their sons to the harmful male genital mutilation known as circumcision, without lending to its prestige by implying that it is a practice worthy of its own policy statement or the subject of a legitimate "debate".

8. It would be appropriate to invite appropriately registered charity organisations such as NORM-UK to partner with the Department of Health and Public Health England to contribute to compiling and improving the use of public health evidence to counteract the mainstream media marketing of circumcision to parents and discourage parents from subjecting their sons to the harmful male genital mutilation known as circumcision, without lending to its prestige by implying that it is a practice worthy of its own policy statement or the subject of a legitimate “debate”.

9. Given questions raised about the professional conduct of some medical practitioners with regard to the continuing practice of male circumcision, whatever system of voluntary regulation may be implemented, it is appropriate that the Department of Health and Public Health England mandate that staff, contractors, agencies, facilities and departments under their auspices, including GPs, GP practices and other public health specialists, will not perform nor refer patients for the harmful male genital mutilation known as circumcision.

10. Given the dearth of research in this area, it would be appropriate for the Department of Health and Public Health England to create incentives for medical researchers to investigate the long-term effects of circumcision on men’s sexual and psychological health and well-being.

June 2011

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Written evidence from Dr Giri Rajaratnam (PH 49)

Basis of submission: Experience as a public health consultant and director of public health working for deprived communities in Yorkshire and West Midlands. Currently employed as a deputy regional director of public health.

Provenance: The views expressed in this submission are the author's. It does not reflect views of any organisation that the author is or has been associated with or employed by.

1. SUMMARY

1.1 The current proposals ignore the notion of leadership for health for local communities. The leadership should rest with the Chair of the Health and Wellbeing Boards (H&WB) and the DPH. The accountability should be to both, the Secretary of State for Health (SoS) and to local communities through HealthWatch.

1.2 The DPH as part of the JSNA process should take responsibility for delivering an independent assessment of health and care needs of local communities and make recommendations relating to evidence based interventions needed to improve population health. This should be the primary responsibility of the DPH and should not be compromised by any other responsibilities that may be locally determined.

1.3 In order to deliver this responsibility, the DPH will require access to data (qualitative and quantitative), to local experts from a range of organisations, to local communities and to be able to influence a range of organisations (public, private and 3rd sectors). He or she will require high quality professional staff that have both the scientific and clinical background and are able to interact with people from very diverse backgrounds; from members of the public to specialist scientists as well with Boards and Councils. This team will clearly need employment with an organisation, however, whether it is the NHS or local government is largely irrelevant because in order to deliver this responsibility with credibility amongst the local populace, they will need to be seen as independent of political and other vested interests. Organisational loyalty will need to be lower down the priority than loyalty to local communities.

1.4 Similar principles apply to Public Health England (PHE). PHE needs to be at an arm's length from DH and the SoS in order to maintain professional independence. This will increase the probability that the outputs of PHE are seen as credible by the population at large, local government, the NHS and the professions. Moreover, PHE needs to be led by the professions and not by career civil servants or the SoS.

1.5 The SoS does have an important leadership role which is about ensuring that the health system works to be benefit of communities. The SoS does not have a management role which needs to be recognised by Parliament.

1.6 Data and information is a fundamental building block of an effective public health system and is vital for both, PHE and the DPH at a local level. There is a danger that the extant meagre resources within PHOs and departments of public health will be further depleted in the name of rationalisation. This must not happen. Both the PHE and the DPH will require considerable analytical support and by this I mean analysts with qualifications/experience in epidemiology, medial statistics or quantitative scientific research.

1.7 The public health workforce is in danger of becoming so fragmented that the integrity of the whole will be lost. It is crucial that if local government is to take on public health responsibilities, it makes an explicit commitment to training (specialist as well as CPD), accept the standards as set out by the Faculty of Public Health and ensure that recruitment is based on the FPH guidance. It is unfortunate that the SoS has indicated that he does not see professional regulation being of importance in public health. I disagree absolutely.

2. INTRODUCTION

2.1 Members of the Health Committee will be aware of the definitions of public health as set out by the Faculty of Public Health. The perspective, I wish to take is that of a DPH. I tend to think of public health in terms of:

- Health surveillance, where the main output is the Annual Report.
- Health policy (local policy development, interpretation of national policy and implementation) and support for commissioning. The key challenge is about translating policies into actions that will improve health and Appendix 1 is my conceptual framework for what this means within a local context. The big barrier has been that financial systems have not been supportive. However, the development of programme budgets makes the applicability of these concepts easier.

- Health protection (communicable & environmental hazards and disease prevention, screening, vaccination, etc).
- Promotion of health (health improvement).

2.2 Of these four functions, the first three require the specialist skills that training in public health provides. In the context of promotion of health (health improvement), this function can be commissioned and delivered by health promotion specialists working in collaboration with public health specialists.

2.3 I have taken this approach because it makes it easier to operationalise the work of the teams that lead. It also makes it easier to think and act to deliver my contributions to the mission of the health system.

2.4 I think the taxpayer funds the health system in order to: “improve, within the resources allocated, the health of local communities by commissioning/delivering;

- Services that promote health and prevent disease.
- Services to diagnose, cure and rehabilitate.
- Services that enable individuals to have a dignified death”.

2.5 The model of health based on life expectancy, that I tend to use is presented in appendix 2. This in combination with appendix 1 enables a rational approach to tailor public health resources. Specialists in health promotion working with partner organisations, lead on the work to influence life styles. Specialists in public health working across the whole system support the delivery of the right balance of services across the various sectors and the interventions that need to be put in place; some focus on care services whereas others on determinants of health. I have undertaken both types of work and can provide examples.

2.6 There are two important attitudes that public health specialists bring to the table—firstly, the obsession with needing to maximise health gain within the funds allocated by parliament and secondly, the need to have a fair and ethically justifiable process for allocating resources to support the diverse needs of local communities and individuals within those communities.

3. *The new public health system*

3.1 It is difficult to see how the new system will allow for this sort of refined approach to be taken forward in a coherent manner. The proposals as currently set out imply that the NHS is not part of the public health system. The proposals do state that the NHS has important contribution to make. The proposals take away the need for the SoS to be responsible for the provision/commissioning of a comprehensive health and care services to meet the needs of the people of England.

3.2 In my view, the proposals as they stand, will lead to fragmentation of the health system and will introduce organisational boundaries that will inhibit the overall public health effort. At the core of it, the proposals for public health will at both national and local levels increase the politicisation of the public health system which will be to the detriment of health of the communities in England.

3.3 I am conscious of the privilege in working within an organisational framework based on the notion of “paying according to income and taking according to need”. I agree that parliament through the government of the day as well as local politicians should take a keen interest and how oversight of the extent to which the health system works.

3.4 In my view the need to provide oversight and empower the professions, apply equally to both the NHS and to the new public health system. In doing so, it is important that there is very close interaction between the NHS and the public health system.

4. *Local Government (LG) and the DPH*

4.1 I think the notion that local government should play a much greater role in aspects of public health is clearly right. It has always been the case that DsPH have worked closely with LG colleagues to influence the whole range of LG functions. I have personal experience of influencing housing regeneration programmes, the transport directorate and the education system. My annual reports covering the period 1996–2010 provide an indication of the successes and failures in the approach that I have personally taken. It is my view that developing good personal relationships offer the greatest potential for influence. In my experience, being part of the same organisation adds very little.

4.2 As a consequence, I cannot see how the current proposals will make any difference to this at all. Why should a DPH employed solely by the LG have any more of an impact than those employed on a joint basis? Indeed in my view, the big risk is that the DPH will be asked to take responsibility for a number of current LG functions that will result in reducing the capacity of the DPH to influence the not just full range of LG responsibilities but also the commissioning system.

4.3 Within the new system, the issue of leadership for health and in particular for reducing inequalities in health outcomes is not made explicit. Indeed the current draft Bill does not make any comment at all on this matter. In my view, the logic of the current proposals would imply that the Health and Wellbeing Board has that leadership and I would strongly argue that the Chair and the DPH take on that particular leadership role.

In order for the DPH to deliver that role, he or she needs to be part of both, local government and the local NHS and at the same time, in order to be credible; the individual will also need to be independent of both. This of course is not to suggest that normal lines of accountability should be ignored but it does mean that the individual needs to have a contract with both, LG and the NHS as well as a system for professional accountability.

4.4 If you accept my view of the DPH needing to take on the leadership role for health and in particular health inequalities, then he or she will require a full range of specialists to fulfil that role because it will mean developing expertise on the full range of health and care services. I would suggest that for the DPH to have the greatest impact, the staff will also require joint appointments with both the NHS and local government. In this context, by the local NHS I mean the GP consortia and so on.

4.5 In my view, the DPH will need to develop a very close relationship with both, HealthWatch and the health scrutiny committee within any locality. Within the new approach to performance management, these two organisations will be the main bodies to take a view on the performance of the local health and care services. The DPH in his/her role in assessing the extent to which need is being met will also take a view on local performance and it is my view that there is synergy with the work that HealthWatch and the Scrutiny Committees will do. Indeed for me this would translate into the public health department actively supporting HealthWatch and Scrutiny committee by allocating specialist support.

5. PHE

5.1 I think the critical issue here is that to do with the independence of PHE from government interference. My view is that PHE needs to be at arm's length of the DH and more importantly, should not be on the same contracts as civil servants. This is because I am told that civil service terms and conditions of service restrict the ability of people to speak out. Although, this maybe reasonable in relation to civil servants, it is totally unreasonable in the case of the professions involved in the health system. In my view civil service conditions of service should not be applied to PHE which should be seen as a clinical organisation.

5.2 Given these dangers and the fact that the SoS wishes empower those in the front line, I am unclear of the rationale for bringing PHE into the DH or for changing the terms and conditions of service.

6. Information and health intelligence

6.1 This is important to both PHE and the local public health department wherever they are located. Currently, there is a shortage of analysts trained in medical statistics, research methods or epidemiology. It is important that we do not compound the current shortage by assuming that by either centralising PHOs or because LGs have information departments, one does not need the current complement of trained analysts.

6.2 My rather extreme view, is that the planning system could be hugely improved with improvements in productivity, if all NHS staff (and in particular those involved in commissioning and delivery) were trained in some aspects of medical statistics and epidemiology. This is not about the ability to add, subtract, divide and multiply but it is about knowing which order to implement those functions in particular circumstances.

7. PH role of Secretary of State

7.1 It is critically important that any new Bill, states explicitly that within the resources allocated by parliament, the SoS will have responsibility for ensuring the availability of a comprehensive health and care services for the people of England.

7.2 The SoS for Health has a very important leadership role, not a management role. He in collaboration with the Health Select Committee should provide the oversight of the system. The individual should set the policy framework, not in terms of structures or rules of engagement but the principles, the values and the outcomes that are expected. The Secretary of State should act as a "critical friend" to those tasked with developing the structures, processes and rules of engagement. I do not believe that the Secretary of State does any of this—he and his predecessors have seen themselves as having an executive function without any of the expertise or experience that one would expect.

7.3 My experience and reading of the scientific literature about the structural changes implemented by Ss of S over the last two decades suggest that they have had very little positive impact on health status. Contrast this with the policies on client groups or diseases such as the national service frameworks. In the vast majority of cases these have had a direct and positive impact on health status.

7.4 I would therefore suggest that in addition to the leadership, the SoS has two other functions:

- Working with the other parts of government to ensure that the whole of the government machinery considers the impact on health and in particular, the reduction of health inequalities and takes action to improve matters. In this respect, it is a shame that despite acknowledging that deprivation is such an important factor in affecting health, this government has stepped away from making that a protected characteristic within the Equality legislation.

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- Identifying areas where the NHS needs to develop policy and implement actions. In undertaking this role, the SoS needs to work closely with the Health Select Committee and the CMO. The SoS should not be developing policy but expect to act as the critical friend to more expert groups set up by the NHS or PHE.

8. *Commissioning of NHS services*

8.1 Public health specialists have an important contribution to make in the commissioning of health care services. At a technical level, there are two areas where they may take the lead; first, the assessment of needs, demand and supply and second, the identification of cost effective interventions. However, the biggest contribution that public health specialist make is as a consequence of their clinical experience and knowledge, being able from a population perspective, to take a critical view of the scientific literature as well as of the claims made by clinical vested interests.

8.2 My impression is that the majority of the GP Commissioning Consortia see the necessity of having access to support from public health specialists. To make best use of the knowledge and skills that a public health specialist brings, he or she will need to be co-located for at least spend part of their time with the GPCC. Clearly, it can be “bought in”; however, the consequence will be some loss of benefit.

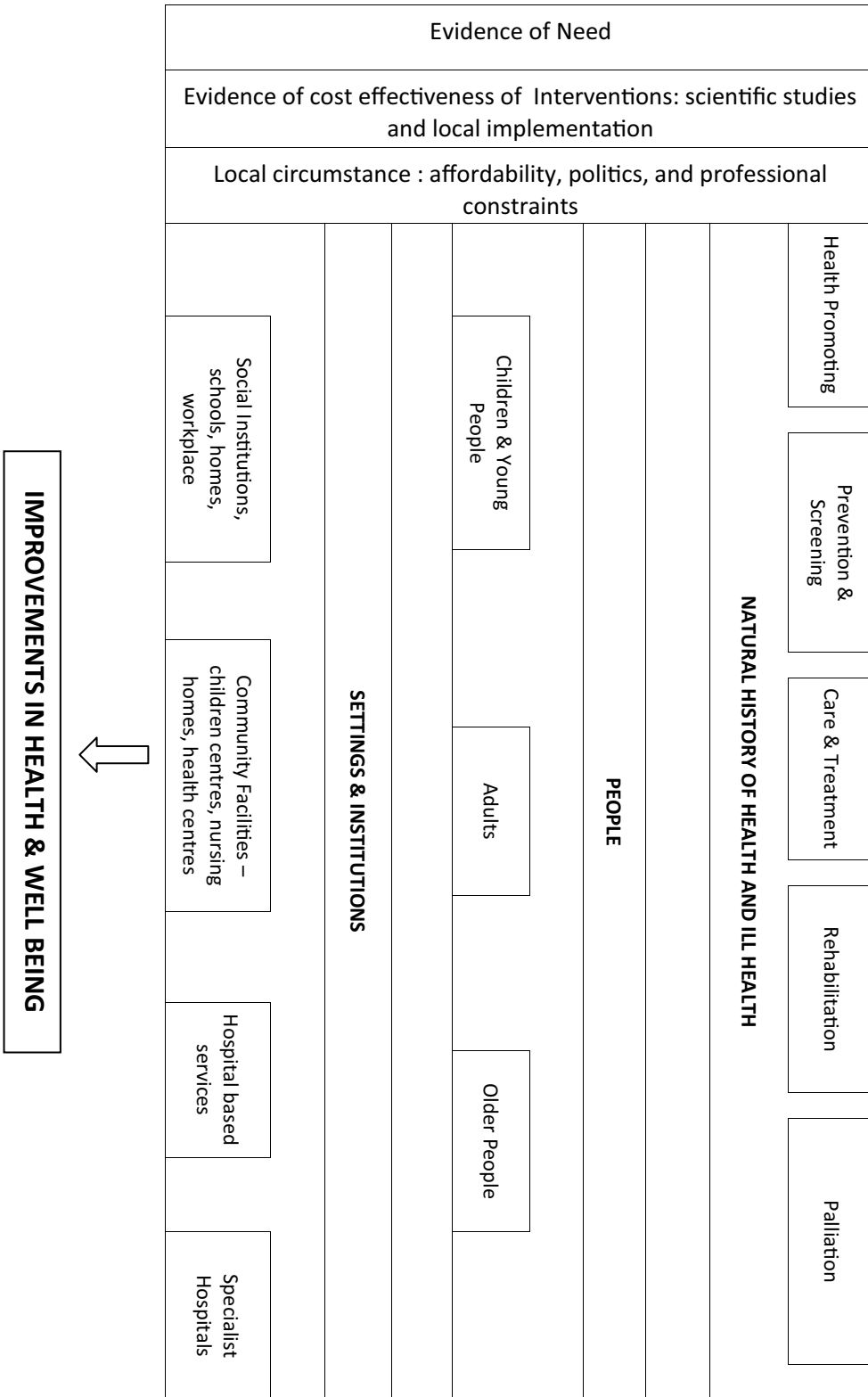
9. CONCLUSIONS

Although, I agree with the analysis presented in the Health White Paper and the public health paper, I do not see the logic of how the proposed changes will impact on the challenges identified by the analysis. In my view, the SoS has ducked the real issues that matter in favour of re-arranging deck chairs..... Assuming that the overall shape of the reforms stay, I think the biggest challenge is to maintain credibility of both, the local DPH and PHE with the wider stakeholder group including the local communities. Credibility of the public health system requires the public health system to be separate from the politicians. Without that separation, it is likely that the new public health system will be seen as an extension of the political system both nationally and locally and therefore will lose credibility.

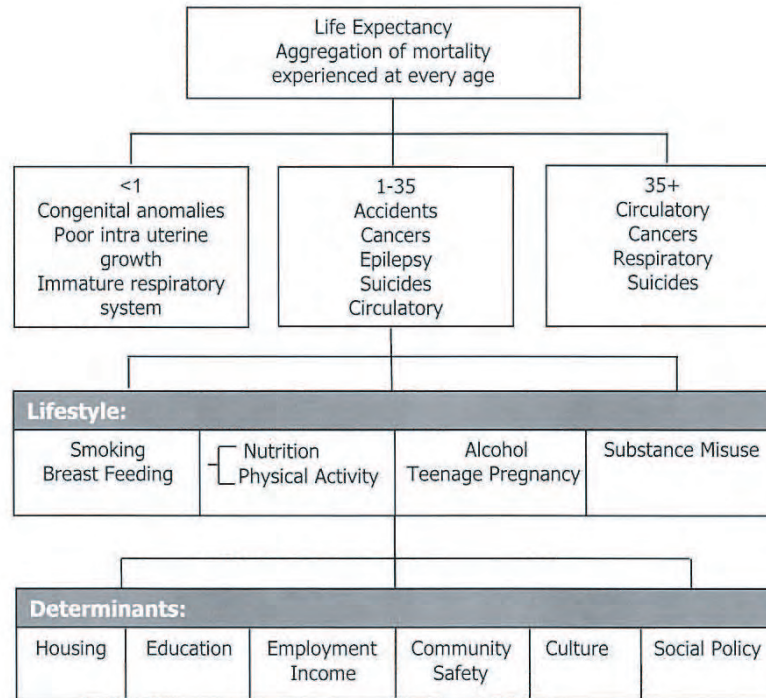
June 2011

Appendix 1

SYSTEMIC HEALTH AND CARE PROGRAMMES



Factors influencing life expectancy



Written evidence from the Royal College of Psychiatrists (PH 50)

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation was prepared by Prof Kam Bhui, Dr Jonathan Campion and Richard Meier of the College Policy Unit.

RESPONSE TO PUBLIC HEALTH: THE CREATION OF PUBLIC HEALTH ENGLAND WITHIN THE DEPARTMENT OF HEALTH

The College has a long-standing commitment to public *mental* health as integral to public health. Last year it collected together evidence to show why mental health must be at the core of the public health agenda, and published this in the form of a position statement (*No Health without Public Mental Health*).⁴¹

The evidence cited in this position statement demonstrated the impact of mental health on a range of public health issues, and is both robust and startling. For example:

- people with mental disorder smoke almost half of all tobacco consumed and account for almost half of all smoking-related deaths;
- depression doubles the risk of developing coronary heart disease;
- half of all mental illnesses begin by the age of 14 and three-quarters by mid-20s;
- people with two or more long-term physical illnesses have a seven-fold greater risk of depression; and
- children from the poorest households have a three-fold greater risk of mental ill health than children from the richest households.

Despite the Government's apparent understanding of the centrality of mental health to public health as a whole (as evinced by documents such as the Mental Health Strategy) the College is very concerned that there appear to be few, or no, commitments or resources within either the Department of Health or Public Health England to take the public mental health agenda forward. This is despite the clear evidence that public mental health interventions could prevent a significant proportion of mental illness and associated consequences, as well as result in considerable economic savings as highlighted in the recent Mental Health Strategy.

The College believes that to realise the Government's public health ambitions there is a need for specialist capacity (ie expertise in public mental health commissioning, policy, management and practice) within Government alongside greater clarity within the new structures (eg Public Health England) about where responsibility for the public mental health agenda lies.

The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)

The College does not believe that the neat division of responsibility for these functions and services between local authorities, Public Health England, consortia and the NHS Commissioning Board is sensible, particularly in relation to public mental health.

Leaving public mental health entirely to Local Authorities will mean that the opportunity for consortia, local authorities and national agencies to work in consort to achieve outcomes will be lost. Furthermore, given the fundamental relationship of mental health and well-being to almost all other aspects of individual and public health, the handing of responsibility for public mental health solely to local authorities will have deleterious consequences for achieving good outcomes in relation to public health more generally. Public mental health is definitely about social conditions but it is not only about social conditions and social care services.

Introducing new bodies to prioritise and commission initiatives to improve public health are welcomed. However, a re-organisation of commissioning processes and structures for care services is also proposed. Public mental health initiatives that focus on social factors alone like housing and leisure might best be commissioned by local authorities, but relocating commissioning of specialist mental health care to local authorities which do not have a track record in this area, nor sufficient interface with other sectors of health, risks fragmenting commissioning and health care for physical and mental health problems. The two should both be commissioned by NHS agencies. The place of forensic psychiatric services, separately commissioned at present, is also not sufficiently integrated.

Arrangements for public health involvement in the commissioning of NHS services

Discussion at national and local levels must take place in order to align outcomes between GP consortia and public health, with the health and wellbeing board serving as a facilitator of such discussion. The College feels it is important to note that—since half of lifetime mental illness arises by the age of 14 (as stated in the Mental

⁴¹ <http://www.rcpsych.ac.uk/policy/policyandparliamentary/parliamentandpublicaffairs/neilspages/publicmentalhealth.aspx>

Health Strategy)—prevention, and early intervention once mental illness has arisen, are crucial, both of which have considerable implications for commissioning.

GP consortia will need to engage with public health priorities; as some of the commissioning that public health will be doing will be buying in through GP consortia an incentive measure can be used to help achieve this. There is a very great spectrum of conditions, contexts, and interventions that will need to be understood, for competent commissioning to happen.

The College also has specific concerns about where forensic care services will sit, given that these represent a key component of mental health provision and that the interface between forensic and generic mental health services (both dealing with safety and risk) already needs to be improved.

Arrangements for commissioning public health services

It is clear that NHS, social care and public health have to align their outcomes and programmed activity to achieve a reduction in health inequalities. Given this overlap, health and wellbeing boards will have a huge responsibility to interact with public health commissioners and GP consortia to ensure that outcomes are achieved through buying in pathways for each disorder across preventive to tertiary care (including social care) rather than focusing on individual components of care.

The structure and purpose of the Public Health Outcomes Framework

The Royal College of Psychiatrists welcomes the Public Health Outcomes Framework and believes that it will work most effectively if it is simple, concise and is truly focused on outcomes rather than processes. However, at a time of such significant financial pressures, the College is concerned that there may not be sufficient resources to fund these good intentions. The College recognises that this represents a major change and upheaval for public health and recommends that a reasonable period of time is allowed to see whether these changes have been effective before any further restructuring is carried out.

A general criticism the College has of the draft framework however is that it makes far too little mention of mental health. This, we believe, is a major oversight given that the mental state, psychological wellbeing and inherited psychological makeup transmitted from parents through experience of parenting are all important in preventing future ill-health. Key public mental health outcomes that the College would like to see include:

- Reductions in the rate of mortality and physical ill-health of people with mental illness.
- More people with mental illness in employment.
- Reduced prevalence of maternal smoking.
- Reduction in smoking rate of people with serious mental illness as well as other mental illness, alcohol problems and drug misuse.
- Improved health-related quality of life for older people.
- Reduction in the suicide rate.
- Increased levels of resilience in children and young people.
- Reduction in alcohol-related problems and other addictions.
- Reduced levels of stigma related to mental illness and discrimination as a factor in the genesis of mental distress.

We therefore feel that the absence of sufficient attention to mental illness and mental health in the outcome framework renders the current public health strategy as a whole less effective, since it fails to address an important determinant of human behaviour and one of the most important that links behavioural change with better health outcomes. We feel that, were these concerns to be adequately addressed, then the framework and overall strategy could be effective.

The future of the public health workforce (including the regulation of public health professionals)

In terms of the role of public mental health professionals, the College asserts the need for mental health specialists to take one of these routes:

- (a) training in public health through an accredited training process equivalent to other public health professions;
- (b) qualifying in public health through passing an RCP and RCPsych jointly-accredited exam; and
- (c) following a pathway which is recognised as a special certification in public mental health but not equivalent to public health qualifications and career paths in general.

Non-psychiatrists in the mental health workforce may also benefit from route *b* (through their own training bodies) or route *c*, although route *a* would be the ideal one to follow.

However, an alternative would be to ensure public health specialists are specialist in public *mental* health rather than relying on mental health professions to take up public health roles.

How the Government is responding to the Marmot Review on health inequalities

Although the Marmot review is referred to, there seems not to be sufficient attention to the social or cultural determinants of ill-health within the Outcomes Framework, for example, work, finance and housing. The draft framework does not pay sufficient attention to well-being and positive aspects of protecting mental health (sometimes referred to as mental capital); these are important for population health.

These all interact and are central to healthy lifestyles and behavioural changes, in prevention and intervention. As yet the document is poor at outlining how these issues will be addressed in the Outcomes Framework.

Public health directors will need to identify and explore factors contributing to health inequality in a local authority catchment area. This intelligence will then inform the prioritisation of local projects, and the outcomes framework will have to take in to account the goals set by such projects. This means that there will have to be a bidirectional movement in terms of outcomes with the local authorities being offered outcomes on health issues on a national basis, whilst local authorities through health and wellbeing boards informing the centre about the locally agreed outcomes.

In spite of the proposal to introduce a health premium, the College remains concerned that those areas which are poorest and with the greatest need will continue to lag and, therefore, that the whole strategy might compound inequalities unless those in the poorest areas or the poorest performing areas are given specific targeted interventions and have adequate resources.

The College feels that a system of measurement needs to be put in place to allow for review of performance against the outcomes put forward in the framework. There will need to be a mechanism for identifying oversights, for example inequalities being compounded. The College would like to see a specific set of outcomes for inequalities by age, gender and ethnicity.

June 2011

Written evidence from Health Professions Council (PH 51)

SUMMARY

1. The Health Professions Council (HPC) is pleased to make this submission to the Health Select Committee Public Health Inquiry. In light of the recommendation of the Scally review⁴² and the Government's subsequent response, we have confined our submission to providing information, which we hope will be of assistance to the Committee, about the current administration's regulatory policy, our work as a multi-professional regulator and the initial stages of exploring voluntary registers.

2. In our submission to the Committee we have addressed issues surrounding the future of the public health workforce, including the regulation of public health professionals. Our submission specifically examines the implications of the White Paper *Healthy Lives, Healthy People* and the Command Paper "Enabling Excellence—Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers" and how it will alter the current system of regulation.

3. The HPC is an independent UK-wide statutory regulator for 15 professions working in the NHS, education, the community and independent practice. We currently register over 210,000 registrants. Our focus is on the protection of the public and we do this by maintaining a register of professionals who meet established standards for training, professional skills, behaviour and health. HPC approves and upholds high standards of education and training whilst investigating complaints and taking appropriate action.

WHITE PAPER *HEALTHY LIVES, HEALTHY PEOPLE*

4. The White Paper *Healthy Lives, Healthy People* outlines the Government's response to the review of the regulation of public health professionals by Dr Gabriel Scally. The Government has made clear in the White Paper that statutory regulation should be a last resort; its preferred approach is to ensure effective and independently-assured voluntary regulation for any unregulated public health specialists.

Command Paper Enabling Excellence—Autonomy and Accountability for Healthcare Workers and Social Care Workers

5. Additionally, in February 2011, the Government published the Command Paper "Enabling Excellence—Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers". This document sets out the current Government's policy on regulation, including its approach to extending regulation to new groups. In particular, it sets out the Government's policy that, in the future, statutory regulation will only be considered in "exceptional circumstances" where there is a "compelling case" and where voluntary registers, such as those maintained by professional bodies and other organisations, are not considered sufficient to manage the risk involved.

⁴² p40 8.1 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122089

VOLUNTARY REGISTERS

6. The Department of Health's Review of Arm's-Length Bodies set out a number of changes for the Council of Healthcare Regulatory Excellence (CHRE) which include extending their remit to "set standards for and quality assure voluntary registers." Since the announcement was first made, we understand a number of groups who hold voluntary registers have contacted CHRE to express their interest in such a scheme including public health professionals.

HPC support the work of CHRE in exploring the various options of quality assured voluntary registers.

7. The HPC currently has no existing powers to set up any voluntary registers. Our work to date has been to consider the implications of the Bill and the Command Paper and in particular to begin to consider how and in what circumstances we might in the future exercise our discretionary powers to establish voluntary registers. We intend to agree the policy and process in this area over the course of this year before beginning to consider which groups might be suitable for voluntary registration. An impact assessment and consultation would then be required before reaching a final decision in respect of a specific group.

8. A voluntary register would mean that it would not be compulsory to become registered (and there would not be any titles or functions protected in law). However, over time, registration might become a requirement of employers and commissioners. Following its meeting on 31 March 2011 the Council has instructed the Executive to further explore the principles for establishing voluntary registers and consider working regulatory models which would govern the HPC's approach in this area. The Council will further discuss arrangements for undertaking this work in due course.

COST-EFFECTIVE REGULATION

9. The Command Paper, sets out plans to move to a more proportionate and effective system that imposes the least possible costs and complexity, while maintaining safety and confidence for patients, service users, carers and the wider public. As a self-funding body, HPC offers cost effective regulation to a wide range of professions.

10. HPC continues to deliver efficient and economic professional regulation. As a multi-professional regulator the HPC benefits from economies of scale, meaning that the costs of regulation are proportionately lower compared to other organisations that only regulate a single profession. Over the last few years the HPC has continued to invest in new systems and processes, for example in online renewal of registration and the disposal by consent of fitness to practise cases, both of which have enabled cost control.

June 2011

Annex

1. The Health Professions Council is an independent, UK-wide health regulator set up by the Health Professions Order (2001). The HPC keeps a register for 15 different health professions and only registers people who meet the standards it sets for their training, professional skills, behaviour and health. The HPC will take action against health professionals who do not meet these standards or who use a protected title illegally.

2. Full details of this hearing will be posted online here: <http://www.hpc-uk.org/complaints/hearings/index.asp?id=2099&month=5&year=2011&EventType=H>

3. Information about the HPC's fitness to practise proceedings can be found on the HPC website here: <http://www.hpc-uk.org/complaints/>

4. HPC currently regulates the following fifteen professions. Each of these professions has one or more "protected titles". Anyone who uses one of these titles must register with the HPC. To see the full list of protected titles please see: <http://www.hpc-uk.org/aboutregistration/protectedtitles/>

Arts therapists
 Biomedical scientists
 Chiropodists / podiatrists
 Clinical scientists
 Dieticians
 Hearing aid dispensers
 Occupational therapists
 Operating department practitioners
 Orthoptists
 Paramedics
 Physiotherapists
 Practitioner psychologists
 Prosthetists / orthotists
 Radiographers
 Speech and language therapists

Written evidence from Intelligence for Healthy Lancashire Group (PH 52)

PUBLIC HEALTH INTELLIGENCE

1.0 INTRODUCTION

The re-organisation of Public Health brings about the issue of public health intelligence within that group. Many experienced and qualified analysts are being lost or having their skills eroded due to them being moved into generalist analyst roles. Through the Intelligence for Healthy Lancashire group the following comments have been gleaned and I submit this on their behalf.

Public health intelligence professionals have been an integral part of public health teams since the first appointed analysts in the late 1980's and early 1990's. Their contribution as trained epidemiologists has played a significant part in the work of public health teams in PCT's up and down the country since that time.

This is a list of threats and challenges which may accrue for Public Health Intelligence (PHI) teams subsequent to the changes to Public Health in the Government White Paper.

Access to recognised and essential data are also potentially under threat.

- There is an expanded customer base for PHI that includes public health, the local authority, GP Consortia and other agencies represented on the HWBB
- If Public Health subsequently leaves the NHS for local authorities there could be a loss of access to NHS data (SUS, monthly and annual births and deaths data etc)—Need regulation change to allow PHI staff to continue to access these datasets.
- Reductions in the availability of core data from national sources may mean that public health intelligence teams will have to produce more information themselves or purchase it from a commercial sources.
- This presents potential problems. The trademark of PHI professionals is our willingness to share expertise/methodologies and assumptions behind data and seek advice from peers in a culture of openness and trust. Reliance on voluntary accreditation and industry-owned standards of good practice poses threat to data quality. Need to Develop Codes of Practice and quality standards for commercial intelligence providers.
- There is a continued need for a national data repository which will allow local benchmarking against national comparators
- Continuity of historic and existing data sets and data flows from which to draw on local level
- The loss of outputs from local PHOs, eg small area data, prevalence modelling, GP practice profiles, standard analytical tools and templates etc will constitute a risk and may place a burden on local PHI teams to replicate these outputs.
- Developing GP consortia have different boundaries to the LA's/PCT's which poses additional questions eg how will we get access to historic trend data for these new areas—(births and deaths)?
- PHI staff currently have access to Quality Outcomes Framework (QOF) data and have used this for analysis for the JSNA and other work. It is unclear how access to primary care data will be managed
- Public Health Intelligence should remain part of multi-disciplinary public health teams to continue to work closely with PH colleagues on health needs analysis, service re-design and health surveillance

2.0 PROFESSIONAL DEVELOPMENT

The skills, knowledge, experience and breadth of work performed by Phi staff must be recognised and planned for/preserved to ensuring that the role of that professional group is not compromised by the NHS restructure.

In his letter of August 2010 the CMO said that "*it is essential that we do not lose Public Health expertise from the system*" There is a real threat that such PHI capacity and expertise may be eroded during the current changes to the NHS and Public Health in particular. Properly trained PHI professionals hold specialist knowledge of statistical and epidemiological methods and sources of information for interpreting and understanding data sets not available elsewhere within the NHS or local authority system

- The Scally report on regulation of Public Health Professionals "the case for statutory regulation of defined specialists is not made—Purpose of regulation is to safeguard and protect the public from harm—such safeguards also pertain to PHI to ensure that intelligence is properly developed and interpreted in a way that allows better commissioning and service re-design.
- Formal recognition through the UKPHR must be maintained to ensure that PHI specialists can gain formal recognition. This will ensure a quality workforce and help to meet the enhanced requirement for adequate and appropriate training and support for PHI and satisfy the need for continuing professional development in this field.

- Developing current trend in replacing PHI posts with generic posts and generic job descriptions. Recommend the use of JDs from the Faculty of Public Health Career Framework to ensure that PHI skills are maintained and developed.

June 2011

Written evidence from Action on Smoking and Health (PH 53)

ABOUT ASH

1. Founded 40 years ago by the Royal College of Physicians, Action on Smoking and Health (ASH) is a health charity, working to eliminate the harm caused by tobacco. ASH is funded by Cancer Research UK and the British Heart Foundation.

EXECUTIVE SUMMARY

2. This response reflects our concerns and priorities with respect to the proposed changes to the organisation of public health services in England, in the light of the impact these will have on tobacco policy.

3. Smoking is by far the largest cause of preventable premature death and disease and the cause of half the difference in life expectancy between richest and poorest in our society, and is therefore the prime public health challenge facing the UK today.

4. Public health has been defined by Sir Donald Acheson as “the science and art of preventing disease, prolonging life and promoting health through organised efforts of society”. The transfer of responsibility from the NHS to local authorities in England presents opportunities to improve the health of the people of England through better integration of society’s efforts. It also carries with it significant risks, particularly in diminishing the science of public health, which must be addressed.

5. Opportunities include integration with children’s services, education and adult social care as well as with services which ensure compliance with public health legislation such as trading standards and environmental health. In so doing, it offers a very strong opportunity to take a “life course” approach to smoking prevention and cessation and to provide greater accountability for public health policy.

6. On the health side, risks include the possible dislocation of preventative medicine from primary and secondary care. Furthermore, some councils may underestimate the effectiveness of many well established measures to reduce smoking prevalence and uptake, which are supported by a strong evidence base, and consequently may fail to provide the appropriate priority and resources to this area of work. At a time of transition there is a particularly acute need to maintain an authoritative, independent and well trained public health profession.

7. Summary of recommendations:

- There should be a statutory responsibility on the face of the Bill for commissioning consortia and local authorities to take such steps as are necessary to improve the health of their populations.
- Public Health England must be at arm’s length from the DH either as a Special Health Authority or alternatively by extending the existing structure and responsibilities of the HPA to encompass those of Public Health England.
- There should be a statutory responsibility on local authorities to employ only suitably registered Directors of Public Health.
- Directors of Public Health must be senior members of the management team reporting to the Chief Executive.
- Any “health premium” incentives to reduce inequalities must focus on measureable behaviours such as smoking which most directly influence health inequalities.
- The Government should give clearer encouragement for bodies to commission jointly on a larger geographic footprint where this provides better value.
- Consortia commissioning plans should require the formal approval of Health and Wellbeing Boards.
- Sufficient funds must be allocated to the ring-fenced public health budget to enable it to deliver public health gains—and provide protection to prevent it being raided to fund other services.
- The Bill must include a statutory duty on public health agencies to make proper arrangements for co-operation with each other, a duty that would apply equally to county and district councils in two-tier local government areas.
- The Government should clarify how it proposes to protect public health policy from the vested interests of the tobacco industry, specifically during the forthcoming consultation on plain packaging for tobacco products.

OUR RESPONSE TO THE NHS AND PUBLIC HEALTH WHITE PAPERS

8. In our response to the consultation on the Liberating the NHS and Healthy Lives, Healthy People, ASH made several detailed recommendations. We welcome developments in Government policy which have gone some way to addressing our concerns. However we continue to have reservations. Specifically:

- Smoking is the primary cause of the gap in life expectancy between rich and poor.⁴³
We are concerned that the proposals in the white paper may not reduce inequalities. We have particular concerns about the “Health Premium”. Health inequalities may be mitigated somewhat by local policy over time but are also influenced by economic and environmental factors and policy initiatives outside the control of local authorities.
- We have two major concerns about the working of the Health Premium, first that any change in local health inequalities will be largely a product of external factors and second that the timescale required for calculating the health premium will be shorter than the time it will realistically take for policies to have an effect. Consequently the Health Premium may further disadvantage some of our poorest communities.
- Current data sources do not afford the statistical power required to assess differences in local smoking prevalence by socio economic group and current proposals to gather these data are inadequate. If aspirations are going to focus on reducing smoking prevalence in areas the size of Local Authorities, the proposed method of collecting the data will not be adequate. To have an 80% chance (the usual criterion for statistical power) to detect a 1% drop in prevalence (which will represent good progress) compared with no change at all will require a sample size of 25,000 per wave. To be able to detect a difference between, for example, 0.2% (poor progress) and 0.8% (acceptable progress) would require substantially more. With a national sample size of perhaps 400,000, for all the surveys that make up the Integrated Household Survey the sample each year for each local area will be completely inadequate. Even data over several years will not be sufficient and in any event will not allow performance to be tracked in a manner that will be useful for policy development.
- **If the Health Premium is to work at all it will have to focus on our most disadvantaged populations and the measureable behaviours such as smoking, which most directly cause health inequalities.**
- We highlighted the need for high quality and accessible local information on public health needs and outcomes, offering the recently published Local Tobacco Profiles as an exemplar. We welcome proposals to produce an update of these profiles but note the continuing uncertainty about the funding for the Public Health Observatories which produced them.⁴⁴
- We welcome the Government’s commitment to protecting health policy from the vested interests of the tobacco industry, in line with its obligations under Article 5.3 of the WHO Framework Convention on Tobacco Control. However, ASH continues to uncover evidence of the tobacco industry subverting these measures through the use of front groups purporting to represent smokers, retailers and the hospitality business. Greater clarity is required, particularly in relation to how government will fulfil its obligations to protect policy on illicit tobacco and the forthcoming consultation on tobacco packaging.
- We have repeatedly expressed concerns about support for local authorities to encourage collaborative working over a larger geographic footprint where evidence supports need and effectiveness. Although the Department of Health (DH) has offered some encouragement for joint commissioning this remains a significant threat to public health and tobacco control in particular.
- We continue to be concerned that Directors of Public Health will have sufficient authority and independence within the new structures to discharge their duties adequately.

PUBLIC HEALTH, TOBACCO CONTROL AND LOCAL GOVERNMENT

9. Smoking is the largest cause of preventable death in England killing over 80,000 people every year.⁴⁵ In England, deaths from smoking are more numerous than the next six most common causes of preventable death combined (ie obesity, drug use, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse).

10. The Coalition Government recognised the importance of tobacco control within its efforts to improve public health when on March 9, 2011 the Coalition Government published its Tobacco Control Plan for England. To be effective, this plan needs to be supported by a clear vision for public health among local authorities. Whilst we wait for the government response to the various “Healthy Lives, Healthy People” consultations we are concerned that some of the proposed revisions to the Health and Social Care Bill arising from the listening exercise risk undermining the strong vision of public health contained in the White Paper.

⁴³ Consultation on the future of tobacco control. Department of Health, 2008

⁴⁴ The Future of Public Health Observatories, Grahame Morris MP <http://www.mutualis.co.uk/societynorth/?p=348>

⁴⁵ Healthy Lives, Healthy People: A tobacco control plan for England. Department of Health, 2011

11. The Health and Social Care Bill 2011 does not include the requirement to provide “stop smoking services” on the face of the bill as it does other core public health activities such as weighing and measuring children. This could lead to post-code lotteries for smokers, who may be unable to access evidence-based help to quit in their own local area. It should be noted that NICE has concluded that stop smoking services are highly cost-effective and that they amongst the most cost-effective healthcare interventions available.⁴⁶ The provision of stop smoking services needs to be a mandated part of public health provision at local level.

12. It is of great concern that responsibility for public health is being transferred to local government not just at a time when public spending is under unprecedented pressure but also at a time when previous structures supporting local delivery such as National Support Teams, Public Health Observatories and regional offices have been terminated or are under threat.

THE CASE FOR “SUPRA LOCAL” PUBLIC HEALTH PROGRAMMES

13. International evidence has concluded that investment at sub-national level on key components of national tobacco control programmes reaps significant benefits that are unlikely to be realised if local delivery evolves in isolation. These components include reducing smoking uptake, improving quit rates and protecting communities from the harm of secondhand smoke. For example, a highly active tobacco strategy in New York City has reduced smoking prevalence from 21% in 2002 to 15.8% in 2009.^{47 48} Similarly evaluations of California’s state-wide tobacco control programme have found that the comprehensive strategy put in place was highly effective, listing mass media among the particularly effective components.⁴⁹

14. Until April 2010 each of the regional Government Offices in England employed a Regional Tobacco Policy Manager supported by a small team. It was the function of these teams to coordinate communications for greater cost effectiveness, support local tobacco control and provide strategic guidance to local smoking cessation services.

15. In the North East, North West and South West of England, the functions were enhanced and further funded through a per capita contribution from PCTs. These three regional teams continue to lead collaborative and comprehensive tobacco control programmes with continued funding from local PCTs. However, the abolition of PCTs and the migration of public health funding and responsibilities to local authorities poses a risk to the future of these collaborative organisations

16. The first of these Regional Offices of Tobacco Control to be established was Fresh Smoke Free North East of England, which started work in 2005. In advance of the introduction of smokefree legislation Fresh coordinated a regional programme, including television advertising, to prepare local businesses for compliance. In the event, the North East saw some of the highest levels of compliance with the legislation requiring fewer enforcement actions and achieving the highest levels of popular support in England.^{50 51 52}

17. Most importantly, since the establishment of Fresh, smoking prevalence in the North East has fallen from the highest in England to England’s average.⁵³

18. Since April 2011 in areas without an Office of Tobacco Control communications on smoking and marketing of cessation services are delivered at PCT level. These tend to be substantially less efficient and effective. People’s work and social lives span wider distances than their own residential area. It makes little sense for a PCT or Local Authority to fund high impact marketing activity that will be seen across a much larger boundary on their own, but by jointly commissioning such marketing achieves great economies of scale while a single contact point allows the public to be directed to the service closest to them. One set of development costs and media buying co-ordinated by one small team communicating with local partners brings much better value to the taxpayer than a dozen sets by a dozen teams. Similarly, regional offices are much better placed to exploit “earned media”, that is to say unpaid editorial coverage from local and regional news outlets. They are very much seen by the media as the first point of contact for press, radio and TV journalists around tobacco issues. The combined purchasing power has permitted broadcast media campaigns helping parents in the North West and North East to reduce the harm of secondhand smoke and dispelling myths about the relative harmlessness of hand rolled tobacco in the South West.

19. A further example of the role of Offices of Tobacco Control is the North of England Tackling Illicit Tobacco for Better Health Programme. In this case the North West, North East and Yorkshire & Humber regions collaborated to coordinate local, regional and national agencies to improve intelligence, enforcement and marketing campaigns encompassing several regions on tobacco smuggling. This initiative would have been unachievable for local councils working alone.

⁴⁶ Cost-effectiveness of interventions for smoking cessation. NICE 2007

<http://www.nice.org.uk/nicemedia/pdf/WorkplaceInterventionsPromoteSmokingCessationEconomicReport1.pdf>

⁴⁷ New York City Smoking Rate Has Declined Almost 20% Since 2002. New York City Department of Health and Hygiene 2007

⁴⁸ New York City Smoking Rates Fall to Lowest Rate on Record. New York City Department of Health and Hygiene 2009

⁴⁹ Hu TW, Sung HY, Keeler TE, Reducing cigarette consumption in California. *AM J Public Health* 1995b; 85(9): 128–22

⁵⁰ Smokefree England—One year on. Department of Health 2008

⁵¹ Smokefree legislation compliance data June Department of Health 2008

⁵² YouGov survey for ASH, 2008

⁵³ General Lifestyle Survey, 2009. Table 1.10 Prevalence of cigarette smoking by sex, country and region of England: 1998 to 2009 ONS. 2011

20. The wider value of such interventions being commissioned and delivered at a higher level is recognised by the Coalition Government. The national tobacco control plan for England makes clear: “*Tobacco control offices in the North West, North East and South West of England have demonstrated the value of such models of working for many years, particularly around marketing communications and tackling illicit tobacco.*”⁵⁴ However, the public health reforms in general and the tobacco control plan in particular provide little encouragement for such cooperation. The likely consequence is a poorer use of health budgets and a greater and preventable burden of disease.

21. The Government should give clearer encouragement for bodies to commission jointly on a larger geographic footprint where this provides better value.

PUBLIC HEALTH ENGLAND

22. The Health Protection Agency (HPA) was established in 2003 by government as an independent organisation to tackle health threats and environmental hazards by providing information and advice to the general public and health professionals. It is proposed to absorb the HPA into Public Health England, which itself will be established within the DH. This is matter of concern, and we recommend that the Government reconsider the proposal, not only for the independence of Public Health England but also for the capacity of the HPA to generate income which, by achieving economies of scale, provides greater value for money to the public.

23. Alternative solutions exist including establishing Public Health England at arm’s length from the DH for example as a Special Health Authority or alternatively by extending the existing structure and responsibilities of the HPA to encompass those of Public Health England.

THE ROLE OF THE DPH AND THE PUBLIC HEALTH WORKFORCE

24. Public health is a distinct and complex discipline with its own career path. Currently, a Director of Public Health (DPH) must be a qualified and registered public health specialist. Increasingly, suitably qualified non-medical DsPH have been appointed and this is to be welcomed. These non-medical DsPH often bring with them long experience in local councils, which will enable them to take full advantage of the transfer of responsibilities to local government. Despite this more inclusive approach adopted in recent years, the public health workforce continues to be under great pressure with insufficient qualified staff, particularly in our major cities.

25. It is all the more important, therefore, that the role of DPH be restricted to suitably qualified professionals, be they medical or non-medical, positioned at the most senior level of the councils, with the professional freedom to challenge publicly gaps in local delivery, and to manage the allocated ring-fenced public health budget to ensure it is used for public health gains. **There should be a statutory responsibility on local authorities to employ only suitably registered Directors of Public Health. Directors of Public Health must be senior members of the management team reporting to the Chief Executive.**

26. Teaching Public Health Networks were established across England to catalyse collaborative working between the public health workforce and further and higher education, to enhance public health knowledge in the wider workforce with a view to enhancing capacity to tackle inequalities and meeting public health targets.⁵⁵ These networks developed innovative public health education and training. Funding for these Networks was withdrawn in 2010. The closure of these networks highlights the longstanding need for developing the public health workforce. This is a need which has been aggravated by the disruption and uncertainty for NHS based public health staff and becomes even more acute for the workforce of the future in the context of the proposed reforms.

LOCAL GOVERNMENT AND THE LOCAL NHS WORKING TOGETHER

27. Although GP Consortia are required to prepare a Joint Health and Wellbeing Strategy with the Local Authority, informed by the Joint Strategic Needs Assessment (JSNA), the GP Consortia Commissioning Plan itself need only have “due regard” to the Joint Health and Wellbeing Strategy. This restricts the opportunity to integrate priorities across public health, healthcare and social care. **GP Consortia Commissioning Plans should require the formal approval of Health and Wellbeing Boards.**

28. The drafting of JSNA should involve all relevant public health practitioners including environmental health officers and trading standards officers, to collect the evidence, assess local needs and attend to implementation.

29. Public health expertise must be embedded in all commissioning bodies, including not only Health and Wellbeing Boards but also GP commissioning consortia and the NHS Commissioning Board, to ensure the effective and efficient commissioning of health services for local communities.

⁵⁴ Healthy lives, healthy people: A tobacco control plan for England. Department of Health 2011

⁵⁵ Orme J, Pilkington P, Gray S, Teaching Public Health Networks in England: An innovative approach to building public health capacity and capability Public Health 2009, 123(12): 800–804

30. We also have concerns about the clarity given to Local Authorities with regards to the funding of certain public health functions. Regulatory services have played an essential role in effective implementation of tobacco policies at local level, for example Environmental Health in smokefree legislation and trading standards in age of sale restrictions and will do so again in implementing the tobacco display ban. These services have been almost entirely funded through council budgets.

31. We welcome the ring-fence as a means of protecting the public health function as it becomes established in local authorities. The ring-fenced public health budget represents a transfer of resources to match the transfer of responsibilities to local government. Some authorities will see the new funding as a means of protecting important existing council services that make a clear contribution to public health. We do not object to the inclusion of these services within the public health budget. However, where functions currently funded by councils are to become funded from the ring-fenced budget, there should be a corresponding adjustment to the size of that budget.

32. Sufficient funds must be allocated to the ring-fenced public health budget to enable it to deliver public health gains—and provide protection to prevent it being raided to fund other services.

33. In some parts of England where there are two tiers of local authorities it is proposed that the public health function sit with the upper tier although the environmental health function sits with the lower tier.

34. The Bill must include a statutory duty on public health agencies to make proper arrangements for co-operation with each other, a duty that would apply equally to county and district councils in two-tier local government areas.

June 2011

Written evidence from Dr Anne Brunton (PH 54)

Area of Expertise: Partnership working between the police and the NHS to lower crime in their communities (eg improving health and safety and well being in communities).

- stop mucking around;
- let local initiatives and partnerships “bed-in”;
- invest in Alcohol misuse initiatives;
- disproportionality in health outcomes will only be solved through cross cutting measures in government—interdepartmental work. Not by mucking about at ground level;
- acknowledge the good work that has been done and ask local actors what would make their jobs easier; and
- most of all—STOP mucking about and renaming things just to make it look like you’re doing stuff.

June 2011

Written evidence from Alyson Learmonth (PH 55)

I am submitting this evidence in a personal capacity.

1. SUMMARY

1.1 This evidence is presented from the perspective of a current jointly appointed Director of Public Health working across Gateshead PCT and Gateshead Council. It takes as a starting point, that the excitement generated by the idea of Public Health leadership transferring to the Local Authority, as an indication that the idea is a good one. Given enough power, Health and Wellbeing Boards could provide an opportunity to relocate leadership in relation to the creation of health where it belongs, in relation to place shaping and the Determinants of Health. My evidence should be given weight because it is rooted in eight years of experience as a Director of Public Health, four of them leading Public Health in a co-terminous Borough and PCT, where the issue has been given a high priority, and the health of the population is disproportionately poor, when compared to the degree of deprivation.

1.2 My commentary below relates to the key headings set out in the terms of reference for the Select Committee, from the perspective stated above. Crucially, the argument presented is that the terms set out so far miss out on one major opportunity arising from the proposed transfer of leadership in relation to Health and Wellbeing. It is that the nature of Public Health “the science and art of preventing disease, promoting health and prolonging life through the organised efforts of society” is essentially political. By recognising this and addressing more clearly the potential for locally elected representatives to lead on public health, aligned with the community and health development function, there is the potential to multiply the potential influence of this transfer both on the health agenda, and on the democratic renewal process. Such an approach would also be consistent with the “community leadership” role of local authorities.

1.3 Secondly, the proposals implicitly recognise, through domain two of the proposed Outcome Framework, the breadth and potential of place shaping to create health enabling environments. This is a key part of the Local Authority role through spatial planning, the regulatory function, etc. However, this should be explicit and clear as part of the role definition which is currently focussed on only one aspect of the agenda: joint commissioning agenda between health and social care.

1.4 Because my evidence is presented from a local perspective, I will start with the functions closest to the ground and work up through the Public Health System. As a system it is the integrity of the whole that is vital, so this is not to imply importance. A second crucial issue which will emerge throughout the commentary is that of resources. At this time of budgetary restraint, can the existing Public Health resource be successfully picked up and rearranged, deliver the savings expected from those parts currently designated as quangos, and continue to stay safe?

1.5 The re-organisation of the small but crucial Public Health resource needs to be supported by sufficient investment. My experience suggests that hosting Public Health within an organisation does in time support further development within that organisation. But can we afford to wait? And what is our change management strategy to safeguard the health of the population in the meantime? Investment in work to improve the health of the population is the only way in the medium to long term, that the we will be able to afford the NHS, as modelled in the Wanless review.

1.6 In classic management models of change there is an “unfreezing stage” where everyone gets ready for change, followed by an adjustment and realignment stage as the system is re-engineered towards the desired end state. Currently, the “unfreezing” is well under way with the desired end state brought into question. It is vital to clarify the direction of travel urgently. Experience shows that massive structural change will slow and possibly halt actual delivery.

2. ARRANGEMENTS AT A LOCAL LEVEL

2.1 *Future role of Local Government in Public Health*

2.1.1 Appointments of DsPH

2.1.1.1 My experience as a Jointly Appointed DPH has been positive. Certainly my current post, which is also jointly funded, has given me significant access to Local Authority strategically and practically. However, the nature of the Joint Appointment proposed with Public Health England (or, worse employment by Public Health England and secondment to the Local Authority) is counter to the Local Authority paradigm of leadership directly from the Elected Members, by superimposing central accountability onto the post. Alternatively accountability to Local Authority Chief Executives will require a powerful set of criteria ensuring the post of DPH is, like the former Chief Medical Officer, at a very senior level and with professional autonomy built into the role. Improving public health outcomes over a period of years, is as important as balancing the books, and this needs to be seen as part of Corporate responsibility at the highest level.

2.1.1.2 Conceptually, this requires a recognition of the vast benefit in terms of democratic renewal, if the role of elected Members is adequately supported and developed, so that it becomes a strength in the cultural changes and place-shaping decisions required to create health. The independent voice of the DPH needs to be recognised as “grist to the mill” in terms of reaching well informed and transparent decisions. Currently, Healthwatch is the only identified part of this agenda (albeit an important one). The larger challenge of engaging and working with and through communities in the way demanded for large scale change is invisible.

2.1.1.3 It is essential that the role of DPH embraces the overall perspective of the **population’s** health in relation to all three domains of public health: health improvement, health protection and health service improvement. Without this breadth of accountability and responsibility, it is possible that GP Commissioners (still at a very early stage in developing a population perspective) may not pick up the benefits in terms of cost-effectiveness and quality measurement resulting from the health service improvement domain. Also, in the health protection sphere, expertise provided through Public Health England will not enable an authoritative response to issues of public safety without local understanding, leadership and authority. The current criteria to enable one person to take on this breadth of role, is Registration with the UKPHR, the GMC or GDC. The removal of this aspect of public protection during a period of radical change is potentially dangerous.

2.1.1.4 The location of my current post in Gateshead reporting to the Group Director of Community Based Services has not restricted my work across the Local Authority, for example around Health Strategy, Health Impact Assessment, Emotional Health and Wellbeing, and Capacity Building to Improve Health. However, in the more tightly managed environment we are moving into, the importance of “position power” (alongside professional expertise and personal influencing), should not be under-estimated. At a national level the Secretary of State responsibility for Public Health through a Cabinet Sub Committee is an excellent step towards working across functions. At a local level it is important to mirror the whole system approach, and not subsume the Director of Public Health within a single function such as adult social care or children’s services. This should be made clear nationally rather than left to local decision-making.

2.1.2 Role of HWB Boards

2.1.2.1 The potential role of Health and Wellbeing Boards is an exciting recognition of the nature of determinants of health, and the power of democratic leadership for health. However, in the current legislation this potential is limited in two ways. The first is lack of authority, or at least clarity about authority and accountability. The HWB provides a strong opportunity in terms of drawing together key players and Members in relation to a strategic approach to the issues around improving health, which should be maintained regardless of the final arrangements for GP Commissioning. The nature of the relationship between GP commissioners/Commissioning Authorities needs to be clarified. For example, what would be the dispute resolution mechanism?

2.1.2.2 The second is lack of clarity about their role. The core role described could simply narrow down to the joint commissioning of NHS and Local Authority services. The proposed domain two of the Outcomes Framework broadens this out with indicators such as children in poverty, overcrowding, first time entrants to the youth justice system, and the proportion of people in long term unemployment. However, the holistic nature of the challenge this sets needs to be recognised in creating an appropriate leadership and membership of the HWB. This outline of the purpose of the HWB needs to include place-shaping roles of the Local Authority, for example through spatial planning and culture.

2.1.3 JSNA

Our experience in Gateshead over the last four years has been that with the skills of a public health analyst as well as access to both local authority information and community networks, it is possible to build up a strong JSNA that includes a wide range of information, and a transparent priority setting process (www.gateshead.gov/jsna). Work is still under way to demonstrate its impact on “Moving Resources Upstream”, which has tracked for three years now the distribution of resources along the care pathway choosing Circulatory Disease, Mental Health and Musculo-skeletal conditions as the first three case studies. The shift has been hard to demonstrate despite a strategic direction that set this out as an explicit goal, with the possible exception of mental health. This is an area where national work through Public Health England would help strengthen the methodology, as well as the use of national levers through the Secretary of State to improve the way in which the allocation of resources is recorded and can be audited. However, the principle of maintaining and strengthening the JSNA is very welcome. Work is underway in Gateshead to develop an overarching “Gateshead Assessment” in order to bring together intelligence from a range of assessment tools, adding value to the JSNA and ultimately helping to inform the commissioning of services.

2.1.4 Joint Health and Wellbeing Strategy

2.1.4.1 Gateshead has developed a prototype Health and Wellbeing Strategy “The Big Shift”. This has been a useful exercise, drawing on the JSNA in relation to needs, recommendations from an OSC review of inequalities, and the Sustainable Community Strategy (Vision 2030), for long term milestones up to 2030. It is currently based on the LA role, but will expand to take on added value from partner agencies where this can be clearly demonstrated, over the next six months. This exercise has been undertaken with the expectation that the HWB would then be able to work with a draft Health Strategy. Stakeholders have already been involved at a variety of stages and support the work to clarify and join up our approaches.

2.1.4.2 Establishing strong links between health development, community engagement and democratic leadership would greatly enhance the overall impact on neighbourhoods and communities in Gateshead. This is an important aspect to re-shaping in the light of the significantly reduced resources allocated to the Local Authority over the next three years.

2.1.4.3 One way in which the strategy in Gateshead is being implemented to ensure that the place-shaping role is fully developed, is through the systematic use of health impact assessment as a tool to ensure that all decisions consider potential effects on health and wellbeing, including distributed impact on different groups within the population. There is a vital link between this work and the sustainability agenda, which is essential in recognising climate change and environmental degradation as one of our key long term public health challenges.

2.1.4.4 Making the most efficient use of resources will require that mechanisms across the 12 LAs in the North East are allowed or encouraged to address common issues and challenges. The London model, for instance, involves a London Health Improvement Board, with a 3% top slice of Local Authority funding to fund public health activity where pan-London work is seen to add value. The London Council Leaders Committee has the power, however, to overturn the proposals.

2.1.5 Arrangements for Public Health involvement in Commissioning NHS Services

This is essential to ensure that commissioning NHS services is based on needs assessment, effectiveness, and quality. The health service improvement domain of public health is virtually invisible in the current description of the Public Health System. Yet, this is the area where public health skills can make the biggest short term impact through correctly targeted services, based on evidence of effectiveness, and using population

based thinking. Local experience has demonstrated the difficulty that even enthusiastic GPs have in moving from a one-to-one case orientated approach to a population approach.

2.1.6 Arrangements for commissioning public health services

2.1.6.1 Scoping work on the commissioning arrangements indicated in the “Healthy Lives Healthy People” consultation on the funding and commissioning routes for public health shows the complexity of the agenda, given the different locations of current commissioning for things like oral health, sexual health, services for children under five etc. One immediate issue arising from current policy implementation is the national commissioning of health visiting services. While the development of the relationship with the national model has been important, if new posts and the retraining programme for current staff is to achieve its potential, then a bridge from national work to local work needs to take place at the first opportunity. However, it illustrates the problems of different timescales for implementation in relation to different parts of the system, and the potential for an inefficient dis-connect of activity with the National Commissioning Board.

2.1.6.2 A second issue, is the division of tiered services for health improvement (sexual health, obesity, weight management, tobacco) where broadly speaking the low key community based tiers will be commissioned through the local authorities, and the more costly treatment services through GPs. It is easy to see that this will exacerbate the difficulties traditionally experienced in securing an adequate balance of investment across the tiers and, from a user perspective, a smooth flow across the tiers. One potential solution could lie in strengthening the authority of the HWB to ensure that pathways are appropriate and use resources effectively at all tiers.

2.1.6.3 A third issue is that investment in health improvement services has been enhanced across the three PCT clusters of NHS SOTW over the last three years. There are currently multiple “stocktaking” exercises going on, with poor definitions leading to fears of “double counting” of scarce resources. There is real concern that instead of consolidating and targeting health improvement services which have been set up for the first time during the last three years and have barely had time to demonstrate their value, we may be faced with major disinvestment to facilitate a nationally established “ring fenced pool”. Where health of the population is as poor as it is here in the North East, this should be recognised in determining ring fenced allocations. There should also be some aspect of the ring fenced budget that allows for current investment to be maintained for a realistic amount of time.

2.1.7 Relationships with GPs

In Gateshead on a personal level, relationships with GP commissioners are excellent. The Pathfinder GP Commissioning Consortium works well into the LA. Currently, a joint exercise using lean methodology to engineer short term progress in relation to the Long Term Conditions agenda is being planned for the autumn. However, the question raised earlier in relation to how would a dispute be resolved remains an important one which would help both parties understand their role boundaries. It may be that when Scrutiny functions were first associated with the HWB (as part of the government’s initial proposals), it was also referring to authority to resolve disputes. This is no longer clear.

2. THE INFRASTRUCTURE

2.2 *The future of Public Health Observatories*

Public health analytical skills are essential and always in short supply. This applies to both the intelligence function underpinning the creation of a JSNA, and the evidence-based function supported by NICE. A significant body of analytical expertise resided in the Public Health Observatories. It would be a serious example of collateral damage if this important resource were to be lost in the transition because of mismatched timescales and contracts. The function needs to be strengthened in PHE, the LA teams and in GP Commissioning Support Units. It is vital to retain the current arrangement in the interim and this needs to be addressed as a matter of urgency.

2.3 *The future of Public Health Outcomes Framework*

2.3.1 The proposed set of indicators is welcome in principle. However there is more work to be done. This is partly technical. While they are called “Outcomes”, in fact they are mixed up with measures of process and outputs. Developing robust indicators that consistently enable people to performance manage using indicators that realistically relate to their actual intervention, is important. At the same time, we need to maintain an evidence-based eye on outcomes, or alternatively a plausible and well evaluated process.

2.3.2 There is also more work to be done to ensure that the indicators are reflective of the important public health issues. For example there is no indicator related to transport, apart from cycling activity. Yet transport is a crucial issue in terms of access to health care, as well as to education, and employment. Active transport strategies are a key element of a systemic approach to tackling obesity.

2.3.3 In Gateshead, we are using Outcomes Based Accountability to enhance the action planning aspect of our Health Strategy; and we are working with NICE to develop a model for evidence-based commissioning. Some of this work could well be done nationally if the right terms of reference for PHE are created.

2.3.4 Domain 2 of the proposed Outcomes Framework is welcome for its breadth, and has been mentioned positively elsewhere in this response, subject to the further development work described above. However, the question arises about how does this fit with the direction of travel for other aspects of the LA role, and the reduction of performance management infrastructure?

2.4 Arrangements for funding public health services including the Health Premium

2.4.1 I have serious concern that a simplistic outcomes based Health Premium will simply exacerbate the North South divide, and damage social cohesion. If the government wish to take Sir Michael Marmot seriously, then it is crucial to recognise that the Health Premium needs to reward long term investment in early years, life long education, a living wage, and a sustainable environment. It is crucial that the work demonstrating that national wellbeing and social cohesiveness depends on not widening the gap is adequately recognised, and incorporated into government policy.

2.4.2 It takes many years to change health status. These timescales make it difficult to “reward” the most high impact medium to long term interventions. It is important that the work of the National Health Inequalities Support Teams is built upon, in relation to the previous PSA target around life expectancy. Health related behaviour and treatment of long term conditions will yield improvements in life expectancy, and may, if targeted, narrow the gap. However “the devil is in the detail” and constructing measures that are sensitive to change in a short timescale, meaningful in terms of responding to interventions, and evidence-based in terms of longer term impact on disability free life years, will present major technical challenges. Smoking prevalence would be a logical choice because it is still the major cause of inequalities in life expectancy. Yet to demonstrate an achievement of say a 1% change in prevalence would require massive data gathering (25,000 sample survey). The issues of practicality around tracking lifestyle need careful consideration.

2.5 Future of the public health workforce including the regulation of public health professionals

2.5.1 The Regulation of Public Health Specialists should be maintained by the UKPHR, and more recent changes to extend its regulatory role to both defined groups of specialists and practitioners should be maintained. Anything else will be a reversal at a time when we need to build capacity. Ultimately, employers will determine the value of the regulatory process.

2.5.2 My experience both in Gateshead and as Head of the School of Public Health (www.sphne.org.uk) is that a key element often overlooked is leadership to improve health and wellbeing, across agencies, and at all levels. It is vital that any new Public Health Workforce Plan addresses this issue. Lesson could be learnt from the Common Purpose programme as a model for aligning the commercial, voluntary and public sectors (www.commonpurpose.org.uk).

2.5.3 A further gap is a lack of attention paid to expanding the academic sector, and addressing issues of quality and effectiveness among health educators.

3. NATIONAL ROLES

3.1 The creation of Public Health England

3.1.1 One major question about the role of PHE is whether it would be better as a Special HA. I do not have a strong view on this structurally. What is crucial is that evidence-based recommendations from Public Health England are made to impact on government policy. This does not necessarily result from being a Special HA, as has been experienced by NICE. I think that the CMO’s links with the SoS are crucial.

3.1.2 I think that access to PHE for timely and locally relevant advice will require a structure below the national level. This should relate to common needs in the population, and existing organisational boundaries.

3.1.3 I am concerned that the resources for PHE will be “top sliced” to leave inadequate local support for DsPH and LAs.

3.1.4 The role of social marketing is not apparently included in the PHE terms of reference but cost efficiencies could be made by conducting some social marketing at a national or sub-national level. Given the links with the “nudge” approach, missing out this element is an oversight. Recent evaluation of community based initiatives in five areas of Gateshead is included in my Director of Public Health’s Annual Report (www.cehi.org.uk) and includes fresh evidence of the impact that well researched national campaigns can have in raising awareness levels.

3.2 Abolition of Health Protection Agency and National Treatment Agency

There are particularly high risks associated with the abolition of the HPA. Change management plans need to recognise the cuts already implemented in this organisation. They also need to recognise that the HPA may look like the nearest infrastructure for the new PHE. However, because its focus has been on only one of the three domains of Public Health activity, it is not fit for purpose without radical re-shaping for its new generic role, incorporating some of the PHO functions alongside social marketing and aspects of the RDPH role.

3.3 Response to the Marmot Review on health inequalities

So far only lip service has been paid to the Marmot Review's six key policy areas. In Gateshead we have used Marmot to inform our work on narrowing the gap in relation to Children's Services, focussing on applying the principle of progressive universalism, prioritising early years and recognising the importance of life long learning. However, changes in the rules for example to do with educational maintenance allowance, and which qualifications are recognised as equivalent to GCSEs at A-C, contradict these efforts. This re-engineering of the very systems that create health for the future undermines attempts to offset inequality and increase social cohesion.

3.4 Public Health Role of the SoS

Enhancing the Public Health role of the Secretary of State is an excellent move, especially if the infrastructure to create a joined up approach across government departments is brought into being in a way that is truly effective. As discussed above, one powerful example of the way this role could be valuable is to assess and prevent the harmful health impacts arising, in this case from the changes to benefits and accreditation related to education and skills development. Educational attainment is known to be one of the best predictors of life expectancy, and to impact on many aspects of health and wellbeing along the way.

June 2011

Written evidence from British Association for Adoption and Fostering (PH 56)

1. SUMMARY

- Submitted by: The Health Group of British Association for Adoption and Fostering (BAAF).
- Focus is on looked after children who enter care with significant burden of health inequality.
- Looked after children have greater health need, and require specialised services.
- Public health should be strengthened and consideration given to addressing the health of looked after children as a public health issue.

2. INTRODUCTION

2.1 This evidence is submitted to express our view on Public Health proposals within the Health and Social Care Bill and wider health reform proposals.

2.2 In 2010 British Association for Adoption and Fostering (BAAF) celebrated 30 years of supporting, advising and campaigning for better outcomes for children in care. (BAAF) is the leading charity and membership organisation for fostering and adoption in the UK. We:

- promote the highest standards of child-centred policies and services;
- speak out on behalf of looked after children;
- influence UK-wide policy and legislation;
- provide much-needed information and advice;
- promote greater public understanding of adoption and fostering; and
- support our members in their work.

2.3 BAAF's main activities are the development, promotion and advocacy of best policy and practice; the provision of advice and information to our members and to the general public; training, consultancy and seminars; child placement services including *Be My Parent* online. We also publish a quarterly professional journal, *Adoption and Fostering*, books and guides for professionals, academics, parents and carers and research studies. The main users of our services are our members comprising local authorities across the UK, voluntary adoption agencies, independent fostering agencies and also individual social care, legal and health professionals, and carers.

2.4 This evidence is being submitted on behalf of the BAAF Health Group, which is also a special interest group of the Royal College of Paediatrics and Child Health (RCPCH). The Health Group was formed to support health professionals working with children in the care system, through training, the provision of practice guidance and lobbying to promote the health of these children. With over 500 members UK-wide, an elected Health Group Advisory Committee with representation from community paediatricians working as medical advisers for looked after children and adoption panels, specialist nurses for looked after children, psychologists and psychiatrists, the Health Group has considerable expertise and a wide sphere of influence.

3. GENERAL PRINCIPLES CONCERNING THE NHS

3.1 While we recognise that this enquiry is focused on public health, we must first state that BAAF believes that whatever changes may be introduced by the Health and Social Care Bill, the fundamental values and principles of the NHS must not be undermined. The NHS must remain:

- a comprehensive service;

- available to all;
- free at the point of use; and
- based on clinical need, not the ability to pay.

4. COMPREHENSIVE HEALTH CARE

4.1 The Bill should make it clear that the Secretary of State has a duty to provide, or secure provision for, a comprehensive health service throughout England, including Public Health.

5. REFORMS MUST DELIVER FOR ALL CHILDREN

5.1 BAAF was a signatory to the Listening Exercise Children’s Sector letter to Secretary of State (attached) submitted by the children’s sector regarding the reforms to the Health and Social Care Bill needed to enhance the effectiveness of the NHS for all children. The joint statement made a number of general recommendations for children’s services. Provision for Public Health must take the unique health and social needs of childhood and adolescence into account; services should not be simply “tacked onto” adult services.

6. LOOKED AFTER CHILDREN HAVE UNIQUE HEALTH NEEDS

6.1 Following on from the general recommendations for children’s services in the joint statement, the remainder of our comments will focus on the particularly vulnerable group of children and young people who are looked after, including those with a care plan for adoption. Additionally, within this group, there are sub- groups with particular needs, such as infants, children of black and mixed ethnicity, disabled children, unaccompanied asylum seeking refugee children, children and young people in residential homes and secure units, and care leavers. At any point in time, there are over 60,000 looked after children in England and many more will enter and leave the care system in a given year.

6.2 In order to understand the potential impact of the Health and Social Care Bill on looked after children, it is essential to appreciate that this group is significantly different from other children in a variety of ways.

7. GREATER HEALTH NEED

7.1 As acknowledged in the 2009 *Statutory Guidance on Promoting the Health and Well-being of Looked after Children*, this group of children has significantly greater prevalence of health problems as well as more complex health needs, particularly mental, emotional and behavioural, arising from the following factors:

- health inequalities on entry to care;
- experience of early trauma and loss;
- physical, emotional and sexual abuse;
- neglect;
- attachment insecurity or disorganisation;
- learning difficulties;
- disability;
- parental misuse of substances;
- experience of domestic violence; and
- multiple moves within the care system.

8. COMPLEXITY OF HEALTH PROVISION

8.1 There are a number of factors which make health provision far more complex for looked after children than their counterparts who live with their birth families:

- Lack of parental advocacy.
- Corporate parenting and integrated services—social care as the corporate parent has responsibility for looked after children, and must work in partnership with health and a variety of other agencies to promote their health and wellbeing. Therefore it is essential that effective structures are in place to facilitate integration of services.
- Different health needs—due to the burden of greater health need described above, looked after children are subject to statutory health assessments and will require a variety of services and interventions to address their unique health needs.
- Need for specialised health services which understand their circumstances and the range and complexity of their needs.
- Need for specialised mental health services which understand their backgrounds and can offer appropriate interventions.

9. COMMISSIONING

9.1 Commissioning of health services for looked after children is a complex area and requires considerable understanding of a vulnerable group of children with above average health burden, and who lack advocacy, thus putting them at risk of occupying an unacceptable low position on the priority list. Specialised expertise is required and we are concerned this will be lacking in GP commissioning consortia.

10. PUBLIC HEALTH

10.1 Public health is a vital, but too often neglected, aspect of the National Health Service. The current constraints on public finances make it more important than ever to limit and reduce the overall demand for NHS services by the public health goals of preventing disease, prolonging life and promoting health. At the same time, the aim of reducing health inequalities becomes ever more pressing as the burden of ill health falls in an increasingly disproportionate way on the poorest, as well as on other disadvantaged social groups.

10.2 We believe it is essential to strengthen the role of public health. At a time of fiscal constraint it would be all too easy to lose sight of the big picture of the population's health when local and specialist services are demanding their share of funding. Public Health is well placed to develop strategies and interventions to address the root causes of health inequalities, and to lessen the impact of the postcode lottery.

10.3 At present there is an opportunity for a shift in thinking, so that the needs of certain disadvantaged sections of the population such as looked after children are seen as a public health issue. For example, the needs of looked after children are complex and straddle the full spectrum of ill-health, including physical and mental illness, and unhealthy lifestyles, such as smoking, other substance misuse and domestic violence. Over the longer term, these may be much more effectively addressed at a population level, so that ultimately significantly reduced numbers of children will enter the care system.

10.4 Increasing the presence and influence of public health within local government may work better as public health doctors need to liaise very closely with health, social care and education departments. Close working relationship within the same organisation, particularly at a strategic level, may help to address the many recognised barriers which currently interfere with effective partnership working.

June 2011

Written evidence from Women's Health and Equality Consortium (PH 57)

1. The Women's Health and Equality Consortium (WHEC) was set up in 2008 as a Strategic Partner to the Department of Health with a view to addressing women's health inequalities across England. WHEC is a partnership of women's organisations, all of whom share the common goals of improved health and equality for girls and women.⁵⁶ WHEC informs policy making by giving women's organisations voice and visibility, and incorporating their views into our work.

2. This submission focuses on the key issues women and girls face to good health and wellbeing. In doing so, it draws on evidence from:

- focus groups we held with over 120 women and girls and with over 80 representatives of the women's sector, about their health and wellbeing; and
- published documents and research reports.

3. SUMMARY

- Women and girls face particular threats to their health, including poverty and low pay, Violence Against Women and Girls (VAWG), discrimination, depression, a lack of confidence in their GP's and not knowing what services and support is available.
- Our research with girls and women showed that these specific barriers they face to accessing health and social care services have a negative impact on their physical, mental and emotional health. Yet the reforms lack a focus on addressing *barriers* to health and social care.
- The NHS reforms and new structures must take account of the health inequalities women and girls face if they are to benefit from the new Public Health System. Gender must be included in any definition of "health inequalities".

The creation of Public Health England within the Department of Health

4. Public Health England should have national oversight, particularly since local authorities face large budget cuts and there is potential for essential services to be lost (for example, Devon council proposed to cut *all* domestic violence services). It is not clear what sanctions will be used for not ring-fencing the public health budget—nor what "public health" is limited to.

⁵⁶ Partners include Platforms 51 (lead partner), FORWARD, Imkaan, Maternity Action, Positively UK, Rape Crisis, and the Women's Resource Centre.

5. Public Health England should work across government to ensure other decisions being made, do not compromise public health efforts (for example, changes to housing benefits,⁵⁷ the cuts to welfare, the loss of jobs, pay freezes and reduced pensions within the NHS, all disproportionately impact women's incomes and therefore health). It will be important that it is able to work effectively within the current context of national and local cuts; both in terms of its own resources within the DH, and in its ability to work more broadly to address some of the major challenges to public health that lie elsewhere. For example, it is not clear where responsibility lies in calculating the health impact of wider government reforms. There is a direct correlation between income transfers through social welfare and improved health outcomes.⁵⁸ Benefits paid to women also substantially improve the health of women and their children.⁵⁹

The public health role of the Secretary of State

6. The Secretary of State should maintain some responsibility over public health to ensure proper accountability and national oversight. There needs to be central leadership to prioritise equality and that the opportunity to utilise the skills and intelligence of the Voluntary and Community Sector is incorporated.

7. Parliament should have a role in scrutinising the work of commissioners and the decisions they make.

The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)

8. Directors of Public Health need to engage with VCS organisations to ensure diverse views and voices are heard. It is important that they have a central role in remaining independent and are responsible for ensuring the best evidence is used—including that of the VCS.

9. Health and Wellbeing Boards should have representation from diverse groups of VCS organisations to fully utilise their knowledge and expertise; and they need to have more powers to hold GP Commissioning Consortia to account. The VCS is not only a service provider, but also has vast and extensive knowledge about the needs of local populations, of what services exist, what works, and where there are gaps.

10. Additionally, the women's sector has a history of directly responding to women's health needs at national and local level, although the services they provide have not been readily linked or identified within JSNA and other local strategies. The sector has an in-depth knowledge of how to deliver services that take a "whole person" or holistic approach, which is able to fully address the multiple causes and consequences of issues women face and the impact on their health.

11. Local authorities will have responsibility for public health, which could allow for a more joined-up approach. However, the cuts to local authorities and social care budgets are likely to result in local authorities restricting services. This will further increase unmet need and gaps that women and girls already face, which will be compounded further by the impact of cuts to women's organisations.

Arrangements for public health involvement in the commissioning of NHS services

12. There was much concern raised in WHEC's consultation events around the shift to using an "any willing provider" tendering process which could mean smaller and less resourced VCS can not compete to bid for contracts. This is of particular concern to small organisations providing specific support to particular people in society eg Black, Asian, Minority Ethnic or Refugee (BAMER) women seeking support for mental health problems. Central and local government play an important role in supporting and promoting the role of the VCS through intelligent commissioning and working in partnership with the sector in identifying need and developing service specifications that promote the role, value and impact of specialist provisions.

13. It is unlikely that preventative care will be invested in within NHS budgets unless there is more central leadership and a duty to do so, since there is more glory in stopping a problem than preventing it, and the impact of prevention is only visible in the long-term. There will need to be more clarity as to how health and wellbeing boards will be able to influence GP Commissioning Consortia, and how consortia will respond to local health and wellbeing strategies. There is also a lack of accountability of consortia in their constitutions around tackling health inequalities.⁶⁰

⁵⁷ Between 2005 and 2008, 53% of housing benefit claimants were women, 22% were couples and 25% were men: Welfare and Wellbeing Group (2010) "Retrospective equality impact assessment for Housing Benefit and Council Tax Benefit".

⁵⁸ Stuckler, D Basu, S and McKee, M (2010) "Budget cries, health and social welfare programmes" in *British Medical Journal* published 24 June 2010.

⁵⁹ Glennerster, H Bradshaw, J Lister, R Lundberg, O (2009) "Reducing the risks to health: the role of social protection". Report of the Social Protection Task Group for the Strategic Review of Health Inequalities in England Post 2010 Published in June 2009; CASE/139 London.

⁶⁰ Department of Health (2011) The functions of GP Commissioning Consortia: a working paper.

14. Our focus groups highlighted mistrust, particularly by younger and marginalised women and girls of their GPs. Additionally the organisations WHEC engaged with have expressed caution about the knowledge GPs and some local authorities with regards to women's health needs, particularly around violence against women and girls (VAWG) and the different forms it takes, for example, the harmful practices women and girls are subject to including FGM. It will be important that GPs receive training about these key public health issues.

15. There are key public health issues that impact women and girls that need much more acknowledgment within the NHS to ensure the appropriate service response. For example:

- Violence Against Women and Girls (VAWG)—More than one in four women (4.8 million) aged between 16 and 59 have been affected by domestic abuse,⁶¹ 23% of women have being sexually assaulted as an adult⁶² and up to 6,500 girls are at risk of female genital mutilation (FGM) in the UK every year.⁶³ Long-term consequences of sexual violence and child sexual abuse include post-traumatic stress disorder, anxiety and panic attacks, depression, social phobia, substance abuse, obesity, eating disorders, self harm and suicide, domestic violence and in some cases, offending behaviour.
- Anxiety and depression—Recorded rates of anxiety and depression are one and a half to two times higher in women than in men⁶⁴ and a staggering 63% of girls and women have experienced some form of low-level mental health problem.⁶⁵ Many of the reasons for this are a direct consequence of gender inequality including experience of violence, economic inequality, debt, pregnancy, gender stereotypes and insufficient support.

Arrangements for commissioning public health services

16. As we have set out in paragraph 12, the “any qualified provider” tendering process risks putting smaller organisations at a disadvantage, who cannot compete with large better resourced organisations (at a lower price and limited capacity to go through lengthy processes). WHEC believe this process will therefore place well established specialist services at risk of closure and in doing so, services that are highly competent in delivering support for women and girls, are marginalised from commissioning processes. For example, there is a great deal of documented evidence and research showing that women trust and use women-only services.⁶⁶ More needs to be done to ensure GPs, for example, are aware of what is available in their areas and the types of interventions that have a positive impact on the health and wellbeing of women and girls.

17. There needs to be more detail as to how the VCS, which already provides effective services that are value for money to groups facing some of the greatest health inequalities, will be supported in the new public health structures. The capacity limitations of VCS organisations and their ways of working must be understood by commissioners and local authorities.

The structure and purpose of the Public Health Outcomes Framework

18. The proposed outcomes framework does not provide detail as to how gender inequality will be measured and monitored, or how the data for the indicators will be broken down by equality characteristic to ensure inequalities can be tackled. The final outcomes framework needs to disaggregate data by equality groups, but also local authorities will need to be encouraged to address the issues that do not make it onto the final framework.

19. There is a serious lack of acknowledgment of the issues women and girls face in the proposed framework, and it is not clear how this will be addressed. Depression, poverty and VAWG should be included as indicators. The main health issues they face across their life course include:

- **Young women's** health issues include higher rates of self-harm (nearly four time more than boys⁶⁷), body image issues (one in five are unhappy with how they look), eating disorders (one in every 20 women will experience some form of eating distress during her lifetime, with the majority of sufferers aged between 14 and 25),⁶⁸ low-level mental health problems and sexual health and healthy relationship issues.

⁶¹ British Crime Survey 2009–10.

⁶² Home Office (2007) Cross government action plan on sexual violence and abuse.

⁶³ FORWARD <http://www.forwarduk.org.uk/key-issues/fgm>

⁶⁴ WHO, 2004, Gender in mental health research, Geneva: World Health Organisation.

⁶⁵ Platform 51 (2011) “Women like me: supporting mental wellbeing in girls and women”.

⁶⁶ A survey by Platform 51 found 82% of women felt it was important to access women-only services.

⁶⁷ Samaritans (2001) Youth and self-harm: perspectives.

⁶⁸ Floy, L (1988) Understanding eating distress. *Mind*.

- There is a lack of investment in ensuring high quality **maternal health** and social care for *all* pregnant women and mothers, despite a pre-election pledge to increase the number of midwives by the Prime Minister. The months surrounding the birth of a baby carry the greatest risk for women of developing mental illness—with 15% experiencing postnatal depression. Perinatal mental ill health is a potentially preventable cause of maternal mortality.⁶⁹ Teenage mothers are three times more likely to suffer from postnatal depression and other mental health problems than older mothers.⁷⁰ Furthermore, more than one in ten women reported significant depressive symptoms *during* pregnancy.⁷¹ The majority do not receive adequate support, and this is even more so for vulnerable women, including mothers living in poverty, BME women, asylum seeker and refugee women and teenage mothers.
- Women in **later life** are often living with the cumulative impact of poverty, having had lower earnings throughout their lives and are more dependent on state pensions than older men. They experience higher rates of long-term illness, but also mental health problems—women aged 50 to 54 have the highest prevalence rates for any neurotic disorder (25%).⁷² Older women are particularly vulnerable to the factors leading to poor mental health including poverty, social isolation, chronic illness, living in care and the loss of loved ones. They are also more likely than men to suffer from physical ill health and longer-term disability, leading to restrictions in mobility and inability to care for themselves.⁷³

Arrangements for funding public health services (including the Health Premium)

20. Funding should be used to address need rather than as a notional reward for progress. Targeting resources to improve health inequalities (by investing where there are high levels of deprivation, households with low incomes and complex needs), would be a better way of supporting good public health outcomes for the nation. The proposal for a health premium could see areas with less complex health issues receive further funding, whilst those with layers of complex public health issues would be penalised. Financial reward being aligned with progress made around the outcomes framework may mean public health issues beyond what is included in the final framework, would risk being ignored.

The future of the public health workforce (including the regulation of public health professionals)

21. Regulation of public health professionals is important for the safeguarding of service-users and to maintain the credibility of the workforce to the public. However, regulation should not result in the exclusion of the VCS as part of the public health workforce because of limited capacity.

22. Training on equality and gender to tackle barriers groups face in receiving care as well as receiving a response that provides appropriate services, is essential.

23. There must be clear processes of accountability within the new public health system and the professionals working within it.

How the Government is responding to the Marmot Review on health inequalities

24. WHEC feels the Government's response has been inadequate. There has not been a rise in the promised number of mid-wives—which is an essential aspect of improving maternity care and the wellbeing of mothers and babies. Additionally, the Government failed to include the Review's essential recommendation to ensure a decent standard of living for all, which is likely to get worse under proposed cuts to public services and job losses. Women also make up larger proportion of those relying on benefits, which are not paid at an adequate level to maintain a healthy standard of living.

25. We are extremely disappointed that pilots on breastfeeding, set out in the strategy, have been cut. As the Marmot Review pointed out, breastfeeding is of central importance for the physical and mental health of women and their children. This decision is of deep concern to the women's sector, and reflects a clear lack of commitment to issues affecting women.

26. There needs to be more integration of disadvantaged groups set out under the Equality Act 2010 (including gender, race and ethnicity, age, disability, religion and/or belief, sexual orientation, gender reassignment, pregnancy and maternity, marriage and civil partnerships) as part of the Government's discussion and action to address "health inequalities".

27. The barriers to accessing health and social care, leading to unequal and unacceptable differences in health outcomes, must be included in any discussion of public health and population wellbeing. Health

⁶⁹ Blue et al (1995) Taken from the WHO Fact sheet:
<http://www.who.int/mediacentre/factsheets/fs248/en/index.html>

⁷⁰ DCSF, "Children and Young People in Mind—the final report of the National CAMHS review" (November 2008).

⁷¹ <http://www.womensmentalhealth.org/posts/depression-during-pregnancy-is-often-not-treated/>

⁷² Office for National Statistics (2000) Psychiatric morbidity among adults living in private households in Great Britain.

⁷³ National Mental Health Development Unit (2010) Equalities in Mental Health
<http://www.nmhd.org.uk/silo/files/nmhd-factfile-5.pdf>

inequalities will narrow where there are appropriate services that respond to need (including women-only services) and where this is fully integrated into the health system.

June 2011

Written evidence from Yorkshire and the Humber Public Health Specialty Registrars (PH 59)

1. SUMMARY

1.1 Public Health Specialty Registrars in Yorkshire and Humber are committed to improving health and reducing health inequalities. We are submitting evidence on the potential impact of proposed national health policy on public health action in the region. This paper is supported by the Yorkshire and Humber Postgraduate School of Public Health.

2. Public Health England

2.1 Consultants in Public Health have responsibility for the health of the local population. As NHS employees they have been able to advocate for their population and develop strategies to address inequalities. As part of the NHS reforms, Directors of Public Health (DsPH) will be joint appointments between local authorities and Public Health England (PHE). Currently DsPH are afforded a degree of independence from central government by being NHS employees. However, placing PHE within the Department of Health will impact on DsPH as they will no longer be independent of central government. Therefore, they will face challenges in opposing central policy decisions that will increase inequalities and are likely to be constrained by the short-term goals of the government of the day rather than the long-term preventative goals to reduce inequalities and illness burden. There is a conflict between working within the aims and objectives of central government, and advocating for the local population as part of the localism agenda.

2.2 Strategic planning requires information to inform decisions, and whilst working within the NHS this information is relatively readily available, but information sharing agreements will need to be drafted and potentially lead to delays or information asymmetry. However, if PHE were to be developed as a Special Health Authority within the NHS, independence will be maintained and the above scenarios could be avoided.

3. The Health Protection Agency and the National Treatment Agency

3.1 What the National Treatment Agency (NTA) and the Health Protection Agency (HPA) share is a clear trusted brand identity that has taken some years to build up. Building brand recognition takes huge resource both financial and in terms of staff efforts. The benefit of a clearly identifiable agency is the increased utility for partnership work; other agencies know who you are, what you do and how you do it. These relationships are essential for partnerships to deliver change for the kind of intractable problems that both these agencies address.

3.2 Confidence from the public is also increased by a strong brand identity and in the case of the HPA, a number of marketable products have been developed by which the agency can generate revenue streams. The work still needs to be done. For these reasons we would recommend retaining the HPA and NTA as individual brands, even if they sit within PHE in the larger structure.

4. Role of the Secretary of State

4.1 There is a lack of congruence between the proposed dispersal of public health capacity and the well-established view of the three domains of public health (health protection, health improvement and health service improvement) working together as a public health system. It is of concern that the secretary of state envisages being personally responsible for the appointment of DsPH, and holding significant powers over them thereafter. There is a real danger is that those experts will no longer have an independent position from which to give their professional advice.

5. Local government in public health

5.1 Many services provided by local authorities impact on health, hence there is huge potential gain from co-operative working between public health and other directorates of a local authority. However there were reasons why public health initially moved from local authorities.

5.2 DPH roles are likely to be increasingly fragmented, and inconsistent between geographical areas—differing job descriptions, varied membership/structure of Health and Wellbeing Boards (HWBs), differing assignment of statutory and non-statutory roles and a lack of coterminous boundaries with GP commissioning groups will all make roles incomparable, making sharing of learning and best practice even more difficult.

5.3 DsPH risk political interference in the appointment process or in the production or dissemination of their reports. Actions requiring a public health response are often politically contentious, yet in the best interests of a society. Elected members wishing to silence their DPH (whose reports may be politically damaging) will have much greater ability to do so under the new arrangements. There is a high level of trust in the NHS which facilitates communication with the public. This may be compromised coming from local authorities who may have to implement spending cuts (eg closing swimming pools whilst promoting physical activity).

5.4 There is significant risk that we lose the focus on public health. Under current arrangements many DsPH are jointly appointed and have a role on councils executive boards, meaning public health messages get heard at the highest level available. Under current plans, many local authorities will not create a directorate of public health, but will instead place public health within existing directorates, effectively muting this voice.

5.5 Staffing public health directorates will present challenges, already implemented rounds of redundancies and potential loss of conditions as staff transfer from NHS to LA contracts mean existing posts will be vacated with little chance of recruiting equivalently able people. This is occurring currently, leading to the loss of experienced staff and organisational memory. Loss of experienced analytical staff and reduced data collection will devalue of reports like the Joint Strategic Needs Assessment (JSNA), which rely on up to date, comparable data.

5.6 Local Authorities may be required to undertake NHS functions for people in their population who are not registered with a General Practitioner. This is a major risk as it could create a two tier system whereby those who are not registered with a GP (out of choice or because they are refused by their GP Consortium) will be the responsibility of the local authority and therefore receive a different level of service. It is essential that GP commissioning consortia retain the responsibility for all people within a defined geographical boundary.

6. Commissioning NHS services

6.1 At present public health teams are central to the commissioning of NHS services. The new arrangements will make it considerably harder for public health to engage with commissioners of many services and conversely will make it harder for commissioners to engage public health support for their decision-making. The current proposals for GP consortia commissioning do not include public health input other than the implicit belief that consortia will work hand in hand with local authorities—a rose-tinted view of collaborative commissioning.

6.2 We propose all organisations with a commissioning function should take advice from specialist public health advice with the board of each organisation including a specialist public health representative, in line with the Faculty of Public Health's (FPH) view. The General Practitioners Committee has recognised "public health doctors...may be appropriate leaders in certain roles" within consortia. GPs as commissioners and the staff they employ will not have the skill set to focus on all three domains of public health or to undertake the systematic reviews of evidence and cost-effectiveness that inform quality commissioning decisions at a local level.

6.3 One of the criticisms of PCT commissioning was that it was not always evidence based but rather evidence was found to support decisions once they were taken. Public health expertise offers rigour. The JSNA identifies local health needs and public health specialists can inform cost-effective decisions to support the implementation of clear commissioning and decommissioning intentions.

7. Commissioning public health

7.1 Splitting public health commissioning between different structures in the proposed new architecture results in a danger of commissioning that's not joined up. Greater accountability between GP commissioning consortia (GPCC), NHS Commissioning Board (NHSCB) and HWBs locally will help to strengthen commissioning arrangements at a more localised level.

7.2 Commissioning of services by GPCC needs to take into account a population-wide and prevention perspective, and not just respond to the needs and wants of those individuals who already access services. Otherwise there's the danger of developing services in response to those who make themselves heard, rather than in response to the systematic identification of population need. There is also a risk that GPCCs have too much of a secondary care focus (as that is their key commissioning role) and not enough focus on primary prevention. Incentives for primary prevention need to be strengthened.

7.3 Engagement of the NHS Commissioning Board NHSCB within this process is weak. Therefore there is a risk that the HWB boards yield little influence over broader commissioning activities. The position of the HWB board needs to be strengthened to ensure that the priorities highlighted in the JSNA are translated into actions by the appropriate commissioners—a firm duty to act on the JSNA must be applied to the NHSCB, as well as local authorities and GPCC.

7.4 GPCC will need the expertise of other professional groups in order to commission services fairly, according to identified need, and from a multi-disciplinary perspective. In order for them to be able to commission most effectively, the consortia would need to include community and hospital clinical colleagues and public health colleagues.

7.5 We agree that overall it is beneficial to have the commissioning of some services take place by one organisation for the country, (eg screening programmes and specialised services). But, there needs to be strong reach-down from the NHSCB into local areas to ensure that on-going commissioning maintains its safety and effectiveness by being informed by local delivery.

7.7 It is not clear who will be responsible for the Child Health Information System.

7.8 Currently in the region we are experiencing difficulties trying to commission care for marginalised groups, for example offender health. It is unclear how to establish new care pathways when everything is in transition and it is unclear where responsibility will ultimately lie. We are concerned that “Cinderella areas” will really suffer when PCTs are in fire-fighting mode and unable to take risks on commissioning innovative work. We are also concerned about the loss of “partnership memory” and good work that has been evolving at a multi-agency level is in danger of disappearing.

8. Public Health Observatories

8.1 High quality health intelligence to support commissioning in Yorkshire and the Humber is provided by the Yorkshire and Humber Public Health Observatory (PHO) and both the Northern and Yorkshire Cancer Registry and Information Service and the Trent Cancer Registry. It will be essential to retain the local links to this specialist resource in the proposed new structures to support the National Commissioning Board, GP Commissioners and Local Authorities to deliver high quality health care and public health commissioning. Both PHOs and Cancer Registries run information request services for local NHS partners. It is important that such services continue to be available to commissioners locally and that the local knowledge involved in dealing with such requests is not underestimated.

8.2 PHOs and Cancer Registries have a dedicated pool of analytical staff whose training has been publicly funded by the NHS. Typical training for band five analytical staff will take two years and include a part or fully funded Masters in Public Health with a focus on epidemiology and statistics. Higher grade staff will have developed further specialism through their continued professional development. It is essential that this resource is retained within future commissioning structures. We would recommend that PHE would be an appropriate home for this specialist resource to ensure it can be accessed by commissioners to ensure high quality information is available for decision making. It is crucial the outputs, skills, and expertise listed above are not lost during transition.

8.3 The retention of the specialist skills and local knowledge of the PHOs and Cancer Registries to support NHS commissioning will be especially important if the proposals to move Public Health specialist staff to Local Authorities are implemented. It is Public Health directorates who lead on local needs assessment, data analysis and evidence appraisal within PCTs, and there is a real danger that the loss of these skills from NHS commissioning will be detrimental to population health.

9. Public Health Outcomes Framework

9.1 There is overlap among the five domains identified. The three domains of public health identified by the FPH might provide a clearer structure for the framework. Too much overlap and lack of clarity between the domains may lead to unnecessary data collection and confusion about who is accountable to which domain.

9.2 There appears to be a contradiction between the purposes of the outcomes as a way to set out the government’s goals, whilst also stating that they do not want them to become a performance management tool. Currently the outcomes and indicators within the framework are not worded as SMART goals or objectives, and to do so would presumably be seen as performance management. However, without these it is hard to see who will hold local authorities accountable for these goals.

9.3 It is often unclear who is accountable for the outcomes and what happens if progress is not achieved in these areas. Frequently local communities are identified as being able to hold local authorities accountable; however there is much evidence that those in deprived areas are much less likely to be actively engaged in these processes. Thus if accountability is left to local communities alone those in poorer areas are least likely to drive up progress in these indicator areas, further deepening health inequalities.

9.4 Data gathered through the public health outcomes must be a driving force for commissioning within the NHS as well as within local authorities. This point does not come out clearly within the purpose specified for the outcomes.

10. Funding public health services

10.1 We support the King’s Fund recommendation that the DH estimates the scale of the public health budget on a proper assessment of need and not solely on estimates of current spending.

10.2 There is a risk that wider changes to the economy, employment, education, and welfare will have a large impact on public health outcomes.

10.3 The consultation on Funding and Commissioning Routes for Public Health stressed the key principles of localism, devolved responsibilities, freedoms, funding. However large parts of the Public Health Budget are being allocated without any input from local areas eg the public health aspects of the Quality Outcomes Framework, all of screening, parts of the immunisation programme. It is understandable that some of these aspects are handled centrally, however there must be the structures to allow local areas to feed contextual intelligence into this central commissioning.

11. *Public health workforce*

11.1 The multi-disciplinary nature of the Public Health workforce is important for the delivery of the breadth of public health practice and should be maintained. In maintaining this workforce diversity is a need to ensure that public health specialists attain a core skill set to provide assurance and appropriate safeguards to the public.

11.2 We would strongly recommend the statutory registration of all public health specialists. Equity between the different routes to specialist registration and the registration requirements for practitioners from all backgrounds is needed. We would recommend that registration for Public Health specialists should require passing the FPH's professional exams and meeting the competencies set out in the FPH curriculum.

11.3 To deliver public health outcomes for their populations, public health specialists will need to be able to maintain a level of independence, providing robust and unbiased evidence and delivering the necessary actions to improve health and reduce health inequalities. There is a potential that the proposed move of the public health workforce to local authorities could affect the independence of public health advice and action, subjecting it to the influence of local politics. Mechanisms to ensure the independent voice of public health must be put in place to retain the ability to present public health evidence in an impartial way to the public and local decision makers. Employment of public health specialists as well as the DPH by PHE could provide an effective mechanism to achieve this, with local teams supporting their local authority to achieve the public health outcomes for which they will be responsible.

12. *Response to Marmot*

12.1 The Marmot Review recommends that to tackle health inequalities action is needed across all the social determinants of health. The current Bill lacks a clear framework for the role and responsibilities of public health in the local authority to allow the actions recommended by the review to be enacted at a local level.

12.2 With the removal of the duty to provide comprehensive care under the proposed legislation, the more profitable health care activities will be pursued by independent sector treatment organisations instead of health promotion activities aimed at reducing inequalities.

12.3 Furthermore individuals will be free to choose their general practitioner without geographical restriction; this implies that general practitioners and hence consortia will also be able to choose which patients are registered with them. This entails a risk that consortia as independent financial bodies will select the healthiest individuals in a population at the expense of the individuals with the greatest health needs to reduce their financial risk, therefore widening existing health inequalities further.

12.4 There is significant risk that the proposed health premium will skew efforts to reduce health inequalities and will have the opposite effect to that intended (assuming the intention is improving the health of the least healthy fastest). Health inequalities within an area are relative—the most deprived areas will have the greatest gap. It is easier to reduce an already small gap by a significant percentage, meaning more affluent areas will appear successful on this measure and attract increased funding over deprived ones. Health inequalities are primarily the result of national economic and educational strategies which are not within the power of local authorities to alter. Shifting public health funding from poor to rich areas can only make this worse. We recommend the health premium should be piloted before general implementation, and should relate to changes in the Slope Index of Inequality for an area.

June 2011

Written evidence from the Socialist Health Association (PH 60)

1. The Socialist Health Association is a membership organisation, established in 1930, which promotes health and well-being and the eradication of inequalities through the application of socialist principles to society and government. We have an extensive and varied membership which provides a wealth of information, knowledge and experience of the care system, both academic and practical.

2. We defend Nye Bevan's original concept of the NHS—a set of socially owned and locally socially accountable organisations. Through these society promotes the health of the people by addressing the determinants of health and by providing health care according to need rather than ability to pay. That concept has been eroded in the numerous reorganisations of the NHS so that some believe that it has been reduced to just the last eleven words.

3. The concept that the NHS addresses the determinants of health was weakened in 1974 when NHS community services separated from local government. Today we find it hard to remember that it was public initiatives that cleared the slums and cleaned the air. Bevan's comment that the NHS would improve the health of the people is often taken as a naive faith in the power of health care. In fact local authority health departments were part of Bevan's original vision, including an occupational health service which never came to pass. That still should remain the objective. Although the model of the NHS adopted in 1974 has now existed for longer than the one adopted in 1948 it is still important to realise what the term "NHS" meant to the founders of the organisation and how, despite its failure to achieve everything that was desired it still achieves the ambition which Bevan described as being "freedom from fear".

4. The concept that the NHS was locally socially accountable underpinned the role of local authorities, and the composition of hospital management committees and executive councils but was eroded by a succession of managerial reforms in the 1980s and early 1990s. This was done to the point that we now speak of the democratic deficit as if it has always been there. Today the concept that socially owned organisations provide health care is under threat. The fear that arises from current proposals is that the NHS may be destined to be no more than a brand name.

5. Our evidence to this inquiry focuses on re-establishing the idea that the NHS exists to address the determinants of health. As a first point we ask the committee not to remove public health from the concept of the NHS but, if it is to transfer to local authorities, to re-establish the 1948–74 status of local authorities as primarily public health bodies, including the concept that they are part of a locally accountable NHS.

The nature and status of Public Health England

6. It is inappropriate for a civil service body to be responsible for the direct provision of important health services. It should be an NHS body with the right to employ medical consultants and with no restraints on the freedom of staff to speak and publish. It must be seen to be independent.

7. If we want a single public health structure at national level there is no reason why a part of the Department of Health (DH) should not operate as a single functional entity with an NHS body chaired by the Secretary of State. Indeed ideally the structure would also contain an Office of Public Health Responsibility or Public Health Commission accountable directly to Parliament. This trio of organisations could operate as a single entity and there is no reason to duplicate administrative or support services. It is more a question of finding the right constitutional status for each function. An organisation of this kind would be more integrated than the current structure of the DH which separates Public Health England, the Policy section of DH and the office of the Chief Medical Officer.

The role of the Secretary of State

8. The prime role of the Secretary of State for Health should be to promote the health of the people, representing this social objective in all Government decision-making. The present Secretary of State appears to support this idea.

9. What should the Secretary of State be doing? Britain faces an alcohol epidemic which has already produced a situation which in many parts of the country means that the generations born since 1970 enjoy worse health to date than did those born in the 1940s, 1950s and 1960s. The Secretary of State should be promoting active travel and policies for healthy active ageing—the most effective way to reduce the burden of health and social care costs of a demographically ageing population. He should be concerned with the pricing of energy for heating, ensuring public health concerns are taken into account on planning applications, enabling walkers and cyclists to be a greater priority on the highway and that streets are used for community interaction, as well as ensuring a realistic minimum price for alcohol to stop people getting drunk cheaply at home and to protect the pub as a community resource. These political determinants of health have more influence on health than anything that can be resolved at local level so it is important to get the structures right. A government committed to a Big Society would boost the role of social networks, oppose the cuts in funding for civil society and articulate a vision of community development to address the health care difficulties about which the Secretary of State frequently reminds us. What will not work is appeals to individual responsibility which ignore the context of commercial irresponsibility which explains so much of the culture of health harm.

10. The promotion of health is linked to improving economic productivity and there is ample evidence to show that healthy working conditions attract new knowledge-based industries, promote economic activity generally and reduce the health damage from economic dislocation. Disparities between indicators of economic progress and indicators of well being were a sign of the emerging speculative bubble (WATKINS, S (2010) “Income and Health—from a Minimum Wage to a Citizen Income?” Int J Management Concepts and Philosophy vol 4 no 2 pp137–144). The work of Martin McKee suggests that a strengthened civil society was the best protector against the alcohol epidemics in Eastern Europe and the work of Wilkinson and Pickett suggest that inequality is itself a prominent cause of ill health.

11. The principle should be articulated that the health of the workforce and the health of householders are paramount. The problem of the current system is bureaucratisation and low morale.

12. Instead of addressing these issues the current Secretary of State spends his energy in reorganising, yet again, the National Health Service—based upon speculative and wishful thinking about the results. He has ignored every single piece of advice, except that offered by organisations and individuals who seek to enhance their self interest.

13. We welcome the Government’s recognition that social responsibility of business is important to health but responsibility deals are unlikely to work unless they are negotiated against the background of an underlying willingness to regulate. These measures should be independently evaluated and evidence-based. At present they lack both. The risk is that they are simply efforts to divert attention away from the problem; in effect a delaying tactic.

14. It was a Conservative, Benjamin Disraeli, following Cicero, who said “the health of the people is the first concern of Government”. We approve of this type of Conservative thinking. That is to say conserving health. This is a tradition of obligation found among socially-responsible Conservatives which appears to have been sidelined. What we have instead is economic liberalism whereby human values are reduced to economic valuations alone. The agenda we describe has still not become the main way of thinking about health of any part of the political spectrum.

The director of public health as a health professional treating a population

15. The Bill defines a DPH as a local government officer overseeing the public health functions transferred from PCTs. The DPH should also be a health professional treating a population, a local representative of Public Health England and an independent advocate for health operating across all agencies and also within the business and voluntary sectors. It is important that public health specialists continue to be seen by the public as health professionals offering them honest and trusted advice and that they continue to have a right of challenge on a multi-agency basis. For this reason they have always had guarantees of professional independence—the Medical Officer of Health was protected from dismissal for exercising their professional independence and in the NHS they have worked under the consultant contract in an atmosphere where there are acknowledged traditions balancing managerial authority and professionalism.

16. Whilst the best local authorities recognise this, there is a danger that if it is left to local discretion public health will be muzzled in the areas where effective public health challenge is most needed. In the nineteenth century many local authorities tried to avoid their responsibilities because they were in thrall to ratepayer interests.

17. DPHs need to be effectively trained and professionally qualified in order to confront the complex factors which determine health. It is essential DPHs are experienced in the field, drawing upon cross disciplinary and multidisciplinary skills. To that end there needs to be statutory provision on appointments and statutory registration for public health specialists.

Health and well being boards

18. We welcome the Secretary of State’s suggestion that Health and Well Being Boards become the democratic voice in the NHS and regret that he proposes few powers for them and does not envisage transferring to them any part of the NHS managerial resource. They should have powers over providers as well as commissioners.

The role of second tier authorities

19. District councils are close to local communities and have important roles in public health including housing and environmental health. They should not be excluded from the Bill as they currently are.

20. Public health departments in county councils will need to work with district councils and to do this properly they will need to provide each district council with a named public health lead. This will command more ownership if it is a joint appointment. People will need to go out from the county to districts and local communities anyway. The question is about how the workforce should be organised not how big it should be.

21. There is a view that the designated specialists to district councils should be called “Director of Public Health” to enhance their standing in the district council, the fact that they serve the population of the district, and to emphasise that in that role they will have direct accountabilities to the district population rather than merely representing the county. On the other hand there are those who think that this would be confusing and would lead to expectations that full scale departments would be established. These questions should be openly addressed.

22. Whatever the role is called it is likely, in all except the largest districts, to be a part time role. Usually it will be combined with a consultant role at county level and this offers professional development opportunities for those aspiring to a full DPH appointment in future as they experience the functioning of a large department but also experience the development of personal relationships and authority in a small local authority. Other possibilities are to appoint somebody who wants to work part time, or to appoint a dually accredited GP/public health physician to work part time in general practice and part time as a consultant in public health.

Health care—public health

23. The subspecialty of health care public health is concerned with optimising the contribution the health care system makes to the health of the people. It is a vital component of NHS commissioning and has received inadequate attention in this process.

24. It is important that it should remain integrated with the rest of public health and that it should also be fully integral to commissioning bodies. This is only possible if public health professionals continue to serve populations rather than agencies.

25. It has a role with providers as well as commissioners.

Workforce development

26. There are significant workplace development needs in public health, partly arising out of the transition to new employers and partly out of shortages resulting from the lower priority past Governments gave to public health.

27. There is no suggestion that Public Health England will be well-equipped for workforce development roles and Government has not fully engaged with this problem. It seems to see it as a problem to be solved locally but the shortage of specialists will make that difficult to achieve. The risk is that specialists will work in professional isolation and with variable support.

28. Even if it were believed that the arms length approach to the development of the system may in principle work well in the longer term it would still have seriously disruptive transitional consequences. These could create an irrecoverable situation. In some areas it may be impossible to recruit the needed specialist skills.

29. Information analysis is another important area of shortfall and the Government is not taking the steps necessary to preserve the skills in the Public Health Observatories, whose existence is being prolonged only by a short term extension with no clear strategy for the longer term. This is a critical matter. There are questions of independence of viewpoint, academic linkages and mix of skills which need to be considered.

30. Public Health England should take on a workforce development role. This should include reserve powers to ration scarce resources and to apply training levies.

31. The medical profession is not the only participant in the public health endeavour. Public health is open to non-medical entrants and we welcome the BMA's acceptance that these are professional colleagues deserving the same standing as medical consultants. There is however a danger that this will simply move the divide from a medical/non-medical divide to a specialist/non-specialist divide in which important groups of public health professionals will be on the wrong side. What is needed is a more flexible career process but this cannot become so flexible that the significance of a qualified public health specialist is lost.

The role of community organisers in public health

32. We support the BMA in calling for community organisers to be employed in the public health field. There needs to be detailed discussion of this proposal and especially of its relationship to local government and to the Localism Bill but detailed questions should be resolved so as to make arrangements for this through general practices, NHS bodies, local authorities, parish councils or voluntary organisations according to local interest and commitment of the various potential sectors..

33. Funding mechanisms need to be discussed and identified but we are aware of BMA calculations which place it at £150 million to £200 million less than 0.2% of the NHS budget

Funding

34. It is important that the division of the NHS budget into prevention and treatment occurs but that this

- does not institutionalise past underspending on prevention;
- does not precipitate a process of asset-stripping of PCTs;
- takes proper account of all NHS contributions to public health and doesn't leave local authorities open to demands for buildings or IT that were not included in the budget or to pay NHS providers for preventive work that was previously accepted as just good professional practice;
- accounts for the forthcoming expansion of health visiting and family nurse partnership as a charge on the entire NHS budget rather than being a charge on a static public health budget;
- similarly accounts for any developments of new national institutions or improved health protection arrangements instead of top slicing them from local budgets;
- provides a mechanism for using savings on treatment costs (for alcohol related diseases for example) to fund preventive programmes; and
- recognises that small sums for the NHS as a whole can be huge sums for public health—1% of the NHS budget is 25% of the public health budget—so minor errors in the division can have major impacts on public health.

35. It is also important to be aware that the NHS contribution is only part of the funding of public health.

Public health in England was once thought to be world-class. That was always an optimistic claim but it remains an important ambition. Public health services locally need to be strengthened but there also needs to be a strong iterative relationship between central government and local government. Furthermore action should be taken across the departments of central government in order to secure public health gain as an overriding aim of economic, transport, social security, farming, and other policies. There is a major opportunity to institute sustainable development through public health in ways which reduce transport emissions, boost physical activity, reduce self-destructive patterns of behaviour, and promote sense of local belonging and trust, upon which a collective vision of a healthy society can be based. Essential parts of this vision were shared by

Disraeli and Bevan. It is definitely not shared by those who think only in terms of business opportunities and not collective health goals.

June 2011

Written evidence from the Stockport Shadow Health and Well Being Board (PH 61)

SUMMARY

1. This submission provides a broad focus on behalf of Stockport, taking into account contributions from and discussions with a range of interested parties including the Health Scrutiny Committee. Public health professionals working in NHS Stockport are submitting separately a more specialised response.

2. One of the major purposes of the HWB is to protect and promote the health of the population in Stockport, which is heavily polarised in terms of inequalities. We believe that a core function for the Local Authority is to support health improvement interventions in our communities. Commissioning services require considerable attention to be given to population health. We welcome the leadership role for the LA in public health and future local authority arrangements require the systematic integration of public health specialists.

The creation of Public Health England within the Department of Health

3. We consider that the independence of the public health function from the management of the NHS would be damaged should Public Health England become part of the civil service machinery of the Department of Health. As the Department is responsible for delivery of services, there are conflicting interests. However in order to achieve the desired integration by the Secretary of State Public Health could be an NHS body chaired by a Minister.

The abolition of the Health Protection Agency (HPA) and the National Treatment Agency for Substance Misuse (NTA)

4. We are unclear as to the arguments and benefits for the abolition of these agencies. The NTA for substance abuse brings together a range of interdepartmental interests, which will continue to exist and need to participate in decision making. Whilst the NTA has at times seemed to struggle because of “competing” interests it should be made to work.

5. In Health Protection, as well as routine activity, Stockport undertook considerable work to prepare for a pandemic—not if but when—of “Bird” Flu. This proved invaluable for the swine flu outbreak. However the local work needs to be within necessary (sub)regional and national co-ordination .

The public health role of the Secretary of State

6. The need for an independent public health voice remains. Whilst public health is a key contributor it is one of many cross cutting contributors to address the wider determinants of health and health improvement. Policy formulation must draw on all.

The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)

7. In Stockport the Director of Public Health’s annual report is now integrated with the Joint Strategic Needs Assessment (JSNA). So recognising the vital contribution of public health to the wider role of local government, would a organisational place other than the local authority be more appropriate? Between 1948 and 1974 the NHS was based on a tripartite structure of which local (health) authorities were one part. We believe that there is no place other than the local authority to which the Public Health function should be transferred. However this has to be done properly, which will include time for considerable organisational preparation and development. Prior to the major 1974 re-organisation a full two years was allowed for this. Reducing tensions and reconciling the varying agenda and viewpoints of professionals and elected members will be a challenge.

8. We support the further development of Greater Manchester Health Commission which provides a sub-regional dimension to health improvement and related public health work. However there always appears to be organisational clutter with some degree of confusion and duplication. The creation of PCT clusters certainly in the short term will add to this.

Arrangements for public health involvement in the commissioning of NHS services

9. We believe there is vital need for Public Health involvement to ensure that the priorities within the JSNA are captured within commissioning priorities and plans. Health and Wellbeing Boards need to have real powers to influence commissioning to ensure these local evidence based priorities were being actioned. We await Secretary Lansley’s decisions following the listening exercise and pause. We hope he will accept the consequences for commissioning to be aligned with the health and well being strategy. However there are

concerns about the powers of the HWB to object to the business plans of NHS providers when these appear in conflict with the strategy.

Arrangements for commissioning public health services

10. Health and Wellbeing Boards should have a clear remit and powers to sign off commissioning decisions. Until clarification is provided we have concerns about the proposed divisions between local and regional/national commissioning. Transition problems will arise from any separation of responsibilities for under and over fives. In supporting a greater emphasis on preventative services, linked to local priorities and through integrated arrangements, greater understanding of the concept of prevention is needed. Some professionals use terminology such as low level in a disparaging and off putting way. Both Black (1980) and Marmot (2010) put an emphasis on simple physical activity such as walking.

The future of the Public Health Observatories

11. We value the excellent information and evidence bases provided by them. In addition to major use in relation to for example JSNAs, we use their health profiles in all our children publications and stress the need for their retention. We do not have the specialist knowledge to comment in detail on the organisation of the observatories. However workforce skills need to be developed locally as well.

The structure and purpose of the Public Health Outcomes Framework

12. The Department of Health and its predecessor Ministry of Health has had performance management arrangements for over 50 years following the Guillebaud report (1956). Measures of progress on key health issues are essential but have to take account that in Public Health they may take many years to achieve. In our opinion some short term measures have not always been credible. Greater dissemination of the underlying practice that gives rise to improved outcomes is required—what works. A focus on quartile, quintile or decile positions alone is meaningless.

Arrangements for funding public health services (including the Health Premium)

13. Legislation must ensure adequate funding for public health services, in particular those local services commissioned through local authorities. This is an area where the devil will be in the detail, so that cost shunting and opacity is avoided. There is a need to prevent conflict between Public Health England and local authorities over the allocation limited resources. Highly polarised districts such as Stockport could suffer unfairly if the health premium is paid on the basis of district-level indicators rather small area (super output) area indicators. Our focus is on improving health and reducing inequalities for Priority People wherever they live in the district. For instance within a ward one super output area with high deprivation can contribute to a reduction of two years lower expectation of life for the ward as a whole.

The future of the public health workforce (including the regulation of public health professionals)

14. Existing arrangements provide a diverse team with a range of skills and professional training. They are part of a wider workforce which contribute to addressing the wide determinants of health (see Black and Marmot below). There is a need for robust arrangements to be in place to ensure future roles are fit for purpose. The holistic nature of public health requires thought out workforce development and a realistic recognition of career paths.

How the Government is responding to the Marmot Review on health inequalities

15. Stockport Council first discussed inequalities in September 1980, following the publication of the Black report. The agenda is little changed, with the challenge still how to harness complex and multiple determinants of health. The importance of linkages between local agencies and partners to deliver effective services to reduce inequalities cannot be over emphasised. We are also concerned that introducing more competition into the NHS would limit opportunities for the integration between primary, secondary and local authority service delivery. Similarly GP consortia would not be able to effectively commission preventative services without the wider, and meaningful, input of local authorities, health and social care professionals and the community. Within the past month Stockport Partnership has devoted a full meeting to exploring these issues. However robust partnership mechanisms will be needed that give stakeholders powers to decide and hold to account.

Written evidence from Fresh—Smoke Free North East (PH 62)

ABOUT FRESH

1. Fresh—Smoke Free North East was set up in 2005 as the UK's first dedicated regional tobacco control office and programme. It is based on international evidence base and implements a comprehensive programme to shift the social norms around tobacco use. Fresh is currently funded by all 12 Primary Care Organisations (PCOs) in the North East and hosted by County Durham and Darlington NHS Trust. It won the Gold Medal in the inaugural public health awards of the CMO in 2009.

EXECUTIVE SUMMARY

2. This response reflects our concerns and priorities with respect to tobacco issues. Tobacco is the single greatest contributor to health inequalities and half of all long term smokers will die prematurely from a smoking related illness.

3. In the North East, around one fifth of the adult population smokes—around 440,000 people. It is an addiction that starts in childhood. The average age for North East smokers starting is 15.

4. Every year, 5,000 people in our region die early from a smoking-related disease—15 people a day and more than the next six most common causes of preventable death combined (drug misuse, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse). 84,000 children in the North East are exposed to smoke in the car and home each year, leading to 13,000 needing GP or hospital treatment.

5. The transfer of responsibility from the NHS to local authorities in England presents opportunities to improve the health of the people of England through better integration of society's efforts. It also carries with it significant risks, particularly in diminishing the science of public health and also politicising public health which must be addressed.

6. Opportunities include integration with children's services, education and adult social care as well as with services which ensure compliance with public health legislation such as trading standards and environmental health. In so doing, it offers a very strong opportunity to take a "life course" approach to smoking prevention and cessation and to provide greater accountability for public health policy.

7. On the health side, risks include the possible dislocation of preventative medicine from primary and secondary care. Also some council may underestimate the quality of evidence supporting many public health interventions and consequently may fail to give appropriate priority and resources.

8. There is also a risk that tobacco control could be subjected to a political "civil libertarian" ideology within some councils which would be very detrimental and ignoring the reality that smoking is not an "adult choice" behaviour but is actually a childhood addiction.

9. The North East approach to tobacco control has been successful through the unique approach taken whereby the PCOs and local councils have worked closely in partnership, and all of the 12 PCOs have commissioned and funded a regional programme based upon eight key strands of evidence based tobacco control delivery. This supra-local commissioning has achieved real economies of scale for essential areas such as media campaigns and also has worked effectively to address specific challenges such as illicit tobacco. This has been highlighted in both Her Majesty's Government publications "A Smokefree Future" (2010) and "Healthy Lives, Healthy People: A Tobacco Plan for England" (2011).

10. The North East has achieved the biggest regional decline in adult smoking in England with a decline to 21% in 2009 from 29% in 2005. This has resulted from a strong regional programme, working in partnership with localities and with other key regional agencies such as the North East Association of North East Councils.

SUMMARY OF RECOMMENDATIONS:

11. The Government should clarify how it proposes to protect public health policy from the vested interests of the tobacco industry, specifically the forthcoming consultation on plain packaging for tobacco products.

12. Any "health premium" incentives to reduce inequalities must focus on measurable behaviours such as smoking which most directly influences health inequalities. There is a need for much better data sources.

13. The Government should give clearer encouragement for bodies to commission jointly on a larger geographic footprint where this provides better value. This has been clearly demonstrated in the North East.

14. A focus too much on "localism" could result in inefficiencies and could diminish the delivery of evidence based programmes, unless effectively planned, delivered and evaluated. The Government should encourage a "locally together" approach to tobacco control.

15. Consortia commissioning plans should receive the formal approval of Health and Wellbeing Boards.

16. Sufficient funds must be allocated to the ring-fenced public health budget to enable it to deliver public health gains—and provide protection to prevent it being raided to fund other services.

DATA, INTELLIGENCE AND THE PUBLIC HEALTH OBSERVATORIES

17. Current data sources do not afford the significance required to assess differences in local smoking prevalence by socio economic group and current proposals to gather these data are inadequate. If aspirations are going to focus on reductions in smoking prevalence in areas the size of Local Authorities, the proposed method of collecting the necessary data will not be adequate. With a national sample size of, perhaps 400,000, for all the surveys that make up the Integrated Household Survey the sample each year for each local area will be nothing like enough.

18. Even collecting data over several years will still not be sufficient and in any event will not allow performance to be tracked in a manner that will be useful for policy development. We also note the current lack of clarity over the future of this survey and this is of major concern to us. We need this survey to be able to track overall progress at the regional level.

19. If the Health Premium is to work at all it will have to focus on our most disadvantaged populations and the measureable behaviours such as smoking, which most directly cause health inequalities.

20. We highlighted the need for high quality and accessible local information on public health needs and outcomes, offering the recently published Local Tobacco Profiles as an exemplar. We welcome proposals to produce an update of these profiles but note the continuing uncertainty about the funding for the Public Health Observatories which produced them.⁷⁴

PROTECTING FROM TOBACCO INDUSTRY INTERFERENCE

21. We welcome the Government's commitment to protecting health policy from the vested interests of the tobacco industry, in line with its obligations under Article 5.3 of the WHO Framework Convention on Tobacco Control. However, FRESH is very concerned of the apparent confidence of the tobacco companies, particularly here in the North East when some industry representatives have been seeking meetings with local councils. In addition, new cigarette brands specifically designed to be attractive to young women are being promoted within the North East.

22. The tobacco industry continues to use of front groups purporting to represent smokers, retailers and the hospitality business. Greater clarity is required, particularly in relation to how government will fulfil its obligations to protect policy on illicit tobacco and the forthcoming consultation on tobacco packaging.

PUBLIC HEALTH, TOBACCO CONTROL AND LOCAL GOVERNMENT

23. Smoking is the largest cause of preventable death in the North East killing over 5,000 people every year.⁷⁵ In England, deaths from smoking are more numerous than the next six most common causes of preventable death combined (ie drug use, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse).

24. The Coalition Government recognised the importance of tobacco control within its efforts to improve public health when on March 9, 2011 the Coalition Government published its Tobacco Control Plan for England. To be effective, this plan needs to be supported by a clear vision for public health among local authorities. Whilst we wait for the government response to the various "Healthy Lives, Healthy People" consultations we are concerned that some of the proposed revisions to the Health and Social Care Bill arising from the listening exercise risk undermining the strong vision of public health contained in the White Paper.

25. We note that the Health and Social Care Bill (2010–11) does not refer to "stop smoking services" in the same way as it does other core public health activities such as weighing and measuring children. This could lead to post-code lotteries for smokers, who may be unable to access evidence-based help to quit in their own local area. The provision of Stop Smoking Services needs to be a mandated part of public health provision at local level. It is highly cost effective.

26. Responsibility for public health is being transferred to local government not just at a time when public spending is under unprecedented pressure but also at a time when previous structures supporting local delivery such as National Support Teams, Public Health Observatories, Strategic Health Authorities and regional offices have been terminated or are under threat.

THE CASE FOR REGIONAL TOBACCO CONTROL PROGRAMMES

27. International evidence has concluded that investment at sub-national level on key components of national tobacco control programmes reaps significant benefits that are unlikely to be realised if local delivery evolves in isolation. These components include reducing smoking uptake, improving quit rates and protecting communities from the harm of secondhand smoke. For example, a highly active tobacco strategy in New York City has reduced smoking prevalence from 21% in 2002 to 15.8% in 2009.^{76 77} Similarly evaluations of

⁷⁴ The Future of Public Health Observatories, Grahame Morris MP <http://www.mutualis.co.uk/societynorth/?p=348>

⁷⁵ Healthy Lives, Healthy People: A tobacco control plan for England. Department of Health, 2011

⁷⁶ New York City Smoking Rate Has Declined Almost 20% Since 2002. New York City Department of Health and Hygiene 2007

⁷⁷ New York City Smoking Rates Fall to Lowest Rate on Record. New York City Department of Health and Hygiene 2009

California's state-wide tobacco control programme have found that the comprehensive strategy put in place was highly effective, listing mass media among the particularly effective components.⁷⁸

28. Until April 2010 each of the regional Government Offices in England employed a Regional Tobacco Policy Manager supported by a small team. It was the function of these teams to coordinate communications for greater cost effectiveness, deliver programmes focussed on reducing health inequalities from smoking, support local tobacco control and provide strategic guidance for effective local stop smoking services.

29. In the North East, a concerted effort has been in place since 2005 to focus efforts to reduce smoking rates, involving a range of partners through the FRESH programme. This programme delivers around eight key strands of activity based upon the World Bank evidence base for tobacco control and has been commissioned by all the PCOs who have been providing funding to FRESH on a per capita basis of between 0.27 and 0.33 pence. This pooled funding has achieved great efficiencies particularly around the development and implementation of world class media and communications activities.⁷⁹

30. The FRESH programme has united a number of partners including the NHS, local councils through the Association of North East Councils, North East Trading Standards Association, Regional Environmental Health Forum, TUC, HMRC, North East Chamber of Commerce, Voluntary Organisation Network for the North East, and galvanised action across a wide range of priorities including: reducing tobacco promotion and marketing, motivating and supporting smokers to stop, protection from secondhand smoke, reducing the availability and supply of illegal tobacco and also all tobacco to children, media and communications and research, monitoring and evaluation.

31. Two other regions have also established similar programmes with the North West launching in 2008 and the South West in 2009—these were based upon the model from the North East. The three regions have worked closely on a number of different programmes achieving even greater economies. However, the abolition of PCOs and the migration of public health funding and responsibilities to local authorities poses a risk to the future of these collaborative organisations if “localism” results in fragmentation and duplication of practice.

32. The North East has delivered the largest shift in social norms around tobacco use, the highest per capita media coverage on tobacco issues, the highest throughput of smokers through NHS stop smoking services and the largest decline in smoking of any region in England.⁸⁰

THE CASE FOR PAN-REGIONAL WORKING

33. A further example of the role of Offices of Tobacco Control is the North of England Tackling Illicit Tobacco for Better Health Programme.⁸¹ In this case the North West, North East and Yorkshire & Humber regions collaborated to coordinate local, regional and national agencies to improve intelligence, enforcement and marketing campaigns encompassing several regions to reduce the demand and supply of illicit tobacco. This initiative would have been unachievable for local councils working alone. It has been highlighted as best practice within the recently published joint HMRC and UK Border Agency “Tackling Tobacco Smuggling—building on success” Strategy⁸² quoting:

“4.38 Trading and consumption of illicit tobacco happens throughout the UK. Joining-up marketing and multi-agency enforcement will be essential to tackle this problem.4.39 The ‘North of England Tackling Illicit Tobacco for Better Health Programme’ is an example of how this can work. The programme combines the use of marketing and enforcement across several agencies to tackle the illicit tobacco market, including the Police, Trading Standards, Licensing Officers and HMRC.”

THE VALUE OF SUPRA-LOCAL COMMISSIONING

34. The wider value of such interventions being commissioned and delivered at a higher level is recognised by the Coalition Government. The national tobacco control plan for England makes clear:

“Tobacco control offices in the North West, North East and South West of England have demonstrated the value of such models of working for many years, particularly around marketing communications and tackling illicit tobacco.”⁸³

35. However, the public health reforms in general and the tobacco control plan in particular provide little encouragement for such cooperation. The likely consequence is a poorer use of health budgets and a greater and preventable burden of disease.

36. Whilst we are fairly confident that the twelve local councils in the North East will work closely together on tobacco control and recognise the benefits of commissioning the regional specialised programme an explicit recommendation around this should be given by the Government. It is not the case that all public health activity

⁷⁸ Hu TW, Sung HY, Keeler TE, Reducing cigarette consumption in California. *AM J Public Health* 1995b; 85(9): 128–22

⁷⁹ Fresh Smoke Free North East Delivery Plans 2005–6; 2006–7; 2007–8; 2008–9; 2009–10; 2010–11. www.freshne.com

⁸⁰ General Lifestyle Survey, 2009. Office for National Statistics Office for National Statistics. 2011 Table 1.10 Prevalence of cigarette smoking by sex, country and region of England: 1998 to 2009

⁸¹ The North of England Tackling Illicit Tobacco for Better Health Programme. www.illicittobacconorth.org.uk

⁸² Tackling Tobacco Smuggling—building on our success. A renewed strategy for HM Revenue & Customs and the UK Border Agency

⁸³ Healthy lives, healthy people: A tobacco control plan for England. Department of Health 2011

within a region such as the North east needs to be undertaken twelve times, but some areas such as media campaigns, training delivery, dedicated programmes around smokefree families and illicit tobacco are better delivered once across the region. We are concerned what the impact of the loss of a regional tier of public health will be for other localities in England.

37. The Government should give much clearer encouragement for bodies to commission jointly on a larger geographic footprint where this provides better value.

LOCAL GOVERNMENT AND THE LOCAL NHS WORKING TOGETHER

38. Although GP Consortia are required to prepare a Joint Health and Wellbeing Strategy with the Local Authority, informed by the Joint Strategic Needs Assessment (JSNA), the GP Consortia Commissioning Plan itself need only have “due regard” to the Joint Health and Wellbeing Strategy. This restricts the opportunity to integrate priorities across public health, healthcare and social care. **We recommend that this arrangement becomes more stringent and that the GP Consortia Commissioning Plans require the formal approval of Health and Wellbeing Boards.**

39. The drafting of JSNA should involve all relevant public health practitioners including environmental health officers and trading standards officers, to collect the evidence, assess local needs and attend to implementation.

40. Public health expertise must be embedded in all commissioning bodies, including not only Health and Wellbeing Boards but also GP commissioning consortia and the NHS Commissioning Board, to ensure the effective and efficient commissioning of health services for local communities.

41. We also have concerns about the clarity given to Local Authorities with regards the funding of certain public health functions. Regulatory services have played an essential role in effective implementation of tobacco policies at local level for example environmental health in smokefree legislation and trading standards in age of sale restrictions and will do so again in implementing the tobacco display ban. These services have been almost entirely funded through council budgets.

42. We welcome the ring-fence as a means of protecting the public health function as it becomes established in local authorities. The ring-fenced public health budget represents a transfer of resources to match the transfer of responsibilities to local government. Some authorities will see the new funding as a means of protecting important existing council services that make a clear contribution to public health. We do not object to the inclusion of these services within the public health budget. However, where functions currently funded by councils are to become funded from the ring-fenced budget, there should be a corresponding adjustment to the size of that budget.

43. Sufficient funds must be allocated to the ring-fenced public health budget to enable it to deliver public health gains—and provide protection to prevent it being raided to fund other services.

June 2011

Written evidence from BD Ltd (PH 63)

BD is a leading global medical technology company that develops, manufactures and sells medical devices, instrument systems and reagents. The Company is dedicated to improving people’s health throughout the world. BD is focused on improving drug delivery, enhancing the quality and speed of diagnosing infectious diseases and cancers, and advancing research, discovery and production of new drugs and vaccines. BD’s capabilities are instrumental in combating many of the world’s most pressing diseases.

Founded in 1897 and headquartered in Franklin Lakes, New Jersey, BD employs approximately 29,000 associates in more than 50 countries throughout the world. The Company serves healthcare institutions, life science researchers, clinical laboratories, the pharmaceutical industry and the general public.

In the UK, BD employs some 1,200 people, with a main administrative headquarters in Oxford and manufacturing facilities in Plymouth and Swindon. We welcome the opportunity to participate in this inquiry.

SUMMARY

- As set out by the Committee, Public health is a vital, but often neglected, aspect of the National Health Service.
- Effective Public Health service provision and early intervention can reduce long term costs and limit the demand and strain on the NHS.
- The overarching goals of public health provision; to prevent disease, prolong life and promote health living can help to manage long term budgets through early intervention.
- Public Health goals should be supported by national standards to ensure progress made and momentum built over recent years is not lost.

- It will be important to ensure that a joined up system is put in place to ensure devolved functions for Public Health are monitored and local decisions are made on the basis of need—reaching the over arching goals of public health provision—rather than based purely on budgetary requirements during this period of financial constraint on public services.
- It is imperative that that the plans for complex structural change be effectively scrutinised to ensure the importance of public health is recognised and to ensure that health services are commissioned effectively at a local level.

RESPONSE

1. As the government pursues its localism agenda, it will be important to recognise the contribution national standards have made to improving public health, whilst acknowledging where such imperatives have had unintended consequences.

2. We are delighted that implementation of screening programmes features in the Public Health Outcomes Framework and would suggest that there is a conscious read across to the NHS Outcomes Framework where joint measures can improve public health.

3. National Screening programmes have undoubtedly had a positive impact on public health—although there are improvements that can be made to ensure greater value for money and to target high risk hard to reach groups.

4. Part of this success is, we believe, due to the role of the Health Protection Agency (HPA) and we are pleased that many of the functions of the HPA will transfer to the newly created Public Health England. However the confusion over precise responsibilities for individual programmes is already creating inertia at an operational level and it is vital that momentum in such programmes is not lost during this period of structural and organisational change.

5. Clarity needs to be given over where responsibility will ultimately fall for commissioning public health services locally and how the devolved power to Directors of Public Health will be monitored and assessed.

6. The responsibility of Public Health England to target areas of inequality and to improve public health through ring fenced funding is to be welcomed, however long term cost implications of any reduction in preventative measures. such as those in national screening programmes, should be recognised.

7. The transition to Public Health England was set out to be developed in alignment with changes to PCTs and SHAs, and the creation of the NHS Commissioning Board (NHSCB). It was expected that the detailed arrangements would be set out in a series of planning letters throughout the course of 2011. Clarification needs to be given as to interim measures if the phased transition of responsibilities from the HPA to Public Health England will be delayed due to the extended consultation process of the Health and Social Care Bill.

8. There has been good progress in the reduction of healthcare associated infections (HCAIs), notably MRSA. However attempts to improve the diagnosis of *C difficile* have been thwarted by a number of factors. Existing guidelines have failed to take account of emerging evidence that recommended tests are inaccurate and result in under diagnosis. This is confounded by the reluctance of Trusts to move to more sensitive tests which would suggest that their performance in infection control was worsening. Associated penalties have resulted in Trusts being reluctant to embrace systems offering improved sensitivity which would demonstrate the true prevalence of *C difficile*.

9. Initiatives need also to be more nimble to incorporate emerging evidence. For example more infections are caused by MSSA than MRSA, but are more easily treated. Despite a recent mandate to report incidences of MSSA, this has not been accompanied by an imperative to screen surgical patients for colonisation and realise the subsequent benefits from reduced infections as seen in work carried out by Blackpool, Fylde and Wear NHS Trust.

([http://www.bfwh.nhs.uk/departments/comms/](http://www.bfwh.nhs.uk/departments/comms/docs%5CBlackpool%20Hospitals%20first%20in%20the%20UK%20to%20screen%20for%20superbug%20MSSA.pdf)

[docs%5CBlackpool%20Hospitals%20first%20in%20the%20UK%20to%20screen%20for%20superbug%20MSSA.pdf](http://www.bfwh.nhs.uk/departments/comms/docs%5CBlackpool%20Hospitals%20first%20in%20the%20UK%20to%20screen%20for%20superbug%20MSSA.pdf))

10. The need for the NHS to maximise its productivity is well rehearsed. At an operational level, however, efficiencies become confused with savings, as individuals are put under pressure to reduce in year budgets. With regard to, for example, HCAIs and the protection of healthcare workers, we have noticed that there is an attempt to screen fewer groups of patients or limit the use of safety engineered needles in an attempt to reduce the absolute cost of such initiatives. We believe there should be zero tolerance to HCAIs or exposing healthcare workers to avoidable risk, such as from sharp's injuries. The risk posed by or to an individual in any given clinical situation can not be known and safety must be the absolute priority. Given that, for example, patients with MRSA infection have a six fold increases in mortality rates and require significantly longer hospital stays, the balance of short term value for money and longer term cost effectiveness must be found.

11. Similarly, many Trusts are reluctant to use rapid, molecular screening techniques for MRSA in the belief that such tests add cost. However work from Achyut Guleri and colleagues from Blackpool, Fylde and Wyre (British Journal of healthcare Management, February 2011: http://www.bjhcm.co.uk/cgi-bin/go.pl/library/article.cgi?uid=81983;article=BJHCM_17_2_64_71) and Katherine Hardy and colleagues for the Heart of

England Trust (Clinical Microbiology and Infection, April 2009) have demonstrated that this approach both significantly reduces MRSA infection and is a cost effective use of NHS resources.

12. There is also evidence (Bagger et al, Lancet February 2004) that there is a link between deprivation and post operative susceptibility to MRSA infection. In the study of heart patients in London there was a seven fold higher infection rate for patients from the most deprived areas to the least.

June 2011

Written evidence from the Men's Health Forum (PH 64)

1. SUMMARY

- (a) In this paper we have focused on the Marmot Review and health inequalities.
- (b) In principal we support the government's approach to the Review and the related policy of passing public health budgets to local authorities.
- (c) We are concerned, however, at how this will work in practice. This is because many local authorities have had to cut existing services and because too great a gulf in responsibilities between local authorities and the NHS could be counter-productive.

2. ABOUT THE MEN'S HEALTH FORUM

- (a) The Men's Health Forum (MHF) is the only independent national organisation campaigning for better health for men and boys. We are a registered charity and a Strategic Partner of the Department of Health.
- (b) Our vision is a future in which all boys and men in England and Wales have an equal opportunity to attain the highest possible level of health and well-being.
- (c) We work to achieve this through:
 - (i) Policy development, research and lobbying.
 - (ii) Supporting other organisations and services to engage more effectively with boys and men on health issues.
 - (iii) Leading the annual National Men's Health Week.
 - (iv) Publishing the award-winning range of mini manual health booklets for men.
 - (v) Running the unique "consumer" website for men: www.malehealth.co.uk.
 - (vi) Working with MPs and government.
 - (vii) Developing innovative and imaginative best practice projects.
 - (viii) Training service providers and others.
 - (ix) Collaborating with the widest possible range of interested organisations and individuals.
- (d) Our work focuses particularly on those groups of men with the worst health and we are striving to ensure that we take account of the diversity of men and their needs.
- (e) Although our concentration is on male health, we are committed to the principle of achieving better health for both sexes. We recognise particularly that the health of men and women is often interconnected. We do not advocate improving male health at the expense of female health nor do we argue in favour of diverting health resources from women to men.

3. HOW THE GOVERNMENT IS RESPONDING TO THE MARMOT REVIEW ON HEALTH INEQUALITIES

- (a) We welcomed the government's White Paper's acknowledgement of Professor Sir Michael Marmot's extensive series of recommendations in this area. **It is crucially important that Professor Marmot's work is not lost—and indeed that that all the earlier work on tackling health inequalities that has been at the forefront of public health activity in recent years should continue to inform future activity.** We will not improve the health of individuals as effectively as we can without also acting in this wider context.
- (b) We welcome the decision to build public health provision around a life-course framework as Professor Marmot's review recommended. We think this approach will be helpful in our own field. Several previously published MHF papers have acknowledged the importance of "transition points" in men's lives and this approach accords with the life-course approach.
- (c) While we welcomed Professor Marmot's Review, we also consider that it largely omitted the inequality issues that cross-cut those related to income, including gender inequalities. The Men's Health Forum believes that the differences in health outcomes between men and women are significant and must be tackled. These differences relate to life expectancy (women outlive men by four years on average) and premature mortality (42% of men die before the age of 75 compared to 26% of women). In the case of one major killer, cancer, men clearly bear an excess burden—they are 40% more likely to die from any cancer and 70% more likely to die from one of the cancers that can affect both sexes—because of their riskier lifestyles, lower symptom awareness and almost certain later presentation to health services. It is

essential that any initiatives to tackle health inequalities take account of gender alongside other key dimensions of inequality, such as race and disability.

- (d) **Our recommendation is that health data in policy and planning documents should always be expressed in gender-disaggregated terms.** The government's public health policy in general, and the aim to focus on outcomes and any attempt to deliver Professor Marmot's recommendations in particular, will benefit from this approach.
- (e) Presenting data routinely in this form would be extremely easy to do, since there are virtually no circumstances where the relevant information is not immediately available. Doing so would offer the considerable advantage of placing gender equality issues in front of policy-makers, planners and health professionals throughout the decision-making process and into service delivery.
- (f) In principle, we support the relocation of public health departments within local authorities, and of the associated decision to "ring fence" budgets allocated to public health. This should enable a greater degree of local sensitivity and democratic accountability. **This should be balanced, however, against the need to ensure it is focused on delivering public health priorities identified by Professor Marmot and is not used to subsidise related services that local authorities have previously provided such as leisure centres and public parks.**
- (g) It should also help with the engagement of local third sector organisations in the planning and delivery of health improvement initiatives. However, the current picture emerging from around the country is that local authorities are cutting back on this type of work. **We are concerned that the local authorities in most need of tackling health inequalities, in particular men's poor health, will be those least able to.**
- (h) The potential difficulty with many aspects of the new arrangement, which has been widely voiced, is the possibility of disengagement of public health from wider NHS service delivery.
- (i) This risk is compounded by the decision in the Health and Social Care Bill to give much greater decision-making powers to GPs. GPs, it is fair to say, do not have a strong track record of prioritising public health issues (albeit for very recognisable and understandable reasons). They also have generally shown little interest in tackling health inequalities, including men's health.
- (j) **If joint-planning and joint-working between GP consortia and public health departments proves hard to achieve consistently across the country, then the capacity to make the necessary progress on public health and health inequalities will be very significantly undermined.**

June 2011

Written evidence from Pharmaceutical Services Negotiating Committee (PH 66)

PSNC promotes and supports the interests of all NHS community pharmacies in England. We are recognised by the Secretary of State for Health as the body that represents NHS pharmacy contractors. We work closely with Local Pharmaceutical Committees to support their role as the local NHS representative organisations.

Our goal is to develop the NHS community pharmacy service, and to enable community pharmacies to offer an increased range of high quality and fully funded services; services that meet the needs of local communities, provide good value for the NHS and deliver excellent health outcomes for patients.

We welcome the proposals to transfer responsibility for public health to local authorities; this should support a joined up approach to public health challenges by tackling the wider determinants of health in a holistic manner.

HARNESSING THE WIDER PUBLIC HEALTH WORKFORCE

Community pharmacies already provide a wide range of public health focussed services such as stop smoking support, NHS Health Checks, emergency hormonal contraception and sexual health screening; we were pleased to see this acknowledged in the Government's White Paper *Healthy Lives, Healthy People*.

Given the scale of the challenge the country faces in improving public health and wellbeing, we cannot afford not to harness the expansive potential of the wider public health workforce, including the 10,700 community pharmacy teams that operate across England.

Given their position at the heart of the communities they serve, and their status as the health professionals with which people most regularly come into contact, pharmacists and their teams are ideally placed to provide an effective gateway into public health networks. In addition to providing high quality health and wellbeing services, and offering informed but informal health advice, pharmacists and their teams have a key signposting role in directing their patients and customers toward appropriate health services.

The new Public Health system should make use of a wider range of professionals, recognising that the expansive capacity of this broader workforce must be used to build robust and integrated public health networks operating at the heart of communities.

HEALTH INEQUALITIES

Community pharmacies are uniquely well placed to reach populations that can be difficult to attract to a conventional healthcare setting. Community pharmacies benefit from convenient locations and long opening hours. There is no need to make an appointment for most services, and they benefit from footfall attracted by the retail elements of the business. 99% of the population, even in the most deprived areas, can get to a pharmacy within 20 minutes, either by walking or using public transport. Some 84% of adults visit a pharmacy at least once a year.

NICE noted in 2008 that “They [community pharmacies] are able to meet the needs of minority ethnic and disadvantaged groups and those who may have difficulty accessing other community services.” Commissioning services from providers based at the heart of communities is an effective means of addressing health inequalities that cannot be replicated in traditional healthcare settings.

AN OPPORTUNITY TO MAKE A BIGGER IMPACT—NATIONAL SERVICES

The accessibility of the community pharmacy network to patients and members of the public who do not frequently use other healthcare services is a key asset that the NHS and local authorities should leverage to improve public health. We believe that many of these services offer undeniable value to the population and would benefit from being commissioned at a national level. For example stop smoking services, observed consumption of substitute medication for treatment of substance misuse, brief interventions on alcohol, emergency contraception services and Chlamydia screening.

While we recognise the desire to provide personalised services for individuals and communities, we believe it is possible to benefit from the efficiencies of a nationally commissioned service, whilst at the same time providing sufficient flexibility for service providers to personalise their service offering to meet the needs of individuals.

Over many years, community pharmacies have developed the skills to allow them to personalise services for their *customers* in order to differentiate themselves from other pharmacies within this very competitive sector. Commissioning at a national level, whilst allowing the personalisation of service offerings at the level of the patient, provides the benefits of efficiency for the commissioner and the provider and a locally responsive approach for the patient.

Community pharmacy already has a public health element within its core NHS contractual framework which provides for provision of opportunistic healthy lifestyle advice to people visiting the pharmacy and involvement in locally organised public health campaigns. We believe that better use of the arrangements for public health campaigns and healthy lifestyle advice could support greater impact on the population's health. For example, using the public health campaigns element of the contractual framework to promote nationally organised campaigns, such as No Smoking Day or DH cancer awareness programmes could see every community pharmacy in England promoting the same campaign over a defined time period, thus extending the reach of health promotion campaign messages.

AN OPPORTUNITY TO MAKE A BIGGER IMPACT—LOCAL SERVICES

The transfer of some commissioning responsibilities from PCTs to local authorities should be informed by the experience of recent years, where we have seen a subtle range of local variations on standard services, such as stop smoking, commissioned by PCTs, without any perceivable benefit being delivered by this varied approach.

In order to support cost effective and efficient commissioning of community pharmacy services by local authorities we suggest that the work to develop standard service specifications we have undertaken with the Department of Health and NHS Employers should be augmented by the agreement of standard contracts or service level agreements and potentially tariff prices for some services.

This approach has the potential to support the delivery of services under an Any Qualified Provider basis; one such example is seasonal flu vaccination. A report published in May 2001 by the Health Protection Agency said last winter's flu outbreak claimed 602 lives in the UK, with more than 70% of the deaths among 15 to 64 year olds. The HPA figures also show just 50% of under-65s in at-risk groups in England and Wales were immunised against flu.

In order to prevent unnecessary deaths from flu next winter, we believe the Department of Health should allow any qualified provider to administer vaccines, making proper use of the consistently high quality service offered by community pharmacists. As the commissioner only pays for flu vaccines administered, pharmacy-led services are a cost-effective way to increase the numbers of those protected against flu, and alleviate the pressure on GPs.

Where community pharmacies already provide vaccines, they have had very positive results in accessing hard-to-reach patient groups, and are really appreciated by the local community. For example, during last year's challenging winter, nine out of ten patients on the Isle of Wight praised their local pharmacy flu vaccination service for being both “excellent” and “more accessible”.

LOCAL COMMISSIONING STRUCTURES

We support the establishment of statutory Health and Wellbeing Boards, but believe that it is essential that decisions and processes are transparent and take the views of health professionals and the wider community into account. A statutory online consultation process should be implemented to allow a wide range of stakeholders to influence decisions being made by the Boards.

Due to the significant impact that community pharmacy can have on the improvement of public health, PSNC believes that there should be representation of the interests of local community pharmacy providers on Health and Wellbeing Boards. Only with such representation, will the health improvement opportunities that community pharmacy can offer be fully realised.

These Boards should help support partnership working and commissioning by local authorities and commissioning consortia. We recognise the benefits of taking a more holistic approach to public health, but we are concerned that there is the potential in the new system for valuable services to “fall between the gaps” created by local authority and consortia commissioning. It is also likely that without careful collaboration between commissioners, there is the possibility of public health commissioning driving conflict with consortia, due to public health services, such as screening programmes, driving unplanned healthcare expenditure.

We are pleased to see the proposal that local authority funds for public health should be ring fenced. In the past such ring fencing has not always been effective in ensuring all funds are spent on the specified area. We therefore suggest that local authorities should be required to publicly account for their spending of the ring fenced public health monies at the end of a financial year.

CONCLUSION

Community pharmacies already provide many health improvement services, but we believe there is an opportunity for this contribution to be enhanced when the new approach to public health commissioning is implemented. The adoption of the suggestions we make above would support the community pharmacy sector to enhance its contribution to public health in an efficient and timely manner.

We would welcome further discussion on these matters with the Committee.

June 2011

Written evidence from Beating Bowel Cancer (PH 67)

Beating Bowel Cancer is dedicated to saving lives by working in partnership with individuals, local communities, clinical communities and government to improve public awareness of bowel cancer and to increase the rate of early diagnosis. We help patients access the treatment they need and provide emotional and practical support to improve the lives of everyone affected by bowel cancer.

SETTING THE SCENE FOR BOWEL CANCER

Bowel cancer is the UK’s second biggest cancer killer. Of the 100 people diagnosed every day, almost 50 will die. However advances in treatment in recent years mean that bowel cancer can be beaten if it is diagnosed at an early stage—a study by the National Cancer Intelligence Network found that 93.2% of patients diagnosed with early stage bowel cancer will survive five years from diagnosis compared to just 6.6% of patients diagnosed with late stage disease.⁸⁴ Bowel cancer is a common cancer killer. With earlier diagnosis there is an opportunity to make it a rarer cancer killer.

Despite the devastating impact of bowel cancer, awareness is still too low. The result is that many people with symptoms do not know to seek help, resulting in later diagnoses and poorer outcomes. There are, however, opportunities to encourage earlier diagnosis.

A key first step would be to improve uptake of the existing national screening programme for bowel cancer. Currently 54% of those eligible in England take up their offer for bowel cancer screening, compared to that for breast cancer (76.5%).⁸⁵

Beating Bowel Cancer has a great deal of experience in communicating to the public about bowel cancer and we are ready to play our part in assisting relevant authorities to maximise the impact of any communications.

1. CONTEXT—BOWEL CANCER AND PUBLIC HEALTH

1.1. Bowel cancer is the UK’s second biggest cancer killer. Of the 100 people diagnosed every day, almost 50 will die. However advances in treatment in recent years mean that bowel cancer can be beaten if it is diagnosed at an early stage—a study by the National Cancer Intelligence Network (NCIN) found that 93.2%

⁸⁴ National Cancer Intelligence Network, Colorectal Cancer by Survival Stage, webpage: http://library.ncin.org.uk/docs/090623-NCIN-colorectal_survival-databriefing.pdf Accessed September 2010

⁸⁵ Breast Screening Programme, England 2008–09 <http://www.ic.nhs.uk/statistics-and-data-collections/screening/breast-screening/breast-screening-programme-england-2008-09>

of patients diagnosed with early stage bowel cancer will survive five years from diagnosis compared to just 6.6% of patients diagnosed with late stage disease.⁸⁶

1.2. Public Health England and local authorities will play a key role in improving outcomes for bowel cancer as they are responsible for both screening and awareness campaigns. Raising awareness of bowel cancer is vital in increasing participation in national screening and ensuring that people with symptoms present to their GPs for a diagnosis. Research by the NCIN on routes to diagnosis found that relative one year survival for patients was 84.5% for patients diagnosed through the urgent or GP referral pathway compared to 48.4% for those diagnosed as an emergency.⁸⁷

2. *The creation of Public Health England within the Department of Health*

2.1. The creation of Public Health England is welcome although joint working with the Department of Health will be important for bowel cancer as it is a condition that spans both Public Health England and the Department of Health. For cancer patients, diagnosing cancer at an early stage can have a positive impact—the Government's new cancer strategy *Improving Outcomes: A Strategy for Cancer* has estimated that 5,000 lives could be saved each year if cancers were detected earlier.⁸⁸

2.2. Public Health England should play a role in ensuring that a proportion of the public health budget is spent by local authorities on targeted information campaigns. Beating Bowel Cancer welcomed the Department of Health's pledge to raise cancer awareness, through a £10.75 million signs and symptoms campaign, focusing on breast, lung and bowel cancers,⁸⁹ and we provided advice and support to the Department to help deliver a successful campaign. Public Health England should monitor the efficacy of the national pilots of bowel cancer awareness campaigns with a view to rolling these out more widely.

2.3. Public Health England will also be responsible for screening programmes. Bowel cancer screening is essential for early diagnosis however only 23% of the population are aware that there is a bowel cancer screening programme⁹⁰ and just over 50% of those eligible are completing their screening tests. Beating Bowel Cancer is calling for an increase in uptake of bowel cancer screening to match the best cancer screening programme participation rates of around 76.5% with the potential of saving up to 1,279 lives each year.⁹¹ Public Health England should prioritise research on improving bowel cancer screening participation, particularly for harder to reach groups, and ensure that participation rates are continually bettered.

2.4 Public Health England should work with local NHS providers to ensure early implementation of the introduction of flexible sigmoidoscopy (flexi sig) for bowel cancer in England. Flexi sig screening has been found to reduce deaths from the disease by 43% and the incidence of bowel cancer by one third when carried out once in those aged between 55 and 64 years. Beating Bowel Cancer welcomed the Government's commitment to allocate £60 million to fund the introduction of a flexi sig screening programme over four years. Beating Bowel Cancer fully supports the introduction of a national flexi sig screening programme for people aged 55 and over—extending to those aged 50 and over as the evidence justifies it. Our Chief Executive is a member of the Bowel Screening Advisory Committee and we are committed to playing our part to ensure the roll out of flexi sig is a success.

3. *The abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse*

3.1 Beating Bowel Cancer does not have any comments on this area.

4. *The public health role of the Secretary of State*

4.1 The Secretary of State should take his responsibilities to protect the population's health seriously. This could include:

4.2 Ensuring that the ring-fenced public health budget is used on measures that are linked to clear health improvements such as awareness campaigns for bowel cancer and improving participation in screening programmes.

4.3 Ensuring that the activities of Public Health England and the Department of Health are effectively coordinated so that services for conditions such as bowel cancer are properly streamlined.

⁸⁶ National Cancer Intelligence Network, Colorectal Cancer by Survival Stage, webpage: http://library.ncin.org.uk/docs/090623-NCIN-colorectal_survival-databriefing.pdf Accessed September 2010

⁸⁷ NCIN, Routes to Diagnosis: Results UKACR and NCIN Joint Conference, June 2010

⁸⁸ Department of Health, *Improving Outcomes: A Strategy for Cancer*, January 2011

⁸⁹ Department of Health, *Improving Outcomes: A Strategy for Cancer*, January 2011

⁹⁰ UCL/NAEDI, Public awareness of cancer in Britain, December 2009

⁹¹ Calculation based on Cancer Research UK's estimate that if 60% of those eligible for participated in bowel cancer screening over the next 20 years, there would be 20,000 fewer deaths and worked out for the current participation rate of 77% over the next two years. Cancer Research UK, Charity predicts 20,000 fewer deaths from bowel cancer, Webpage: <http://info.cancerresearchuk.org/news/archive/pressrelease/2007-07-24-charity-predicts-20000-fewer-deaths-from-bowel-cancer> Accessed: November 2009

4.4 Ensuring that measures in the Public Health Outcomes Framework are focused on real health outcomes such as the proportion of patients diagnosed at Stage one or Stage two cancer and improved bowel cancer survival.

5. The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)

5.1 Directors of Public Health should take a lead in ensuring that local government focuses on measures that have a tangible public health impact.

5.2 Health and Wellbeing Boards will be key to ensuring that services are joined up—these should include input from local cancer networks. Where necessary, there should be joint performance measurement across the NHS, public health and social care as some of these interventions will require high quality commissioning from more than one commissioner. For example, early diagnosis may involve awareness (public health), screening (public health), primary care diagnostics (NHS) and secondary care investigation (NHS). Therefore it will be important to develop joint commissioning outcome indicators which can be shared at a local level.

6. Arrangements for public health involvement in the commissioning of NHS services

6.1 Health and wellbeing boards should work to ensure that specific public health expertise within a local area are consulted on. On issues relevant to bowel cancer, the cancer networks should be included in relevant discussions around commissioning. Charities such as Beating Bowel Cancer should also be consulted as we have a wealth of experience in running effective public awareness campaigns on a local level. We are accredited by the Information Standard, a certification scheme for health and social care information, supported by the Department of Health. The Information Standard enhances our reputation as a reliable and authoritative source of bowel cancer information by helping us ensure that we provide clear, accessible information for everyone affected by bowel cancer.

7. Arrangements for commissioning public health services

7.1 Coordination will be key to commissioning effective public health services. Some public health interventions will require high quality commissioning from more than one commissioner. For example, early diagnosis may involve awareness (public health), screening (public health), primary care diagnostics (NHS) and secondary care investigation (NHS).

7.2 Cancer networks should play a key role in coordinating the commissioning of cancer services to ensure seamless care for the patient. This will also ensure that appropriate expertise is available to inform commissioning. It is welcome that future funding for cancer networks has been secured to support the implementation of the reforms to the NHS and public health service.

8. The future of the Public Health Observatories

8.1 Public Health England and local authorities will be responsible for the functions of Public Health Observatories and cancer registries. This change in responsibility should allow time for reflection in the timeliness of data collection around cancer.

8.2 Beating Bowel Cancer has been analysing the availability of bowel cancer data in England, with a focus on the following key areas:

<i>Topic</i>	<i>Data that could be included</i>
Epidemiology	Diagnosis, prevalence, mortality, survival
Early diagnosis	Screening uptake, proportion diagnosed through two week referral, staging data (where it is available)
Treatment	Number of patients received surgery, Cancer Drugs Fund cases
Care	Patient experience survey

8.3 In compiling the data for this, we have noticed that information published on incidence and mortality is now four years old. This kind of time-lag is unacceptable and should be remedied. If the *Information Revolution* is to work in practice, these systems should be streamlined to ensure that data are collected, verified and published as quickly as possible. Public Health England, in conjunction with local authorities, should take a lead in making this happen.

9. The structure and purpose of the Public Health Outcomes Framework

9.1 The overall structure and purpose of the Public Health outcomes framework is welcome. It is positive that when the management of conditions span across all three areas, such as bowel cancer, there are shared indicators in the NHS, public health and social care outcomes frameworks.

9.2 The inclusion of cancer survival measures across public health and NHS outcomes frameworks is welcome. The indicator on: *Patients with cancer diagnosed at stage one and two as a proportion of cancers diagnosed* in domain four is particularly welcomed as this is an area where coordination between the NHS and public health services will be vital.

9.3 Beating Bowel Cancer is committed to working with local authorities on awareness campaigns and to improve participation in screening programmes to support local authorities in improving outcomes.

Case Study: Thames Valley Cancer Network NAEDI campaign

We partnered in a major public health campaign in the Thames Valley under the banner “Early Diagnosis Saves Lives”, highlighting the possible signs of bowel and lung cancer and urging people who have the symptoms to go to their doctor as soon as possible.

More than 250,000 pieces of literature were distributed by the Thames Valley Cancer Network as part of the campaign, Don’t Sit on Your Symptoms’, to libraries, GP surgeries, hospital waiting areas and community centres.

10. Arrangements for funding public health services (including the Health Premium)

10.1 It is important that the funding for public health services is directed at evidence-based interventions that are directly linked to health improvement such as the national bowel cancer screening and bowel cancer awareness programmes.

10.2 Local authority budgets are being reduced and there is a risk that many activities that may be cut could be covered by a public health budget. In order to maintain a focus on reducing inequalities, there should be measures focused on at-risk groups—for example those with an increased chance of developing bowel cancer.

11. The future of the public health workforce (including the regulation of public health professionals)

11.1 The public health workforce should be encouraged to be flexible and spread across wide areas of the community including the use of health in the workplace schemes, forging new partnerships across primary care and supporting the implementation of national awareness programmes.

12. How the Government is responding to the Marmot Review on health inequalities

12.1 It is concerning that certain elements of the equality impact assessment within the Department of Health’s public health white papers were not properly analysed.

12.2 Public awareness and screening campaigns should be targeted at harder to reach groups, including older people, ethnic minorities and deprived communities.

12.3 There are three forms of information that are vital in reducing inequalities in cancer outcomes:

- Information to enable patients to make informed decisions about their treatments. To support this, information prescriptions should be rolled out without delay.
- Information on quality and access of services to enable all patients to make a choice not just about where or when they access treatment but what form and what team delivers it.
- Information for the continuing professional development of clinicians to ensure early recognition and diagnosis of high risk cancers.

12.4 Steps should be taken to ensure that patients have access to the best treatment across the patient pathway as soon as possible—this will help to ensure outcomes improve to match the best in Europe.

12.5 Community action to improve the awareness of bowel cancer, particularly in screening, access to services and outcomes will be vital if inequalities in bowel cancer are to be effectively treated.

12.6 *Improving outcomes: a strategy for cancer* (IOSC) and the National Cancer Equality Initiative (NCEI) have underlined the need for the NHS, public health and social care to have information that is appropriately analysed by “*inequality/equality group, to enable them to make the right decision around commissioning and providing quality services*”⁹².

12.7 The Equalities Portal is an early example of how the principle of the information revolution can be applied to cancer services. The commitment in IOSC to examine survival, mortality and incidence by geographical data and to publish one-year survival data is welcome as it will support identification of groups that are more likely to present late. National pilots for a bowel cancer awareness campaign are currently underway—equalities data could support the public health service in introducing targeted awareness campaigns aimed at particular equality groups to improve early diagnosis of the cancer.⁹³

June 2011

⁹² Department of Health, *Improving outcomes: a strategy for cancer*, 12 January 2011

⁹³ Department of Health, *Improving outcomes: a strategy for cancer*, 12 January 2011

Written evidence from Council for Healthcare Regulatory Excellence (PH 68)

SUMMARY

- CHRE welcomes the opportunity to contribute to the Health Committee's inquiry into Public Health, particularly the future of the public health workforce, including the regulation of public health professionals.
- We do not believe a robust case has been made for extending statutory regulation to public health practitioners.
- We consider that voluntary registration as part of a framework that is supported by existing legislation and regulation, contractual terms required by employers, and the education and professional development of public health practitioners themselves, does provide proportionate protection for the public from the risks posed by the public health workforce.
- The Government is proposing an assurance scheme for such voluntary registers in the Health and Social Care Bill and this should support public trust in public health practitioners.

INTRODUCTION

1. The Council for Healthcare Regulatory Excellence (CHRE) promotes the health and well-being of patients and the public in the regulation of health professionals. We scrutinise and oversee the work of the nine regulatory bodies⁹⁴ that set standards for training and conduct of health professionals. We share good practice and knowledge with the regulatory bodies, conduct research, and promote the concept of *right-touch regulation*.⁹⁵ We advise the four UK government health departments on issues relating to the regulation of health professionals. We are an independent body accountable to the UK Parliament.

2. CHRE advocates the use of *right-touch regulation*,⁹⁶ which is applying the minimum regulatory force required to achieve the desired result. This is the approach we adopt in the work we do, it is the approach that we encourage our regulators to work towards, and it frames the contributions we make to wider debates about the quality and safety of healthcare and the development of regulation. It complements the well established principles of good regulation, promoted by the Better Regulation Executive. Applying right-touch regulation helps us to answer questions about the appropriate regulatory framework for different groups working in health and social care.

THE FUTURE REGULATION OF PUBLIC HEALTH PROFESSIONALS

3. The Government outlined its position on extending statutory regulation in its recent Command Paper, *Enabling Excellence*:

*...the extension of statutory regulation to currently unregulated professional or occupational groups ... will only be considered where there is a compelling case on the basis of a public safety risk and where assured voluntary registers are not considered sufficient to manage this risk*⁹⁷

4. Much of the public health workforce is already subject to statutory professional regulation, such as the 27,000 specialist community public health nurses on the Nursing and Midwifery Council register. Health professional regulatory bodies ensure the skills, competence and behaviour of registrants are sufficient to protect the public and promote confidence in the professions. Unregulated public health practitioners often come from a variety of professional and academic backgrounds, and can fulfil senior roles in public health.

5. Questions about the level of regulation required for public health professionals have been examined in a recent report, *Review of the Regulation of Public Health Professionals*⁹⁸ which recommended statutory regulation for all practitioners. However, it is our view that the report fails to make the case for statutory regulation. Statutory regulation for the public health workforce would be an overly burdensome and inappropriate way of managing the risks that are presented.⁹⁹

6. Right-touch regulation means that there is usually more than one way to solve a problem and that regulation is not always the best answer. Public health practitioners fulfil a wide range of roles in society from individual nutritional advice to the management of environmental hazards and disease control. Failure to

⁹⁴ General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Health Professions Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland.

⁹⁵ Right-touch regulation means always asking what risk we are trying to regulate, being proportionate and targeted in regulating that risk or finding ways other than regulation to promote good practice and high-quality healthcare. It is the minimum regulatory force required to achieve the desired result.
CHRE. 2010. *Right-touch regulation*. http://www.chre.org.uk/_img/pics/library/100809_RTR_FINAL.pdf [accessed 21 February 2011]

⁹⁶ CHRE, 2010. *Right-touch regulation*. <http://www.chre.org.uk/policyandresearch/336/> [accessed 21 February 2011]

⁹⁷ Department of Health. 2011. *Enabling Excellence: Autonomy and Accountability for Health and Social Care Staff*. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124359 [accessed 8 June 2011]

⁹⁸ Scally, G. 2010. Review of the regulation of public health professionals. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122089 [accessed 8 June 2011]

⁹⁹ CHRE. 2011. *CHRE response to: Healthy Lives, Healthy People: Our strategy for public health in England*. http://www.chre.org.uk/_img/pics/library/pdf_1299078307.pdf [accessed 8 June 2011]

manage risks in these areas can lead to harm for individuals or entire populations in extreme circumstances. Whilst the potential for risk is high, we have not seen compelling evidence to suggest that the existing mechanisms of control are failing to mitigate them effectively. We do not consider therefore, that additional statutory regulation of professionals is needed. Given this we should seek other ways to enhance the delivery of high-quality public health to the public. Non-regulatory safeguards currently exist, including voluntary registers, professional organisations, chartered institutes, existing safety legislation, plus oversight and performance management by employers.

7. Our view that extending statutory regulation would be inappropriate is supported by a recent report from the UK Public Health Register on risk in public health practice. It concluded that although some form of regulation is required at all levels of public health practice, quality assured voluntary regulation would successfully protect the public.¹⁰⁰

THE BENEFITS OF ASSURED VOLUNTARY REGISTRATION

8. Under current proposals in the Health and Social Care Bill 2011, CHRE will become the Professional Standards Authority for Health and Social Care (“the Authority”) with powers to assure voluntary registers. We will

*set standards against which the governance, procedures, registration criteria and performance of voluntary registers can be judged to establish whether they are sufficient to provide assurance to the public and employers about the training, skills and conduct of their registrants*¹⁰¹

9. The benefit of this approach means that assured voluntary registration will provide greater flexibility and give the public and local employers greater control and responsibility for how they assure themselves about the quality of staff.¹⁰²

10. Ultimately what keeps patients safe is health professionals’ personal commitment to acting competently, ethically and compassionately. Those who willingly sign up to a voluntary register demonstrate that commitment. In addition, the Authority will provide assurance that the register is being managed effectively and that it is delivering good outcomes for service users.

11. Under the Authority’s scheme, organisations operating assured voluntary registers will be required to:

- Act in the best interests of the consumer.
- Behave with integrity and authority.
- Promote high standards of training, education and practice.
- Apply rigorous standards to itself and its registrants.
- Provide clear and accessible information to the public.
- Act swiftly to protect the public when necessary.¹⁰³

12. Practitioners will benefit from registration with an organisation that is accredited by the Authority as an indicator to service users and employers that they are competent and committed to providing good standards of care, treatment, therapy or other service.

13. Employers can be confident that they can rely upon registration of a practitioner by an accredited body as a quality indicator, alongside reference checks of their own. Effective management of a professional’s performance with ongoing career-based training can benefit the individual and the reputation of the profession as a whole.

14. The relationship between employers and organisations running voluntary registers will be of benefit to both groups. Endorsements by employers choosing or requiring applicants belonging to an assured voluntary register will allow it promote standards within the workforce for the benefit of patients and the public. The existing voluntary register for public health specialists, the UKPHR, is endorsed by the NHS at senior levels.¹⁰⁴

15. CHRE considers that an **assured voluntary register of public health practitioners** would be an appropriate safeguard for the unregulated public health workforce. Membership of such a register will indicate the mark of safe, quality service expected from a public health professional, without the burden of unwarranted regulation and costs associated with this. As a pre-existing and successful voluntary register, CHRE has held

¹⁰⁰ UKPHR. 2011. *Response To Healthy Lives, Healthy People*. http://www.publichealthregister.org.uk/files/WhitePaper_ResponseFromBoardAnnex1.pdf [accessed 8 June 2011]

¹⁰¹ CHRE. 2011. *CHRE response to: Healthy Lives, Healthy People: Our strategy for public health in England*. http://www.chre.org.uk/_img/pics/library/pdf_1299078307.pdf [accessed 8 June 2011]

¹⁰² Department of Health. 2011. *Enabling Excellence: Autonomy and Accountability for Health and Social Care Staff*. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124359 [accessed 8 June 2011]

¹⁰³ CHRE. 2011. *Professional Standards Authority Scheme for Assured Voluntary Registers Discussion paper (draft—30 April 2011)*. http://www.chre.org.uk/_img/pics/library/Item_11_Paper_07_-_Accreditation_Scheme_for_Assured_Voluntary_Registers.pdf [accessed 8 June 2011]

¹⁰⁴ Faculty of Public Health. *Senior public health consultant appointments: employer’s guidance*. http://www.fph.org.uk/uploads/Employers_guidance.doc [accessed 8 June 2011]

constructive provisional discussions with UKPHR about developing relevant and functional standards for accreditation.

FURTHER INFORMATION

16. We would be pleased to expand on any of the areas we have discussed if that would be useful to the Committee.

June 2011

Written evidence from The Prostate Cancer Charity (PH 69)

1. INTRODUCTION

1.1 Prostate cancer is the most common cancer in men in the UK. Each year 37,000 men are diagnosed¹⁰⁵ and 10,000 men die from the disease.¹⁰⁶ 250,000 men in the UK are living with and beyond the disease.¹⁰⁵

1.2 The Prostate Cancer Charity herein “the Charity” is the UK’s leading charity working with people affected by prostate cancer. The Charity funds research, provides support and information, and campaigns to improve the lives of men with prostate cancer.

1.3 The Charity provides the most comprehensive range of services dedicated to prostate cancer providing vital support for everyone affected by the disease, including men concerned about the disease as well as men who have been diagnosed, their partners, friends and families.

1.4 In this submission the Charity provides written evidence about the potential impact of the Governments proposed changes to the organisation of public health services on prostate cancer care in England.

1.5 The Charity would also welcome the opportunity to provide a witness to give oral evidence to the Committee on the issues raised.

2. EXECUTIVE SUMMARY

2.1 The Charity welcomes the opportunity to contribute to the Health Select Committee’s inquiry on public health and would like to raise the following points in our evidence submission:

2.1.1 The Charity welcomes the proposals set out in the Department of Health’s Public Health White Paper to establish a public health services which will be “*created to ensure excellence, expertise and responsiveness.*”¹⁰⁷

2.1.2 As the most common cancer affecting men in the UK prostate cancer is a public health issue. In the absence of a national screening programme, all men should be able to make an informed choice about the PSA test—a simple blood test that helps to identify a man’s risk of having prostate cancer.

2.1.3 The Charity is concerned by the lack of clarity about where the responsibility for commissioning and developing information about prostate cancer and the PSA test will lie in the new public health system. The Department of Health needs to clarify how information on PSA testing will be commissioned under the new public health structures.

2.1.4 Currently, very little is being done to improve men’s awareness of prostate cancer and the tests available to them. The National Awareness and Early Diagnosis Initiative (NAEDI) does not currently address prostate cancer awareness but has the potential to do so in the future. The Department of Health must clarify how NAEDI will be incorporated within Public Health England’s remit.

2.1.5 Devolving power to local authorities creates an opportunity for the development and delivery of targeted awareness campaigns that reach men at higher risk of prostate cancer. However, local authorities will need to be provided with adequate support, guidance and expertise to carry out their new functions as set out in the White Paper.

2.1.6 Careful planning must be undertaken to address the different geographic and administrative boundaries between local authorities and NHS organisations to ensure there are no gaps in public health services and initiatives, leading to the exclusion of some populations.

2.1.7 Indicators should be included within Domain 4 of the Public Health outcomes Framework to measure awareness and uptake of the PSA test to ensure that all men have the opportunity to make an informed choice about the test. An additional indicator is needed to measure the “take up of the NHS Health Check programme”.

¹⁰⁵ Cancer Research UK (2011). Prostate cancer—UK incidence statistic.
<http://info.cancerresearchuk.org/cancerstats/types/prostate/incidence/>

¹⁰⁶ Cancer Research UK (2011). Prostate cancer—UK mortality statistics.
<http://info.cancerresearchuk.org/cancerstats/types/prostate/mortality/>

¹⁰⁷ Department of Health (2010). Healthy Lives, Health People: Our strategy for public health in England.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127424.pdf

2.1.8 Steps must be taken to improve GPs' awareness of public health issues, including prostate cancer. GPs should receive training to enable them to proactively engage with men at higher risk of prostate cancer about their risk of the disease, the PSA test and the options available to them.

2.1.9 Educating primary care nurses and Community Health Champions to deliver key messages about prostate cancer and the PSA test would be an effective and cost effective way of raising awareness of the disease.

3. BACKGROUND: PUBLIC HEALTH AND PROSTATE CANCER

3.1 As the most common cancer affecting men in the UK and the second highest cause of male deaths from cancer, prostate cancer is a public health issue.

3.2 In the UK, national screening programmes have been introduced for breast, cervical and colorectal cancers, helping to reduce mortality from these diseases. However, there is currently no prostate cancer screening programme. This leaves men at a significant disadvantage.

3.3 Currently, the UK National Screening Committee (UK NSC) advise against the introduction of a national screening programme for prostate cancer using the PSA test because evidence indicates that such a programme would lead to significant levels of over-diagnosis and potential over-treatment of the disease.

Box 1: The PSA test

The PSA test is a simple blood test that can indicate whether a man has a problem with his prostate. This problem may be prostate cancer but it could also be a benign condition, such as Benign Prostatic Hyperplasia. Currently, the PSA test cannot be used in a national screening programme because it cannot diagnose prostate cancer. It is also unreliable and can lead to a significant number of false positive and false negative results. Despite its limitations, it is the best available tool to help a man identify his risk of prostate cancer.

3.4 The Charity currently supports the UK NSC advice. However, recent research tells us that some men will benefit from having their prostate cancer diagnosed earlier when it has a greater chance of successful treatment.^{108, 109} This creates a need for all men at higher risk of prostate cancer to have the opportunity to consider the pros and cons of having a PSA test and make an informed choice about whether it is right for them.

3.5 To make an informed choice about the PSA test men need first to be aware of prostate cancer and the test. They then need information and one-to-one support from a health professional to guide them through the decision making process. The UK NSC recommend that in the absence of a screening programme men should be able to make an informed choice about the PSA test. In response, the Department of Health have developed the Prostate Cancer Risk Management Programme (PCRMP)¹¹⁰ to ensure that men who are concerned about the risk of prostate cancer receive clear and balanced information about the advantages and disadvantages of the PSA test and treatment for prostate cancer. The Programme consists of an information pack that has been sent to GPs across the country to assist them in the counselling of men who enquire about testing.

3.6 Aside from the review and redistribution of the PCRMP in 2009, there has been no significant activity to improve awareness and early diagnosis of prostate cancer since the publication of the Cancer Reform Strategy in 2007, and the condition has not been a priority for the National Awareness and Early Diagnosis Initiative.¹¹¹

4. COMMISSIONING OF PUBLIC HEALTH SERVICES

The Prostate Cancer Risk Management Programme

4.1 The Charity's primary concern about the proposed changes to the organisation of public health services in England is that there is currently no clarity about where responsibility will lie for commissioning and providing information to men about prostate cancer and the PSA test.

4.2 The *Healthy Lives, Healthy People* strategy proposes that Public Health England should be responsible for funding and ensuring the provision of screening programmes already in place.¹¹² In the absence of a screening programme for prostate cancer, the Department of Health must ensure that measures are in place to provide information about prostate cancer and the PSA test to men so that they have the opportunity to make an informed choice.

¹⁰⁸ Schröder, F H et al. (2009). Screening and Prostate-Cancer Mortality in a Randomized European Study. *New England Journal of Medicine*: 360;13.

¹⁰⁹ Department of Health (2011). The Likely Impact of Earlier Diagnosis of Cancer on Costs and Benefits to the NHS. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123576.pdf

¹¹⁰ NHS Cancer Screening Programmes (2011). Prostate Cancer Risk Management Programme. <http://www.cancerscreening.nhs.uk/prostate/index.html>

¹¹¹ Cancer Research UK (2011). Find out about the National Awareness and Early Diagnosis Initiative. <http://info.cancerresearchuk.org/spotcancerearly/naedi/AboutNAEDI/>

¹¹² Department of Health (2010). *Healthy Lives, Health People: Our strategy for public health in England*. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127424.pdf

4.3 The Charity would welcome clarity about how information on PSA testing will be commissioned and funded in the future, as well as the agency that will be responsible for producing and disseminating relevant information and guidance to GPs about PSA testing.

4.4 Changes to public health services should also take into account the current problems with the delivery of information to men about prostate cancer and the PSA test through the PCRMP. Currently for men to access information through the PCRMP they must first be aware of prostate cancer and the PSA test. Then they must also visit their GP for advice. However, two thirds of men over 50 are unaware of the PSA test.¹¹³ In addition, one in five GPs never talk about the test with at-risk groups, unless they have potential symptoms of prostate cancer,¹¹⁴ despite early stage prostate cancer often having no symptoms. This means many men are not able to make an informed choice about whether to take the test.

Awareness raising

4.5 Section 4.3 of the strategy outlines that Public Health England is to also receive a ring-fenced budget. Clarity is needed about the manner in which initiatives such as the National Awareness and Early Diagnosis Initiative (NAEDI) will be incorporated within the remit of Public Health England. It is vital that the work of NAEDI continues to complement other work that aims to improve cancer services and outcomes, which are currently largely led by the Department of Health. Improvements in cancer outcomes will be best achieved through a combination of activities at local, regional and national levels, and as such, these activities must be delivered in a cohesive manner rather than in isolation. The Charity is keen to work with the Secretary of State for Health, the Chief Medical Officer and Public Health England to improve men's awareness of prostate health issues.

4.6 To reduce mortality from prostate cancer, it is essential to increase the numbers of men with aggressive forms of the disease diagnosed at a stage when the cancer is amenable to treatment and decrease the numbers diagnosed with advanced disease. There has not been significant activity to improve awareness and early diagnosis of prostate cancer since the publication of the Cancer Reform Strategy in 2007, and the condition has not been a priority for NAEDI.

4.7 Increased and appropriate awareness work needs to be carried out to ensure all men are aware of prostate cancer, prostate cancer risk and the potential signs and symptoms of the disease. However, raising awareness is complex because there is no national screening programme for prostate cancer to direct people to and early stage disease often has no symptoms. **National and local prostate cancer awareness campaigns to promote informed choice about the PSA test need to be funded and carried out in close partnership with the voluntary sector and informed by the target audience.**

4.8 It is critical that activities undertaken to improve public health are evidence-based and we welcome the emphasis on this as set out in the Public Health White Paper.¹¹³ However, further detail on what types of evidence will be included in informing the public health evidence base is needed.

4.9 Programmes are already underway which aim to provide evidence about how interventions may be effective in raising awareness of cancer, such as the NAEDI. However, prostate cancer has to date been omitted from this initiative.

4.10 Through the Charity's *Testing Choices* campaign, pilots to test new ways of providing information to men about the PSA test will take place. These pilots will provide new evidence about how best to raise awareness of prostate cancer and enable men to make an informed choice about the PSA test. The Charity would welcome the opportunity to share the findings from these pilots and work with Public Health England and local governments to develop awareness campaigns.

4.11 Public Health England should make funding available for national and local prostate cancer awareness campaigns, which should be carried out in close partnership with the voluntary sector and informed by the target audience.

4.12 As Public Health England will be responsible for commissioning health checks, the Charity also recommends that a wider range of conditions is discussed with men at the NHS Health Check. This check offers an excellent opportunity to provide information about prostate cancer and the pros and cons of PSA testing targeted at higher risk men. The Charity could provide advice on how best to approach this.

5. NEW ROLE OF LOCAL GOVERNMENT

5.1 The Charity broadly welcomes the decision to give local authorities responsibility for commissioning public health services locally as they will be best suited to understand the public health needs of local populations. Targeted approaches to raise awareness of prostate cancer and the PSA test are needed to ensure men at higher risk of the disease have the opportunity to make an informed choice about the test. **Devolving**

¹¹³ Department of Health (2010). Healthy Lives, Health People: Our strategy for public health in England. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127424.pdf

¹¹⁴ Kantar Health conducted web based interviews on behalf of The Prostate Cancer Charity with 505 GPs from England and Scotland drawn from TNS healthcare professional panels. Interviews took place in February 2011. A quota was set to achieve a sample of 94 GPs based in Scotland. Kantar Health is a member of the Market Research Society and this study has been conducted in accordance with ISO 20252

power to local authorities creates an opportunity to commission targeted prostate awareness campaign. However, the Charity is concerned that local authorities will be expected to broaden their remit significantly and steps must be taken to ensure that they have sufficient capacity, resources and insight into delivering this role effectively.

5.2 In addition, careful planning must be undertaken to address the different geographic and administrative boundaries between local authorities and NHS organisations to ensure there are no gaps in public health services and initiatives, leading to the exclusion of some populations.

5.3 The Charity supports the establishment of local health and wellbeing boards which will play an important role in ensuring greater integration of NHS, public health and social care services. When developing their Joint Health and Wellbeing Strategies (JHWS) and Joint Strategic Needs Assessments (JSNAs), local health and wellbeing boards should work with the emerging clinical commissioning consortia to tackle variations and take steps to improve outcomes for men at risk of developing prostate cancer and those already diagnosed with the disease.

5.4 Recent figures published by the Charity have continued to show disparity in the rate of deaths across England—with twice the rate of deaths in Sandwell than in Kensington and Chelsea.¹¹⁵ The data on death rates from prostate cancer, averaged over a three-year period (2007–09), reveals a two-fold variation between Primary Care Trust (PCT). Of the 151 PCTs in England, 24 have a mortality rate which is more than 10% above the national average of 24 deaths per 100,000 of the population.¹¹⁵

5.5 Through national support and guidance, health and wellbeing boards will need to take steps by working with local NHS commissioners, to address these unacceptable variations by raising awareness of prostate cancer locally among those most at risk of developing the disease and the treatment options available to them.

5.6 The Charity believes voluntary sector involvement in designing and delivering public health services is important and we welcome proposals for Directors of Public Health to work “*in partnership with the local NHS and across public, private and voluntary sectors*” when seeking to deliver improvements to health inequalities locally.¹¹⁶ This will be particularly important when seeking to improve public health outcomes for cancer.

5.7 Raising awareness of prostate cancer is a complex issue and many local authorities will not necessarily have the specialist expertise to undertake work in this area. Organisations such as The Prostate Cancer Charity have the experience and expertise to guide and inform public health initiatives (see Box 2)—supported by input from our service users—in order to make certain that the right information is provided in the right way.

5.8 Health and wellbeing boards should be encouraged to actively seek to engage with voluntary organisations when developing JSNAs, JHWSs and wider public health initiatives.

Box 2: The Prostate Cancer Charity Older and Wiser project

The Older and Wiser project, run by the Charity between 2007 and 2010, raised awareness of prostate cancer amongst African Caribbean groups in three London boroughs (Newham, Hackney and Lambeth). Volunteers were trained and supported to raise awareness in their local community, for example by giving talks to local community groups or holding information stands at local events. Amongst other results, we demonstrated that:

- It is effective to have a programme that is user-driven and adapted to reflect the community’s needs and settings.
- Community champions are useful because they: know their community; know how to communicate effectively with their audience; and devise innovative ways to get health messages across.
- Educating men about their rights to information and PSA testing increases willingness to visit a GP with concerns about prostate cancer.

6. THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

6.1 While uptake of “*national screening programmes*” is a proposed indicator of Domain 4 in the proposed Public Health Outcomes Framework, the Charity is concerned that there are no indicators designed to encourage local public health commissioners to promote the provision of information on other forms of testing.

6.2 The Charity has highlighted above (see points 4.1 to 4.4) the need for clarity over the commissioning of information about prostate cancer and the PSA test to ensure that men are able to make an informed choice about the test. To support the commissioning of this information, indicators will also be required within Domain 4 of the Outcomes Framework regarding awareness and uptake of the PSA test. The “take up of the NHS Health Check programme by those eligible” should also be included as an indicator to measure provision of this service across the country.

¹¹⁵ Hansard, 9 February 2011, Col. 361W:

<http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110209/text/110209w0006.htm>

¹¹⁶ Department of Health (2010). Healthy Lives, Health People: Our strategy for public health in England. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127424.pdf

6.3 Local partnerships need to have access to, or be able to derive, the relevant data to identify inequalities in their area. In many areas of health we lack the necessary data to identify any inequalities that may exist. For example, data on the clinical outcomes from prostate cancer of people from particular ethnic or socio-economic backgrounds has not been routinely collected. As such it will currently be difficult to assess which groups within local populations need to be targeted to improve prostate cancer awareness. Furthermore, to ensure the Outcomes Framework can contribute to a reduction in health inequalities the collection of outcomes data must include information on different demographic factors, such as locality, age, ethnicity, sexuality, disability and socio-economic background.

6.4 The Charity believes that an indicator relating specifically to men's health should also be included in the Outcomes Framework under Domain 5. This would encourage local authorities and their NHS partners to take action over time to address the causes of premature mortality among men.

7. FUTURE OF THE PUBLIC HEALTH WORKFORCE

7.1 The Charity welcomes the proposals to "*strengthen the focus on public health issues in the education and training of GPs.*"¹¹⁷ The Charity believes this training should include information about how to *proactively* engage with men about prostate cancer (particularly those at higher risk of developing the disease) and to discuss the disease and all of the options available to them, including the PSA test.

7.2 GPs are often the first point of contact for men concerned or at risk of developing prostate cancer. As a result, it is vital that they are adequately trained and educated on public health issues.

7.3 Findings from a survey conducted by the Charity found that two thirds of GPs were unaware of the Prostate Cancer Risk Management Programme.¹¹⁸ This is despite efforts by the Department of Health to promote and disseminate a revised resource pack to GPs about the programme between July 2009 and March 2010.

7.4 If investment is targeted towards increasing public awareness about health conditions, prompting them to seek professional help when they have concerns, it is vital that GPs are aware of the latest programme and also motivated and able to implement them. Only then will we be in a position to ensure that all men at higher risk of prostate cancer are able to exercise their right to an informed choice about whether or not to have a PSA test.

7.5 The Charity is interested to see that the strategy recognises the importance of Community Health Champions. Educating community champions to take key messages into their community would be an effective and cost effective way of raising awareness of prostate, and other, cancers. The Charity has experience of training community champions to take these messages to their communities (see Box 2) and is willing to share its experience with local authorities.

7.6 The Charity will also be piloting the provision of a primary care nurse-led service to deliver information to men about prostate cancer and the PSA test, as a time and cost saving alternative to the PCRMP model of delivering this information through the GP.

June 2011

Written evidence from University College London's Division of Population Health (PH 70)

SUMMARY

Our response focuses on five of the committee's areas of inquiry:

1. The future role of local government in public health.
2. Arrangements for public health involvement in the commissioning of NHS services.
3. Arrangements for funding public health services (including the Health Premium).
4. The future of the Public Health Observatories.
5. How the Government is responding to the Marmot Review on health inequalities.

¹¹⁷ Department of Health (2010). Healthy Lives, Health People: Our strategy for public health in England. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127424.pdf

¹¹⁸ Kantar Health conducted web based interviews on behalf of The Prostate Cancer Charity with 505 GPs from England and Scotland drawn from TNS healthcare professional panels. Interviews took place in February 2011. A quota was set to achieve a sample of 94 GPs based in Scotland. Kantar Health is a member of the Market Research Society and this study has been conducted in accordance with ISO 20252

1. *The future role of local government in public health*

- Consultants and Directors of Public Health need to be vested with the necessary independence and authority to advise public authorities and implement evidence-based policies in health promotion, disease prevention and health services provision. A mechanism to achieve this is to transfer the NHS based public health workforce to an NHS Special Health Authority or an Executive Agency called Public Health England. This body should retain control of the public health budget to ensure investment in Public Health is retained.

2. *Arrangements for public health involvement in the commissioning of NHS services*

- Commissioning consortia should be required to fully involve and be effectively supported by public health consultants in the commissioning and evaluation of services. These are both key areas of Public Health expertise.
- GP commissioning consortia must ensure that robust responsibility—monitoring—accountability frameworks are in place to improve population health across the social gradient.

3. *Arrangements for funding public health services (including the Health Premium)*

- The basis on which the health premium is awarded is crucial. The current proposal may widen health inequalities. A UCL research team was recently funded by the Advisory Committee on Resource Allocation (ACRA) to review and suggest improvements for the health inequalities element of the NHS weighted capitation formula. Their recommendations should be considered with respect to both the allocation of commissioning funds to GP consortia and to ring fenced public health budgets to local authorities.

4. *The future of the Public Health Observatories*

- To achieve effective surveillance and health intelligence at population level, including that provided by the Health Observatories, these functions must continue to operate at regional levels.
- Further investments in data linkage would significantly improve the value of routinely available data. The regulatory frameworks for sharing patient information across organisational boundaries should be reviewed.

5. *How the Government is responding to the Marmot Review on health inequalities*

- To achieve its stated commitment to aims of the Marmot Review, we urge the Government in committing to evidence based policy making, to include regulation, legislation, taxation and subsidy, where voluntary responsibility deals fail within a reasonable and agreed timescale.
- Improving the implementation and dissemination of evidence based public health requires an embedded public health research culture within public health systems. Joint appointments and a stronger research training component between and within academic and service units can facilitate this.

1. *The future role of local government in public health*

1.1 The challenges associated with implementing the proposed reforms in the context of efficiency savings and major restructuring of the NHS has been widely discussed. However, with respect to public health practitioners' ability to deliver on improving health and reducing health inequalities through the new structures proposed, we predict that the anticipated lag in implementation¹¹⁹ will be compounded by the 28% budget reduction to local government.¹²⁰ Of particular significance are any proposed cuts in services that invest in children's and young people's development. Furthermore there is a danger that public health priorities will be downgraded and that the public health budgets will be "re-designated" in ways that were never contemplated.

1.2 Consultants and Directors of Public Health need to be vested with the necessary independence and authority to implement evidence-based public health policies both within and outside the NHS. A mechanism to achieve this is to transfer the existing NHS based public health workforce to a new body which could be still called Public Health England. This body would ideally be an NHS Special Health Authority or an Executive Agency. This idea was published in a recent *Lancet* article and has received widespread support from the public health community.¹²¹ In addition to independence, this model would allow Directors of Public Health to retain control over the public health budget ensuring that sound investment in a professional Public Health service is retained; supported by a critical mass of public health expertise. It will be crucial for Directors of Public Health to be accorded the necessary standing within Local Authorities to promote and safeguard the

¹¹⁹ Walshe K. Reorganisation of the NHS in England. *BMJ* 2010;341:c3843.

¹²⁰ HM Treasury Spending Review: "There will be overall savings in funding to councils of 7.1% a year for four years." http://www.hm-treasury.gov.uk/spend_sr2010_speech.htm

¹²¹ McKee, M, Hurst, L, Aldridge, R W, Raine, R, Mindell, J S, Wolfe, I, Holland, W W Public health in England: an option for the way forward? *The Lancet*, Early Online Publication, 28 February 2011. doi:10.1016/S0140-6736(11)60241-9.

health of the population and to have the capacity to influence wider local authority budgets, for example in housing.¹²²

2. Arrangements for public health involvement in the commissioning of NHS services

2.1 The third domain of public health expertise, that of efficient, equitable and effective health services, is largely overlooked in the Public Health White Paper.

2.2 We urge the Government to ensure that commissioning consortia are required to involve public health consultants (and clinicians) in the commissioning and evaluation of health services. This is crucial given the Government's policy of maximising competition and the number of providers and the revisions to the Health and Social Care Bill, which removes the duty of the Secretary of State to provide comprehensive care.

2.3 These arrangements may impact on population health and widen inequalities through:

- Introducing inequalities between areas: The Bill requires each commissioning consortia to provide only “such services or facilities as it considers appropriate.” Individual consortia may construct different definitions and criteria for the “services it considers appropriate” to provide. Given the abolition of restrictions on GP practice registration, it is likely that it will be the more affluent populations who have the resources to allow them to “shop around” for their care.¹²³
- Reducing entitlement to services for unregistered populations: the Bill states that consortia “may” have responsibility for “persons who have a prescribed connection with the consortium’s area”. However, without clear requirements for consortia to have responsibility for providing and commissioning care, unregistered residents—often vulnerable groups such as the homeless or asylum seekers—may lose access to essential healthcare.
- A shifting balance between services that address “wants” (offered as a result of market choice) versus “needs”.
- Multiple new entrants into the market for complex services (eg cancer). Here quality and outcomes have improved by focusing care within centres of excellence. This was achieved by *reducing* the number of providers and patient choice.
- Reductions in provision or quality in some services. In particular, in situations where there are no providers, the Bill makes provision for local authorities to provide health services. Local authority provision would occur in the context of extensive local authority budget cuts; without necessary expertise and with none of the Government's proposed levers designed to drive quality or efficiency in the healthcare sector. This scenario may disproportionately affect complex chronic disease services eg services for the elderly , mental health.

2.4 For GPs to play a key role in public health, they will need to work in partnership with Directors of Public Health on Health and Wellbeing Boards. The expertise that public health consultants have in the commissioning and evaluation of services should not be overlooked. Public health consultants should be fully involved and effectively support by GP commissioners in this role.

2.5 GPs will need to adopt a public health perspective and understanding of epidemiological principles of relevance to commissioning decisions in partnership with local Public Health professionals. This can be achieved by inclusion in undergraduate training and GP postgraduate curricula.¹²⁴ Of particular relevance for commissioning to improve public health are the population needs assessment, the annual report (on health improvement, protection and health services) and recognition that public health requires change both within and outside the NHS.

2.6 We also recommend that responsibility- monitoring- accountability frameworks are strengthened to enable GPs to reduce health inequalities (as recommended by the Public Accounts Committee¹²⁵). This will require:

- commissioning requirements for routine data on service access and uptake to be collected by socio-demographic group (age, sex, socioeconomic circumstances, and ideally ethnic group) at each significant point in the patient pathway;
- performance standards by socio-demographic group to promote strategies to provide appropriate services solely on the basis of clinical need;

¹²² PH Outcomes framework para 27 p 13: “a small number of the indicators would focus on health improvement relating to the causes of the greatest burden on disease and death ...The rest of the indicators would cover other domains of public health, ... and reflect the wider determinants of health, to link in the different local services that play a part in delivering health and wellbeing ...”.

¹²³ House of Commons Health Committee. Commissioning. Third report of session 2010–11. Stationery Office, 2011.

¹²⁴ PH White Paper para 4.51 Public Health England will strengthen the focus on public health issues in the education and training of GPs, as part of the Department of Health's development of a workforce strategy.

¹²⁵ House of Commons Committee of Public Accounts. Tackling inequalities in life expectancy in areas with the worst health and deprivation. London: Stationery Office, 2010.

- mechanisms to be put in place to hold providers to account over whether they apply evidence based interventions to improve population health and that have been agreed during the commissioning process. The NHS Commissioning Board should identify and implement the action needed to stimulate the wider adoption of these interventions so that health care providers in all areas comply with accepted good practice; and
- strong leadership from the NHS Commissioning Board to achieve these changes.

2.7 We also recommend that:

- collection of cancer incidence data becomes a mandatory commissioning requirement;
- the Government reconsider proposals that fragment commissioning arrangements for different components of public health services particularly those for sexual health, child health and vaccinations.¹²⁶ With respect to sexual health, for example, under the current proposed arrangements, HIV falls under the NHS commissioning board, STIs are the responsibility of local authorities, and GPs will provide or commission contraception. Such an arrangement will undermine attempts to provide an integrated sexual health service; and
- appropriate mechanisms are in place to ensure the continuation of integrated collection of surveillance data on infectious diseases.

3. *Arrangements for funding public health services (including the Health Premium)*

3.1 The basis on which the health premium is awarded is crucial. The premium may not reduce health inequities if it is paid retrospectively to reward areas that have made progress in health improvement. This is because some areas may have insufficient funding to start making progress in the first place. This approach may widen health inequalities if progress is more likely to be made in more affluent areas. In addition, the total budget for the premium must be at least as big as the health inequality adjustments in council and Department of Health resource allocation formulae, otherwise inequalities may widen.

3.2 The White Paper states that the Department of Health will ask the Advisory Committee on Resource Allocation (ACRA) to support the development of its approach to allocating resources to local authorities. We suggest that DH refer to the recent review of the health inequalities elements of the NHS weighted capitation formula undertaken by a team of researchers led by Professor Steve Morris from UCL and commissioned by ACRA.¹²⁷ On the basis of their findings, we suggest that the underlying principles of the proposed health premium are clearly delineated and that the methods used to calculate it are justified.

3.3 The UCL report included proposals for improving the current health inequalities adjustment. One option could be an area-based adjustment to reduce health inequalities based on the relationship between funding and health outcomes. We suggest that these proposals are considered with respect to both the allocation of commissioning funds to GP consortia and to ring fenced public health budgets to local authorities.

4. *The future of the Public Health Observatories*

4.1 We consider the future of Public Health Observatories as part of a wider issue concerned with the availability and validity of information necessary for surveillance, monitoring of population health and planning healthcare.

4.2 Maximising the value of public health information depends upon the existence of a critical mass of skills and expertise. However the proposed removal of Regional public health intelligence and surveillance functions are likely to lead to fragmentation of public health skills. The workforce in each local authority will be too small to undertake all the required functions; they will cover a geographical area which is often too small to produce meaningful data for decision making for rare serious outcomes; there will be duplication of tasks in neighbouring local authorities and loss of the ability to disseminate learning or to develop specialist knowledge, which will have a deleterious impact at both organisational and individual levels.

4.3 Moreover, the combination of actual and threatened job cuts and structural changes to surveillance and monitoring functions (eg abolition of the HPA) may lead to loss of capacity. There is therefore a genuine risk to the *existing* availability of information. This may lead to gaps in surveillance and monitoring and directly affect our ability to produce robust data to inform public health policy and in particular to reduce health inequalities.

4.4 We therefore urge the Government to ensure that public health intelligence and surveillance functions continue to operate at regional levels within Public Health England. During this current state of uncertainty we advise that interim surveillance and monitoring systems are established to prevent loss of data collections. We also recommend that current robust systems of surveillance and monitoring are enshrined in commissioning requirements.

¹²⁶ PH Funding and Commissioning Routes consultation, Table A, pp16–26; PH White Paper para 3.43 We will work towards an integrated model of service delivery to allow easy access to confidential, non-judgemental sexual health services.

¹²⁷ Morris, S *et al* Research on the health inequalities elements of the NHS weighted capitation formula. Final report. 2010. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_122620.pdf

4.5 The utility of public health information and intelligence could also be significantly enhanced by linking individual patient data on social determinants, behaviours and outcomes. This is possible and currently used to powerful effect in Scotland. However, in England, systems have moved backwards in this area. To enable faster and more extensive data linkage, we recommend that investment is made in data linkage systems and that the regulatory frameworks for sharing patient information across organisational boundaries are reviewed and simplified. Adequate funding of the UK Data Archive's proposed secure data function will address many problems.

4.6 With an increase in private healthcare providers, there is a significant risk of losing comprehensive datasets on the pretext of commercial confidentiality. There is evidence that an increase in private provision has already had this effect, seriously compromising the capacity of regulators to monitor the quality of patient care.¹²⁸ In addition, the Government's consultation paper, *An Information Revolution*, proposes to increase the range of information providers. In contrast to current central data collections, which provide NHS data analysts with full access to data and have transparent methods for their analysis, **there is a risk that commercial sensitivity may present barriers** to sharing data, including sources and methods of analysis. We recommend that it is mandatory for all providers of NHS health care and information on healthcare to collect, provide and make available data on the same basis and to the same standards as the NHS.

5. *How the Government is responding to the Marmot Review on health inequalities*

5.1 The Government states that the White Paper responds to Professor Sir Michael Marmot's *Fair Society, Healthy Lives* and that its strategy for public health is evidence driven. With this in mind, we draw the Government's attention to the research evidence which, if acted upon, is likely to produce the greatest public health impact.

5.2 Tobacco control: We welcome the Government's announcement on the removal of tobacco displays in shops and their commitment to look further at tobacco packaging. Research evidence on the effects of plain packaging consistently shows that package brand imagery reduces the impact of health warnings. The Australian government is well advanced with this intervention. We urge to Government to implement this policy and independently evaluate it without delay.

5.3 Voluntary "responsibility deals" have been agreed with industry to remove artificial trans fats, to reduce salt content in manufactured food and to display nutritional information in restaurants and takeaway outlets. However, long established voluntary codes have yielded consistently disappointing results. We therefore urge the Government to commit to the implementation of regulation if these voluntary measures fail within a reasonable and agreed timescale. In addition we urge the Government to accept widespread expert advice to implement an effective minimum price for a unit of alcohol (ie £0.50 a unit minimum).

5.4 Insights from behavioural science clearly demonstrate that behaviour change campaigns only modestly increase knowledge and modify attitudes and have minimal effects on long term behaviour changes (Appendix). Moreover, there is comprehensive, long standing 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. Finally, strategies which rely on individual behaviour change generally widen health inequalities because the most socially advantaged people are more likely to have the material or psychological resources to promote risk avoidance and to adopt protective strategies.

5.5 In sum, we believe that there is compelling evidence in a number of areas of a greater impact of regulatory policies at the population level in comparison to individual approaches alone, for improving health and reducing health inequalities.

6. *The future of the public health workforce (including the regulation of public health professionals)*

6.1 We support Dr Gabriel Scally's recommendations for statutory regulation of non-medical public health consultants. Consultants in public health and public health medicine are eligible for the same professional roles and increasingly have undergone the same specialist training. Therefore, it is a logical and necessary progression to make both subject to statutory regulation.

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¹²⁸ Godden and Pollock, 2008. Independent sector treatment centres: evidence so far. *BMJ*.336; 421-424.

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June 2011

APPENDIX

DIETARY INTERVENTION VERSUS NO INTERVENTION AMONG HEALTHY PEOPLE. SYSTEMATIC REVIEW OF RANDOMISED CONTROLLED TRIALS

The Cochrane review examined the effects of one-to-one or group dietary advice with or without printed materials in healthy people. The findings using objective as opposed to self-report outcomes show that advice is, at best, a weak intervention. It will not generate the health gain and financial saving to the public purse the Government is looking for if systematic change in UK food culture and obesogenic environment is not pursued.

Outcome	N studies	N participants	Net change (85%CI)
Systolic BP (mm Hg)	8	6,223	-2.1 (-3.2 to -1.0)
Diastolic BP (mmHg)	8	6,223	-1.2 (-1.9 to -0.5)
Serum cholesterol (mmol/l)	17	2,124	-0.2 (-0.3 to -0.1)

Median follow-up =10 months, range 3–48 months.

Source: Brunner et al. *Dietary advice for reducing cardiovascular risk. Cochrane Database of Systematic Reviews 2007 (CD002128)*

Written evidence from Child Accident Prevention Trust (PH 71)

“...illness and injury can have a long-lasting impact on a young person’s life and ultimately on their life chances and therefore on our economy and society. In turn this can impact significantly on their family’s life. So this matters for all of us.”¹²⁹

1. SUMMARY

We believe that the following priorities are key to the development and implementation of new proposals for public health organisation and delivery. A new approach to public health should:

- retain a strong focus on children and young people;
- ensure that child injury prevention, with its extensive links to the wider determinants of health and health inequalities, is recognised throughout this process and during the subsequent transition period as an essential and fundamental prerequisite of children’s wellbeing; and
- ensure the retention of the proposed key drivers for improvement, including health and wellbeing boards and the hospital admissions/child injury indicators of the draft Public Health Outcomes Framework.

2. BACKGROUND

The Child Accident Prevention Trust (CAPT) is the UK’s leading charity working to reduce the number of children and young people killed, disabled or seriously injured in preventable accidents, and thereby enhance children’s life chances. We have contributed to and followed with interest the continuing debate and discussion on the planned NHS reforms. We have been actively involved in strategic leadership events such as the Public Health Congress. **We would like to use the opportunity of the Public Health inquiry to reinforce what we believe should be key considerations for ensuring the health, safety and wellbeing of children and young people.**

3. Childhood accidental injury is one of the biggest killers of children, second only to cancer. In 2009, 193 children and young people under 15 died in accidents in England and Wales. 105,000 children and young people under 18 were admitted to hospital as a result of unintentional injuries in 2007–08. Children from the poorest families are 13 times more likely to die from accidental injury and three times more likely to be admitted to hospital with serious injuries. **Child injury prevention is therefore a significant public health and inequalities issue.**

¹²⁹ *Achieving equity and excellence for children: How liberating the NHS will help us to meet the needs of children and young people* Department of Health, September 2010
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119449

4. KEY CONSIDERATIONS

(i) *Ensuring a focus on children and young people*

We share the concern, expressed by many practitioners, that the debate on NHS reforms has, once again, marginalised the role of children and young people. This is in spite of:

- the conclusions of the **Kennedy Review** that services for children and young people have a low priority; that many GPs have little or no experience of paediatrics as part of their professional training, and that the investment in services for children and young people is at its lowest in the early years;¹³⁰
- the findings of the **King's Fund** inquiry that despite the potential to promote the health and wellbeing of the population covered by GP practices, *there has been little success in drawing GPs 'beyond the surgery door'*, and GPs still concentrate on clinical activities;¹³¹
- the commitment—clearly set out in *Achieving equity and excellence for children*—to improve experiences and outcomes for children and young people through “strong joint arrangements and local partnerships”; and¹³²
- **the moral, social and economic imperatives** to use every opportunity to improve prevention and to reduce the numbers of children admitted to hospital or attending A&E departments. With unintentional injury resulting in over 100,000 hospital admissions each year among under 18s in England, we strongly endorse the evidence-based finding that *“too many children are admitted to hospital ... it should not be forgotten that admission is traumatic and distressing for the child and his or her family and it is a very expensive option.”*¹³³

(ii) *Ensuring that children's safety and wellbeing are at the heart of action to address inequalities*

5. The wellness and wellbeing of children, and the positive impact this has on “starting well”, “developing well” and future life chances, depends on children being able to lead fulfilling, active lives which are free from the disabling effect of serious accidental injury. The strong links between preventable childhood injury and deprivation underline the fact that this should be a key priority for action to tackle health inequalities.

6. Given the wider determinants that influence children's safety and wellbeing—including families and parenting, housing and the built environment, roads and traffic, and community development—there is strong evidence of the need for effective joint working to reduce unintentional childhood injury. The experience of successful local partnerships confirms that a coordinated approach contributes to the achievement of wider health and wellbeing benefits for children and young people.

(iii) *Ensuring that the new public health system incorporates drivers for children's safety*

7. At a time of scarce resources—for health and local authorities alike—it is clear that there must be strong and explicit drivers for improvement as a focus for local accountability, ownership and joint working. Through our first hand experience of working with local services, and as part of the *Making the Link* programme, we recognise how challenging it can be in practice to bring together health and local authority specialists and to achieve greater integration around shared aims, common ‘language’ and organisational cultures.

8. Health and wellbeing boards, and the draft public health outcomes framework (with “lifecourse” indicators which include children's hospital admissions due to unintentional injury), are therefore vital to the success of the new public health system.

9. CAPT's original response to the consultation on funding and commissioning routes for public health stated that: *“The health and wellbeing board will be a key driver for the kind of local action and partnership work which has characterised good practice in the field of child injury prevention. Coordinated planning and partnership working is, for example, at the heart of the evidence-based recommendations contained in NICE public health guidance on preventing unintentional injuries among under-15s”*¹³⁴. *To achieve the ‘deep and productive partnerships’ envisaged in the DH Next Steps document, it is appropriate that health and wellbeing boards are the right place to bring together ring-fenced public health and other budgets.”*

10. We were therefore concerned to read the Commons Health Select Committee recommendation that the proposal to establish Health and Wellbeing Boards “should be dropped”, This was in spite of the Committee's agreement that *‘it is important to encourage the development of collaborative working between NHS*

¹³⁰ *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs.* Department of Health, September 2010

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119445

¹³¹ *Improving the quality of care in the general practice: report of an independent inquiry commissioned by The King's Fund* March 2011 http://www.kingsfund.org.uk/publications/gp_inquiry_report.html

¹³² http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119449

¹³³ *Fundamentals of Commissioning Health Services for Children Child Health and Maternity Partnership*, March 2011

<http://www.chimat.org.uk/resource/item.aspx?RID=106744>

¹³⁴ <http://www.nice.org.uk/ph29>

commissioners and local authorities’ and the need to broaden the basis of stakeholders who are involved in the NHS commissioning process.”¹³⁵

11. CAPT shares the belief of many public health professionals and practitioners that the health and wellbeing boards—with their central roles in Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies—have the potential to provide a real incentive for the type of coordinated local action and ownership which is needed to address deeply entrenched public health issues. The apparent success of the invitation for local areas to establish “early implementer” health and wellbeing boards appears to suggest that this is also an approach which is rooted in reality, as opposed to more fragmented concepts.

IN CONCLUSION

Based on our experience of working closely with health and local authority teams, the Child Accident Prevention Trust has been a strong advocate for changes in public health which will see greater levels of partnership working and a sharper focus on the needs of children, young people and their families. We have also argued that the safety and wellbeing of children must be explicitly included in the role of health and wellbeing boards, and in the final version of the public health outcomes framework. Finally, we believe that child accident prevention should be recognised as a public health and local partnership priority, reflecting the clear recommendations of successive studies and reports in the last 10 years.¹³⁶

June 2011

Written evidence from Office for Sexual Health, NHS South West (PH 72)

PUBLIC HEALTH COMMISSIONING OF SEXUAL HEALTH SERVICES

1. *Issue: The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)*

Response

It would improve governance of commissioning and provision of sexual health services by local authorities as well as the NHS Commissioning Board and GPs if there was a Sexual Health Partnership Sub-Group of the Health and Wellbeing Board to ensure clinically-led commissioning (similar sub-groups might be required for other public health commissioned services such as drug and alcohol services).

2. *Issue: Arrangements for public health involvement in the commissioning of NHS services*

Response

Public Health England will require a **strong framework for the NHS Commissioning Board** for its responsibilities for commissioning sexual health services such as **HIV services** to ensure a robust approach to prevention and that commissioning is **integrated with local authority responsibility for commissioning of other related sexual health services** (this could include standard service specifications across the full pathway and HIV tariff that has already been developed).

3. *Issue: Arrangements for commissioning public health services*

Response

Public Health England will require a **strong framework for local authority commissioning of sexual health services** to ensure statutory and legal duties are met and that commissioning is built on evidence and best practice (this could include **standard service specifications** that can be adapted at local level and use of **sexual health tariffs**, including those already developed).

4. *Issue: The structure and purpose of the Public Health Outcomes Framework*

Response

Public Health Outcomes framework should include sufficient sexual health indicators to ensure priority is balanced across the sexual health system from **prevention through to treatment**. Public Health England could require **local areas to develop their own outcome frameworks** to supplement the national framework and monitor this (South West have already developed a framework of sexual health outcomes for monitoring).

¹³⁵ *Commissioning: further issues—Health Committee*
<http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/796/79605.htm>

¹³⁶ See, for example: *Better safe than sorry: Preventing unintentional injury to children Health national report*, Audit Commission and Healthcare Commission, February 2007
<http://www.audit-commission.gov.uk/nationalstudies/health/publichealth/Pages/bettersafethansorry.aspx>

5. Issue: Arrangements for funding public health services (including the Health Premium)

Response

Public Health England will wish to ensure sufficient, ring fenced funding for all elements of **commissioning** sexual health building on a **tariff based approach** that addresses some of the **unacceptable variation** in spend that currently exists in contracts such as local enhanced services with primary care and the lack of clarity about funding that exists where funding is incorporated into block contracts with acute trusts.

June 2011

Written evidence from Durham County Council (PH 73)

ABOUT COUNTY DURHAM

1. Durham County Council is a large unitary authority comprising a mix of urban and rural settlements with a population of 498 706. The area is characterised by high levels of deprivation together with smaller pockets of wealth in the university city of Durham and market towns of Barnard Castle and Middleton Teesdale. County Durham has high levels of unemployment, incapacity claimants and subsequent health inequalities with male and female life expectancy in County Durham being significantly lower in County Durham than England.

INTRODUCTION

2. Durham County Council is pleased to provide evidence to the Health Select Committee's inquiry into public expenditure and public health.

3. We have focused on those areas which are of most relevance to the County Council:

Key Points

- (i) Durham County Council wholly supports the conclusion made by the Marmot Review which confirmed the role of local government as pivotal in tackling health inequalities; Local councils hold the power to secure the economic and environmental health and well-being of their population.
- (ii) The County Council therefore welcomes the proposal for local authorities to assume responsibility for public health with Directors of Public Health working within local authorities. The proposal creates the potential for greater synergy between public health interventions and the services delivered by local authorities to jointly tackle the wider determinants of health.
- (iii) The Council supports the proposal for Health and Wellbeing Boards and suggests that these could be developed along the lines of Community Safety Partnerships with similar freedoms to respond to local need.
- (iv) It is recognised that strong collaboration between Commissioning Consortia and local authorities is needed to develop a robust and evidenced based Joint Strategic Needs Assessment (JSNA). This is essential to informing the agreement of a Health and Wellbeing Strategy which articulates a shared view of commissioning priorities against which relevant agencies will be required to deliver.

THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

4. Durham County Council welcomes the proposal that local authorities should have a lead and strengthened role in Public Health. The Council believes that any action on health improvement and inequalities must address the wider determinants of health. The contribution of local authorities to these through housing, regeneration, leisure, social care, employment (direct and indirect via business support and promotion) education and children's services, is enormous.

5. A Public Health Service within Local Government can ensure that public accountability and transparency is strengthened with public health services being held to account by locally elected Councillors who have been given a mandate by their constituents and who know the public health needs of their communities.

6. Similarly there is potential for Councillors' role as community leaders to be more readily utilised to generate support to tackle the health problems in their communities, particularly those which are most deprived.

7. The severe reduction in Local Government funding arising from the Government's Comprehensive Spending Review has placed unprecedented pressures on Councils' ability to maintain service delivery. This also jeopardises Councils' ability to maintain core services that deliver against health inequalities, which could in turn result in a widening of the "health divide".

8. The resources transferred to local authorities in future should reflect the need in their area and should be no less than the historic level of funding for the relevant functions from the NHS locally. This is key to ensuring that local authority funding pressures are not augmented by cuts in Public Health services.

9. In the context of Public Health services, it would be helpful to clarify what will be the strategic ground rules for Public Health set nationally and what scope will local authorities and Directors of Public Health have for local interpretation and service design?

ARRANGEMENTS FOR THE APPOINTMENT OF DIRECTORS OF PUBLIC HEALTH

10. The Council welcomes the proposal for the Director of Public Health to be an officer of the Council and the public accountability that this will bring. This will create enhanced opportunities for democratic public debate on local health issues, for example as a result of the scrutiny process, the accountability of the Director of Public Health (DPH) to elected members and their communities.

11. There are concerns at the potential conflict of interest if the DPH is accountable to both the Local Authority and the Secretary of State for Health. This needs to be clarified and explicit in any legislation. For example it would be helpful to determine the parameters for local freedoms to act in response to local circumstances, and those situations which may require a degree of prescription from the Secretary of State for Health.

12. Whilst the Council would support the creation of a statutory DPH post in each local authority it should be for local authorities to determine the reporting arrangements for the DPH, consistent with the principles of localism. It will be essential that Directors of Public Health have the freedom and authority to work across the whole council and its partnerships, in order to realise their influence upon all council services which constitute wider determinants of health as well as to fulfil their statutory role effectively.

13. A local authority DPH will ensure closer engagement and involvement of public health services in reviewing core priorities of the Sustainable Community Strategy and Council Plan as well as reflecting any legislative developments in the field of Public Health.

14. A “core” Public Health service hosted by the local authority will be able to integrate its Public Health services with other core local authority services.

HEALTH AND WELLBEING BOARDS

15. Durham County Council notes the requirement for local authorities to establish Health and Wellbeing Boards (HWB) and supports the proposed functions for HWBs set out in the Bill. However, the County Council believes only limited prescription of the functions of the HWB from Government is required. This is because a similar approach to that taken to successfully developing Community Safety Partnerships, could be adopted; this arrangement requires local authorities to establish the Partnership and publish a plan, and makes requirements of certain other bodies to participate in the Partnership. Furthermore, there is some prescription of the issues that Community Safety Partnerships must address (for example Anti-Social Behaviour, Reducing Re-offending,) although how these are addressed is for local partners to determine.

16. The Health and Well being Board will be pivotal in ensuring that local commissioning intent reflects public health priorities, and that it is joined up and consistent across the local authority area. This is essential to avoiding inequalities in service access and outcomes arising within and across larger geographical local authority areas.

17. Durham County Council suggests there are additional functions that the HWB should perform locally, including:

- (i) The approval of Joint Commissioning Strategies and intentions.
- (ii) Receiving Scrutiny reports relating to health and wellbeing.
- (iii) Commissioning arrangements for Local HealthWatch.

JOINT STRATEGIC NEEDS ASSESSMENTS

18. A Director of Public Health based within the local authority will be able to further embed and support collaboration between the local authority and Partner Commissioning Consortia covering both current and future needs around wider health determinants.

19. We consider that with the DPH role sitting within the Local Authority there are opportunities for the preparation of JSNA with Commissioning Consortia and subsequently the monitoring of progress against the JSNA will be more robust.

20. Access to locally sensitive data will be crucial to developing the JSNA and this will be an issue for consideration in relation to the Public Health Observatories.

21. The issue of co-terminosity between Commissioning Consortia and local authorities is relevant here. There are possible difficulties in co-ordinating and managing the data flows that will inform the JSNA and the Health and Wellbeing Boards, particularly where organisations are not party to existing information sharing agreements.

JOINT HEALTH AND WELLBEING STRATEGIES

22. A collaborative approach with Partner Commissioning Consortia to developing the Joint Strategic Needs Assessment creates a strong foundation for a robust and evidence based Joint Health and Wellbeing Strategy against which all relevant agencies can deliver.

23. We welcome the commitment to integrating performance frameworks for public health, NHS and adult social care outcomes since this will support a cohesive Health and Wellbeing Strategy.

ARRANGEMENTS FOR PUBLIC HEALTH INVOLVEMENT IN THE COMMISSIONING OF NHS SERVICES

24. To achieve the benefits equated with local authorities and wider determinants of health the Public Health service should be a service wholly based/located within local councils and not split to have a “Public Health Commissioning Arm” within the Commissioning Consortia.

25. The transfer of Public Health services to local government should not be seen as an invitation for the NHS to step back from its crucial role in Public Health through providing NHS Services that promote the reduction in avoidable illness, and tackle secondary and tertiary prevention.

26. It can be foreseen that commissioning could result in a postcode lottery, resulting in an unacceptable variation in service access nationally.

27. DCC support the view that it is important to evaluate all health improvement measures to ascertain what works and its value for money in order to inform commissioning intentions.

28. DCC considers that Public Health expertise could greatly assist Commissioning Consortia to develop a population based approach to preventative health care.

29. To ensure that local authority activity can maximise its potential benefits upon health inequalities we would propose that health impact assessments should be undertaken to determine how proposed projects/programmes will impact in health and wellbeing in the local authority area. This will obviously create a need for staff to interpret findings and may necessitate protocols for sharing information and accessing data.

ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

30. Clearly all commissioning must be based upon need. The JSNA is an important commissioning tool that will assist the Council and its partners to commission services and develop interventions to improve health and address health inequalities. The Marmot review on health inequalities should provide the basis for commissioning intent in delivery of a public health agenda and action to reduce health inequalities.

31. Commissioning Consortia should reflect public health priorities and action to reduce health inequalities in their commissioning strategies drawing on all of the above. They should also be encouraged to invest further in local Public Health services where appropriate in the context of the Health and Wellbeing Strategy.

ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES (INCLUDING THE HEALTH PREMIUM)

32. The proposal to ring fence the public health budget at a local level needs to be in conjunction with freedoms to utilise the budgets flexibly to ensure Councils are not prevented from spending their budgets in smarter more collaborative ways. For example in 2009, NHS County Durham Primary Care Trust agreed to provide additional funding of £1 million to Durham County Council towards an enhanced winter service provision with a view to increased health benefits and outcomes, particularly in relation to reducing the numbers of slips, trips, falls and accidents during the winter period. This contribution was referred to in the Chief Medical Officer’s Report 2009 under the Section “Winter Kills”. The County Council considers it is essential that the new public health arrangements bring with them sufficient ring fenced resources that allow for effective whole system interventions.

33. A new health premium to reward Councils for progress made against elements of the proposed public health outcomes framework, taking into account health inequalities is to be welcomed. However such a system must be fair, robust and transparent with safeguards to ensure that other key health priorities are not excluded. Such a system must also reflect the respective baseline starting points for local authorities’ who may have experienced deep-seated health inequalities.

34. The links between poverty, social disadvantage and health inequalities are well known. There is concern that developing a health premium which measures health gain may have the unintended consequence of further depriving communities of resources where there is greatest need. This is particularly an issue in areas of high unemployment at a time of economic recession.

35. Additionally in areas where demographic projections demonstrate that the working age and economically active population will decline, with a corresponding increase in older and less advantaged groups, it would be helpful to understand how the health premium will avoid widening the health gap and augmenting possible under-funding.

36. For this reason the criteria for allocating the new Health Premium needs to be robust and transparent. The Government should also explain who will undertake the assessment of whether Councils have delivered successfully, and how this will be undertaken against a backdrop of Government reduced Performance Target setting and reporting.

37. The Council suggests that the health premium should be designed in such a way that it can also reward sustained action by local authorities as improvements in public health can take many years to achieve. The health premium should also take account of the fact that greater efforts are needed to improve entrenched health inequalities which feature in deprived communities.

38. In terms of utilising resources local authorities should be free to determine how to commission or provide public health services without prescription from the Government. Guidance however would be welcomed.

39. The Council considers that there are public health services which are better commissioned on a larger scale either nationally or regionally; paid advertising is an example where greater efficiencies can be achieved through collaboration. Unpaid and third sector media however can be more effective when commissioned at very local levels.

40. There needs to be in place robust and measurable public health outcomes. These could reflect the six Marmot policy objectives.

HOW THE GOVERNMENT IS RESPONDING TO THE MARMOT REVIEW ON HEALTH INEQUALITIES

41. The Marmot Review of Health Inequalities “Fair Society; Healthy Living” stated that reducing Health Inequalities would require delivering against the following six policy Objectives, namely:

- (i) Give every child the best start in life.
- (ii) Enable all children young people and adults to maximise their capabilities and have control over their lives.
- (iii) Create fair employment and good work for all.
- (iv) Ensure healthy standard of living for all.
- (v) Create and develop healthy and sustainable places and communities.
- (vi) Strengthen the role and impact of ill health prevention.

42. The Marmot Review identified the role of local government as pivotal with a crucial role to play in renewal of local democracy and giving citizen’s voice in developing the prospects for their local area. Local councils hold the power to secure the economic, environmental health and well-being of their population. This calls for the effective exercise of community leadership in drawing together citizens, communities and key partners to build health, well-being and resilience through transformational leadership of sustainable community strategies and health and well-being boards. These roles become even more important as understanding of the social determinants of health has developed. If inequalities in early child development and education, housing, employment and working conditions, place and the built environment, and sustainability are driven by the same causes, it requires a concerted effort across the whole system. A number of policy strands are being developed as part of the transition process for public health moving into local government. This can only strengthen what the Marmot review concludes.

43. The Director of Public Health and Local Authorities generally again are best placed to help deliver against these policy objectives, shaping their services accordingly to reduce health inequalities within their communities. These six policy objectives should form the basis of the Council’s JSNA, Health and Wellbeing Strategy and Sustainable Communities Strategy.

44. The County Council welcomes future Government guidance to clarify the points about which it has raised concern.

June 2011

Written evidence from Barbara James (PH 74)

I am making a brief submission to highlight concerns about:

- the importance of an ongoing focus on health inequalities;
- placement of the public health function and the need for statutory accountability mechanisms; and
- the benefits of and need for strong regulatory arrangements in relation to public health.

1. MY BACKGROUND

I have been freelance for the past 11 years, working internationally on a range of strategic national initiatives as well as with UK government departments (Office of the Deputy Prime Minister/ Communities and Local Government, Department for Education and Skills/Department for Children, Schools and Families, Department

of Health) as well as in the Healthcare Commission and Care Quality Commission (CQC, where I was head of public health). Before that I worked in east London in the NHS.

2. HEALTH INEQUALITIES

2.1 Under previous Conservative governments, while there were helpful and progressive national policies to address key health issues, there was not a strong strategic approach to reduce health inequalities. Indeed, health authorities were required speak of “variations” rather than inequalities. The Labour government focused on reducing health inequalities both between and within local areas.

2.2 Health inequalities are a stark reminder of how much work is needed before the UK can consider itself a fair society. A life expectancy gap of close to 30 years between the richest and poorest neighbourhoods in the UK, postcode lottery access to services and poor performance by the UK compared to similar countries must be tackled.

2.3 One of the Healthcare Commission reviews I worked on was *Are we choosing health?* (Healthcare Commission 2008), a consideration of the previous 10 years of policy and its impact on public health. It found that targets on their own often had mixed results, including “gaming” and inappropriately focused resources. However, when part of a programmed approach targets could make a significant difference. This approach includes needs-based planning, focused resources including knowledgeable staff, use of evidence-based approaches, broad-based partnership and engagement with relevant communities, measures to address wider determinants and strong performance management.

2.4 I believe that the programmatic approach to teenage pregnancy and tobacco control—while not fully achieving all targets—had considerable impact, let alone the fact that it is unlikely that teenage pregnancy (a cause and result of inequalities) would have been tackled at all without a target. However, obesity (a target under the previous Conservative government, but dropped for several years by Labour) and alcohol had had no such framework to support the targets, and much less progress was made over the period.

2.5 While national inequalities targets were not all achieved, there was tremendous progress in a large number of critical public health/health inequalities areas. It will be important to maintain a means of focusing on both national and local priorities, as well as maintaining means of comparing and measuring the differences. In addition to the now widely discredited targets, a great range of expertise was built up—for example, in the National Support Teams for a range of key health inequalities issues.

2.6 Many initiatives to tackle health inequalities have now been abolished, reduced (eg targets) or dispersed (teams of expertise in DH, PCTs, government offices, regional health authorities). It will be important to ensure the evidence-based tools, expertise and resources developed over the past 15–20 years are not lost, that “the baby is not thrown out with the bathwater”. When re-establishing programmes and initiatives for public health improvement and tackling health inequalities, it will be helpful to identify useful resources and mechanisms and to make effective use of these.

2.7 CQC’s report—*Closing the Gap*¹³⁷—on health inequalities and cardiovascular disease and smoking found that GPs in deprived areas are less likely to refer smokers to stop-smoking services or to prescribe nicotine replacement products and do not manage the cholesterol levels of their patients well.

2.8 Without technical support for lesson learning and disseminating good practice on reducing health inequalities to GP commissioners and local authorities, it will be difficult to make significant progress. Evidence of effectiveness on health improvement from, for example public health observatories and NICE, as well as the guidance on good practice by NSTs, needs more than simply being available on a website for it to be used in the field. An institution providing technical support located centrally or regionally will be essential for cost effective and effective lesson learning and delivery.

3. PLACEMENT AND ACCOUNTABILITY AND REGULATION

3.1 *Placement and accountability*

The placement of public health in local authorities has the *potential* to bring a health inequalities/health improvement approach together with the wider determinants that can have the most significant impact on these issues. However, local authorities will be challenged to cover their remit in a difficult financial climate. When located in PCTs, a focus on public health has had to be balanced with the need to address urgent treatment and care issues. In local authorities, public health will need to establish its place alongside crime, housing, education and a range of other urgent local issues.

3.2 Without a clear understanding of how (and the need) to take health into account when addressing these wider issues (for example through meaningful use of health impact assessments along with specific targeted public health interventions), many of the benefits of the placement of public health within local authorities will not be realised.

3.3 Evidence shows that GPs—with their main responsibility dealing with the ill health of individuals—are not always focused on health improvement or on reducing health inequalities (see 2.7, above).

¹³⁷ http://www.cqc.org.uk/_db/_documents/Closing_the_gap.pdf

3.4 It will be important to ensure strong, statutory accountability mechanisms between GP Commissioning Consortia and local authorities to ensure commissioning is based on and responsive to local need and that it is contributing to health improvement and reducing health inequalities.

4. REGULATION

The Healthcare Commission assessed all healthcare providers in relation to the public health elements of the *Standards for Better Health*, the quality standards for the NHS. The Healthcare Commission did research to assess the impact of this regulation and found that both in PCTs and in other trusts—acute, mental health/learning disabilities, ambulance—all respondents felt “strongly” that the inclusion of public health in the regulatory framework had resulted in significant developments in public health in all sectors.

4.1 For example, in many acute settings, no previous effort had been made to take advantage of the health promotion and disease prevention opportunities when people have experienced ill health or injury. Making public health part of the regulatory framework meant that acute trusts were beginning to take these issues into account.

4.2 A reduced focus on public health in CQC (eg there is no longer a public health function in CQC), combined with lack of specific training on public health issues and understaffing have meant that public health has not been a priority for CQC in the past year. It will be important to ensure an effective regulatory function is in place that focuses on public health. Ideally, that would be within CQC to ensure an integrated approach across health and social care.

4.3 The regulation of public health should consider the joint role of GP commissioning and local authorities in improving the health of local communities and reducing health inequalities between and within local areas.

June 2011

Written evidence from National Children’s Bureau (PH 75)

SUMMARY

- As children develop their health and wellbeing is influenced by a broad range of factors and the contribution made by a range of services has a long term impact. We are therefore particularly keen to see the Marmot Review’s call for action across all social determinants of health implemented.
- We urge the committee to consider how this broad agenda for public health can be better supported by the proposed public health structures and funding mechanism for public health, as we believe they should go further.
- Education, early years services, leisure, housing and transport policy have a significant impact on the health of children and young people. As the relevant services are largely planned and commissioned at a local level, the committee should consider how such services can have a closer relationship with the local authority’s public health functions and the operation of the health and wellbeing board.
- In addition to locally managed services, national issues such as fuel poverty and the benefits system also impact on children and young people’s health. We urge the committee to consider how Public Health England will need to work across government including with the Department for Work and Pensions the Department for Energy and Climate Change and the Department for the Environment and Rural Affairs.
- We welcome the recognition in the draft public health outcomes framework of the importance of children’s health, wellbeing and development. We urge the committee to consider how the experience of children and young people can be accurately captured and acted on and how accountability for broader public health outcomes can be secured.

ABOUT NATIONAL CHILDREN’S BUREAU (NCB)

NCB’s mission is to advance the well-being of all children and young people across every aspect of their lives. As the leading national charity which supports children, young people and families, and those who work with them, across England and Northern Ireland, we focus on identifying and communicating high impact, community and family-centred solutions. We work with organisations from across the voluntary, statutory and private sectors through our membership scheme, and through the sector-led specialist networks and partnership programmes that operate under our charitable status.

1. Local arrangements: Scope

1.1 While *Healthy Lives, Healthy People* acknowledges the role of other a range of children’s services such as schools in public health we believe that the overall strategy still underestimates the full range and extent of the impact of such services on child health and the consequent need for them to work closely together.

1.2 Schools have a key role to play in promoting better public health for children and young people and this should be reflected in the remit and planning functions of health and wellbeing boards. As a universal service

with which children and young people will have significant contact, they are well placed to identify health related problems in this part of the population and to disseminate and sign post to public health information. Engagement with other services will also enable schools to better coordinate on broader support for children and young people.

1.3 Making information and support available to young people at the right age will be crucial and have an impact on their health for the rest of their lives. *Changing Behaviour, Improving Outcomes* highlights¹³⁸ the high numbers of children and young people of secondary school age experiencing tobacco, alcohol and sex for the first time, yet detailed discussion of the role of the school in informing healthy behaviours is notably absent from this strategy paper.

1.4 Young people that attended our consultation event¹³⁹ suggested that specific actions in schools such as more discussion of healthy eating in PSHE would be helpful but also that, due to concerns about confidentiality and a desire to talk to someone who can communicate well with young people, they would want the to access public health advice from sources beyond their GP, schools and school nurses. In addition to the welcome involvement of specialist organisations such as Terrance Higgins Trust and The African HIV policy network nationally in providing alternative sources of information, the efforts of schools will need to be coordinated locally with those of other agencies to ensure that all children and young people get advice and support they need.

1.5 The way a school operates itself will also have an impact on health, and the engagement of schools with other local services will help them to tackle issues such as bullying and ensure that children with specific health needs can have those needs met in their chosen school setting. The Marmot Review also presented evidence of the strong influence on cognitive development on a persons broader and long-term health.¹⁴⁰

1.6 The contribution of early years services to public health should mean that they are placed more centrally and are an obvious partner for other services represented on health and wellbeing boards. As identified in the Marmot Review,¹⁴¹ what a child experiences during the early years lays down a foundation for the whole of their life. A child's physical, social, and cognitive development during the early years strongly influences their school-readiness and educational attainment, economic participation and health. Sure Start has the opportunity to play an unrivalled role in setting the conditions for life-long healthy living. Reductions in funding, however, may limit centres' ability to deliver health improvement among young children and families. The current proposals would mean that sure start centres do not benefit from the ring-fenced public health grant as they are funded through the non-ringfenced early intervention grant and other local government funding streams, which are reducing in size.

1.7 Active play is widely recommended as an important element in combating childhood obesity, a complex issue where, according to the government's engagement paper *Achieving equity and excellence for children* (DH, September 2010), "many agencies and groups have a role to play to deliver change, and in supporting preventative child social care". Great Britain is below the OECD average for levels of physical activity¹⁴² and recent years have seen a significant increase in the number of overweight children, with well-documented implications for long-term health and financial impact on health services. Children who do 15 minutes of exercise a day reduce their chances of being obese by 50%.¹⁴³ Research by University College London found that outdoor and unstructured play is one of the best forms of exercise for children, being more effective than many structured sporting activities.¹⁴⁴ This shows how play can have a major role in reducing obesity and its financial burden on health services.

1.8 Support for school sports is welcome. However, if physical activity is equated only with competitive sport, it will be difficult to engage many children and young people whose interests lie elsewhere. Provision of wider opportunities for physical activity and play will need to be a focus of public health interventions. Young people at our consultation event made suggestions for encouraging exercise which included: Creating a directory of local information for young people where they can access exercises and outdoor activities; Free swimming and other activities. Such actions would require partnership working leisure services, directors of public health and health and wellbeing boards.

1.9 Transport will need to be appropriately planned and coordinated for children to be able to access all of the above services and feel the associated benefits to their health. Young people at our consultation event suggested free bus service to leisure centres for young people should be a part of an effective exercise campaign.

¹³⁸ *Changing Behaviour, Improving Outcomes: A new social marketing strategy for public health*, DH (2011)pp 57–8.

¹³⁹ NCB's Voluntary Sector Support Programme developed and delivered a consultation in order to raise awareness of the policy proposals and explore what public health and wellbeing mean to young people. A programme was developed that was structured around questions contained in the formal public consultation documents. The participants came from a variety of age (11 to 18 years), geographic and service user backgrounds. A report is available here http://www.ncb.org.uk/vss/policy/consultations/young_people_and_public_health.aspx

¹⁴⁰ *Fair Society Healthy Lives: The Marmot Review*, (2010) pp 64–5.

¹⁴¹ *Fair Society Healthy Lives: The Marmot Review*, (2010) p 75.

¹⁴² OECD 2009, *Doing Better for Children Chapter 2*, OECD.

¹⁴³ *Objectively Measured Physical Activity and Fat Mass in a Large Cohort of Children*. ALSPAC, the Avon Longitudinal Study of Parents and Children, University of Bristol. *PLoS Medicine*, March 2007.

¹⁴⁴ Mackett R L (2004), *Making children's lives more active*. London: Centre for Transport Studies, University College London.

1.10 The availability of good quality housing is also key determinant of children's health so the local planning and management of housing will be very relevant to the public health functions of local authorities and health and wellbeing boards. A study carried out by Shelter in 2006¹⁴⁵ suggested that children in bad housing conditions are more likely to have mental health problems, such as anxiety and depression, to contract meningitis, have respiratory problems, experience long-term ill health and disability, experience slow physical growth and have delayed cognitive development.

1.11 Owing to the impact the impact these issues have on child health and development we urge the committee to consider how education, early years, leisure, transport and housing can be closely coordinated with the work of the health and wellbeing board and director of public health locally.

1.12 While we welcome government's commitment to provide "sufficient flexibility in the legislative framework for health and well-being boards to go beyond their minimum statutory duties to promote joining-up of a much broader range of local services for the benefit of their local populations' health and well-being"¹⁴⁶ we think the government needs to go further. An explicit duty on health and well-being boards to set and oversee a local commissioning strategy across all children's services, covering the NHS, public health, education, social care and youth, early years and other relevant services may form part of a more effective approach. Boards with such a role would substantially improve efficiency, reducing the likelihood of gaps and duplications arising from multiple commissioners. We urge the committee to consider this as a possible solution.

2. Local arrangements: The health and wellbeing Board arranging certain services relevant to public health

2.1 There are good reasons for commissioning in certain areas to be conducted at the level of health and wellbeing boards, rather than at that of GP commissioning consortia level. Placing commissioning for CAMHS services in tiers 1 and 2 (and some of tier 3) with HWB Boards would allow commissioning of services over a wider area than that covered by individual GP consortia and also, crucially, permit closer integration with preventative services. Preventative mental health care that has long been neglected and so presents an area in which a properly positioned public health strategy might hope to make real advances.

2.2 The Healthy Child 0–5 Programme may be another example of a service that should be commissioned locally with health and wellbeing boards having regard to NHS Commissioning Board requirements. This would enable consistency and joined-up commissioning for children and families across the 4–6 divide but with appropriate direction from the Department for Health and/or the NHS Commissioning Board would also allow for national co-ordination of the Government's Health Visitor programme. We urge the committee to consider how the role of health and wellbeing boards may be developed to oversee the commissioning of services that have overriding relevance to public health.

2.3 It is of concern that there has been very limited reference to children's safeguarding in the setting out of reforms and more clarification is required regarding lines of accountability and how it could work in the new system. Through their legal responsibilities and representation on local safeguarding children's boards, PCTs have taken a lead on safeguarding in the NHS, with SHAs also playing role. While it is welcome that the relevant duties regarding the establishment of safeguarding children boards will be transferred to the successor agencies, it is not clear how this will work in practice. Flexibility in boundaries of GP consortia and in the NHS commissioning board's regional presence may make it harder coordinate safeguarding efforts and ensure that any commissioning of relevant services is undertaken across the appropriate geographical area. We urge the committee to consider how responsibility for safeguarding within the NHS may be better coordinated and the role of the health and wellbeing board in securing this.

3. The Role of Public Health England

3.1 The remit of Public Health England should reflect the full range of policy areas that impact significantly on children and young people's health. We urge the committee to consider how this can be secured.

3.2 A public health input to the Department for Work and Pensions would be valuable to inform the development of the welfare system that plays its part in promoting the health and wellbeing of children and young people. The Marmot Review highlighted a number of issues¹⁴⁷ that suggest this may be necessary. Firstly, that progress on reducing child poverty has stalled since 2005. Secondly, unemployment can trigger distress, anxiety and depression. Many psychosocial stressors contribute to poor health not only among the unemployed themselves, but also among their partners and children. And thirdly there is evidence that income has a direct impact on parenting and on children's health and well-being. For example, according to Gregg *et al*, "Holding constant other types of parental capital, income is strongly associated with types of maternal psychological functioning that promote self esteem, positive behaviour and better physical health in children."

¹⁴⁵ Harker L (2006) Chance of a lifetime: The impact of housing on children's lives. London: Shelter.
http://england.shelter.org.uk/professional_resources/policy_library/policy_library_folder/chance_of_a_lifetime_-_the_impact_of_bad_housing_on_childrens_lives

¹⁴⁶ *Healthy Lives, Healthy People*, para 4.14.

¹⁴⁷ *Fair Society Healthy Lives: The Marmot Review*, (2010) pp 69, 76.

3.3 Fuel poverty is also well known as a health risk for children and the Marmot Review identifies it as such.¹⁴⁸ The Marmot Review team published a report on the impact of fuel poverty, which points out that:¹⁴⁹

- More than 1 in 4 adolescents living in a cold house are at risk of multiple mental health problems, compared to 1 in 20 teens who've always lived in warm homes.
- Cold, poorly heated homes have a significant impact on children's health, affecting infant's weight gain and development and increasing the frequency and severity of asthmatic symptoms.
- Living in a cold home negatively affects children's educational achievement, emotional well-being and resilience, which can worsen their life chances and increase health inequalities. Public Health England may also need to work closely with the department of energy and climate change as well as with DWP and DCLG to tackle this issue.

3.4 The recently published Natural Environment White Paper makes welcome reference to the children and young people's relationship with their natural environment and the importance of green spaces for mental and physical health. Public Health England will need to work closely with the Department for the Environment and Rural Affairs to ensure these policy are developed and implemented in a joined up way for the benefit of children and young peoples health.

4. *The Public Health Outcomes Framework*

4.1 The draft public health outcomes framework has a much needed focus on the wellbeing of children and young people, including a number of specific measures. This is justified given the huge impact that experiences during childhood and adolescence can have on long term health an wellbeing, which has recently been documented in reviews by Michael Marmot,¹⁵⁰ Frank Field¹⁵¹ and others. We urge the committee to consider how this may be implemented effectively, with particular regard to the following issues.

4.2 Development of measures to record self reported wellbeing will need to capture the views and experience of children and young people. Article 12 of the United Nations Convention on Rights of the Child requires that children are able to express their views on issues that affect them and that these views are given due weight. As children and young people will have a different perspective, responding to different language and different view on what is important for a happy an healthy life, the development of a series of separate age-appropriate mechanisms would help to achieve this.

4.3 It will be vital to involve children and young people in the development of these measures as well as all other aspects of public health reform. There is extensive experience of developing the engagement of children and young people to be harnessed from the children voluntary and community sector including members of Participation Works.

4.4 The proposed scope of domain 2 of the outcomes framework ("Tackling the wider determinants of ill health") is notable in that it reflects the more wide ranging approach to public health which we have called for above. It also bears resemblance to the 5 outcomes that young people at our consolation event suggested should be included in the frame work. These were: Ensuring everyone can live in a healthy clean environment; Better accessibility of services for everyone; Better health education; Better education; Working together—make sure everything works together to make the NHS more efficient. We particularly welcome the inclusion of child poverty, school readiness, housing overcrowding and fuel poverty. It will be vital that all the required work to develop effective measures for these outcomes are carried out.

4.5 In order to make governmental accountability to be as clear as possible for the outcomes in domain 2 it may be appropriate to further pin down specific departmental responsibility. This is particularly relevant for outcomes that relate to education such as truancy and NEET rates. Due to the expansion of the academies programme the department for education is effectively the commissioner of education for an increasing proportion of children and young people in England. It may therefore be more meaningful for the Department for Education (rather than the NHS or local authorities) take lead responsibility for these outcomes.

June 2011

¹⁴⁸ *Fair Society Healthy Lives: The Marmot Review*, (2010) p 80.

¹⁴⁹ The Marmot Review Team, *The Health Impacts of Cold Homes and Fuel Poverty*.

¹⁵⁰ *Fair Society Healthy Lives: The Marmot Review*, (2010).

¹⁵¹ The Foundation Years: preventing poor children becoming poor adults: the Independent Review on Poverty and Life Chances (2010).

Written evidence from NHS Sefton's Public Health Directorate and Sefton Council (PH 76)

This is NHS Sefton's Public Health Directorate and Sefton Council's joint submission to the Health Committee inquiry into Public Health.

NHS Sefton's Public Health Directorate and Sefton Council have previously responded to the White Paper consultation related to the proposed Public Health reforms and this forms the basis of this submission. In addition this submission has been informed by the Association of Directors of Public Health (ADPH) evidence to the Inquiry.

OVERVIEW—CONCERNS FOR THE PUBLIC HEALTH SYSTEM

We recognise that the proposed reforms raise opportunities for public health and welcome the increased formal role of Local Authorities (LAs) in the health agenda and integration of local DsPH into LAs.

However, England needs an integrated system for delivery of public health outcomes, and we are concerned that there is a significant risk that the proposals could have adverse effects on fragmentation:

- of the public health workforce across a number of organisations;
- of commissioning and finance responsibility for public health programmes; and
- and loss of clarity on accountability, particularly in the area of health protection.

LAs should be accountable for improving and protecting the health of their population at all times (with support from Public Health England). However, in order to ensure a coherent system-wide approach to public health, the Health & Social Care Bill should place a statutory duty on all health and social care bodies (including NHS funded providers) to cooperate in efforts to improve and protect health and in responding to public health incidents and emergencies.

There must be clear lines of accountability, communication and access between PHE, GP consortia, NHS and DsPH working within local authorities.

RESPONSE TO SPECIFIC ISSUES TO BE CONSIDERED BY THE HEALTH COMMITTEE

1. *The creation of Public Health England within the DH; the abolition of the HPA and the NTA for Substance Misuse*

Public Health England (PHE) can only effectively operate as a national public health service if it encompasses all three domains of public health:

- health protection (infectious diseases, environmental hazards and emergency planning);
- health improvement (lifestyles, inequalities and the wider social, economic and environmental influences on health); and
- health services (service planning, commissioning, audit, efficiency and evaluation).
- PHE should operate as a supporting organisation which can:
 - provide independent scientific evidence-based advice to national and local government, the NHS and the public on all matters relating to the maintenance, improvement and protection of health;
 - offer expertise to the National Commissioning Board (NCB) in support of its role in providing national leadership in commissioning for quality improvement, commissioning national and regional specialised services, and allocating NHS resources; and
 - provide effective, expert and adequately-resourced specialist PH capacity to support the work of local DsPH and their teams.

It is unlikely that these aims can be achieved if PHE becomes a fully-integrated part of the Department of Health. It should be established as an NHS body which would:

- facilitate the employment of public health staff by PHE;
- enable pooling of scarce and specialist public health capacity;
- enable the continuance of external income streams that currently support national health protection activity; and
- facilitate the separation of science from policy and therefore re-enforce the independence of DsPH and health protection for the populations' health and protection.

HEALTH PROTECTION

- Capacity for emergency preparedness and response must be maintained within the new structures—and robust interim arrangements to ensure a stable transition.
- Clarity is vital over which part of the system will lead responses to incidents at local and sub-national/supra local or regional levels.

- There needs to be clear agreement on the roles and responsibilities for DsPH and local health protection units, including assurance that health protection work carried out in second tier local authorities is connected with coordination and planning mechanisms organised at the top tier of local government.

2.2 *The public health role of the Secretary of State*

We welcome proposed new duties on the Secretary of State to have regard to the need to reduce health inequalities. However these duties are narrowly drawn, only applying to the role of the NHS in providing services to patients. The duties should reflect the broader role of the NHS in promoting public health as a provider, commissioner and major employer.

2.3 *The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)*

DsPH are the frontline leaders of public health working across the three domains of health improvement, health protection, and health care service planning and commissioning. DsPH must be enabled—through primary legislation—to provide oversight and influence across all these determinants of health within local authorities, the NHS and primary care, and other appropriate sectors and agencies in order to secure the improving health of their population.

- A DPH should be an individual trained, accredited, and registered in specialist public health.
- DsPH should be jointly appointed by LAs and PHE and should have a contractual relationship with both. However the supporting HR framework and clarification of terms/conditions and accountabilities are urgently needed. There is an immediate and transitional risk of loss of PH professional staff and expertise through uncertainty and staff concerns over the implications of potential transfer out of NHS employment.
- DsPH will need clearly defined responsibilities and powers and the professional status and enablement to express an independent view in order to provide advocacy for the health of the population.
- DsPH will require a well-resourced, professional and co-located Public Health team providing the skills and experience to input to local service planning and commissioning, and to deliver Public Health programmes and advice across the health economy, supported by access to high quality local and national data and scientific evidence base.
- There should be a statutory requirement for top tier Local Authorities to appoint a DPH with the appropriate professional training and accreditation; The DPH should work at corporate/strategic director (top team) level as a full executive member of the corporate leadership team with direct access to the local authority Cabinet and councillors—influencing and working alongside other Local Authority Executive Directors and normally reporting or accountable to the CEO or equivalent.
- The DPH should be recognised as the principal adviser on all health matters to the local authority, its elected members and officers, and its Health & Well Being Board, on the full range of local authority functions and their impact on the health of the local population as stated in Annex A of the PH White Paper.
- The professional status of the DPH and ability to express an independent view in order to advocate for health improvement and reducing health inequalities within their local population and act for the protection of the local population—and the independent DPH annual report—must be protected.
- Clarification of the resources that will support the DPH role in local authorities is urgently needed. Funding for DPH and PH team development will be crucial to support effective transformational change.

HEALTH & WELL BEING BOARDS/JSNAs

- There is a lack of clarity regarding the statutory role of Health and Wellbeing Boards. The powers granted to Health and Well Being Boards are weak and there is a risk that health and social care integration may be more difficult to achieve.
- The Boards have not been granted sufficient powers to meet the expectation that they will join up commissioning between the NHS and local authorities. The interface between GP consortia and local authorities will be critical in ensuring that services meet the full range of local population health needs. However, while Consortia must consult Boards in drawing up their commissioning plans, there is no requirement for Consortia to have regard to the views of the Board.
- Health and Wellbeing boards must have the power to sign-off local commissioning plans, ensuring that they are aligned with the joint strategic needs assessment and address the identified needs of the population.

- The DPH should act as a principal advisor to the Health and Well Being Boards.

The JSNA must:

- be asset-based, wide-ranging and thorough and include qualitative “citizen” views (not just service-user or patient views);
- include preventative and health protection issues; and
- be the basis for all local commissioning.

2.4 Arrangements for public health involvement in the commissioning of NHS services; arrangements for commissioning public health services

Public Health oversight of and input to commissioning will be essential to achieve real improvements in health outcomes and the reduction of health inequalities.

The proposed reforms:

- lack clarity over who will be responsible for providing “local system leadership” and planning services across GP consortia boundaries following the abolition of SHAs/PCTs;
- include few requirements on the governance of consortia;
- do not require GP consortia to promote integration between health and social care—an omission that will be exacerbated by lack of co-terminosity between consortia and local authorities;
- do not appear to place a duty on GP consortia to promote and protect the health of their local health population; and
- will lead to fragmented commissioning for a number of public health priorities eg screening, sexual health which will threaten the meeting of local needs, compromise service quality and reduce accountability.

Locally, the DPH should provide oversight and the Public Health team input to GP consortia commissioning, supported by additional resources and expertise held within PHE. GP consortia should be required to work through and with DsPH to ensure consortia decision-making is underpinned by expert, professional public health advice. DsPH should have a formal relationship with GP consortia, and local commissioning plans should be signed-off by the Health and Well-being Board.

GP Consortia (and NCB) should be responsible for improving inequalities of health outcome rather than just inequalities of access to health services. Clarity is required over where responsibility lies for ensuring GP consortia meet their responsibility for improving outcomes and how consortia are to be held to account for PH outcomes.

The population size of GP consortia should be based on evidence of effectiveness, as should decisions as to whether services are commissioned and delivered nationally, regionally or locally. Consortia should develop structures for stable joint commissioning where these would best serve their population. It must be recognised that for many services a whole pathway approach to commissioning is vital to ensure efficiency savings are met e.g. tackling increasing alcohol admissions needs to be addressed through interventions along the entire pathway from prevention to treatment.

2.5 The future of the Public Health Observatories

The new system must ensure that all those working in public health have access to timely, comprehensive and appropriate data and analysis to inform their decisions and advice.

Reliable data and information are essential to the understanding of health needs, modelling of future scenarios and assessment of impact and efficacy. This is relevant both for service planning and design and for the recognition of and response to hazards and outbreaks.

The reforms could result in disruption of existing flows of data and the loss of analytical expertise. Arrangements for maintenance of the public health observatory function and for ensuring access to health service data at local and national levels need urgent clarification.

2.6 The structure and purpose of the Public Health Outcomes Framework

The use of outcomes as opposed to targets is a positive development. However:

- there are no socio-economic outcomes, despite the acknowledgment of health inequalities and the acceptance that good health is only 30% attributable to health services. The outcomes also fail to reflect the life course approach set out in the Public Health White Paper *Healthy Lives, Healthy People* and the Marmot review *Fair Society, Healthy Lives*;
- greater emphasis should be put on ensuring that the Public Health framework is relevant to all sectors—with greater emphasis on linkage across the NHS, Social Care and Public Health outcomes frameworks;

- public health analytical capacity is essential to delivery of public health outcomes and current capacity must be preserved and enhanced; and
- investment will be needed in national surveys relating to health and wellbeing to ensure LA data can be assembled.

2.7 Arrangements for funding public health services (including the Health Premium)

The ring fenced budget

The scope of the ring-fenced budget must be defined clearly and the funds available in the ring-fenced budget must be sufficient to meet the needs for which that budget is intended.

PHE will require adequate resources to immediately and effectively fulfil its wide remit—and vitally to invest in the continuing development of public health expertise and the public health workforce.

In relation to the local ring-fenced public health budget:

- it should be explicit what will fall within this budget, and equally explicit that excluded activities with a bearing on public health will continue to be resourced from other / existing Local Authority and GP commissioning consortia budgets;
- within the LA these budgets should be deployed with flexibility for DsPH to direct resources to best meet the needs of the local population based on the JSNA and Health & Well Being strategy; and
- it should be clarified as to how baseline budgets will be set. Public health resources have already and will continue to be lost through the impact of local financial savings—any baseline must not be based on reduced resources.

Resources will also be required to support transition—including funding for DPH and PH team development to support effective transformational change, plus funding an awareness programme to ensure that politicians (national and local) fully understand the DPH role and all key PH functions.

Health premium

The health premium should:

- target need;
- reward relative improvement; and
- identify and reward “value added” activity/outcomes.

We are concerned over potential unintended consequences and that the health premium may create greater health inequalities.

The extent of the health premium is unclear but may not provide significant additional resources. Learning and evidence from existing programmes (such as the Spearhead approach) may provide useful evidence/outcomes to inform development of the health premium. We recommend that a full assessment of Spearhead experience should inform the further development of the health premium concept.

2.8 The future of the public health workforce (including the regulation of public health professionals)

- We support the recommendations within Dr Scally’s Report on the Review of the Regulation of Public Health Professionals.
- The Faculty of Public Health is the standard setter for all public health practice in the UK.
- The title “Specialist in Public Health” should be a protected title, required by statute to be registered.
- The training of public health specialists should be planned and delivered through Health Education England and should be consistent with arrangements for training other health professionals. It is vitally important that Public Health specialist Registrars continue to be trained at a high level in all three domains of public health supervised by accredited trainers.
- The independent PHE should act as the employing body for public health specialists, seconding them to other organisations as necessary, to ensure their primary responsibility is to the public. The use of honorary contracts can facilitate this model.

2.9 How the Government is responding to the Marmot Review on health inequalities

- The current reorganisation of the NHS and of Public Health significantly underestimates the role of the NHS in addressing health inequalities.

- We welcome new duties on the Secretary of State, NHS Commissioning Board and GP consortia to have regard to the need to reduce health inequalities. However these are narrowly drawn and do not reflect the broader role of the NHS in promoting public health as a provider, commissioner and major employer. There are also no equivalent duties on the Secretary of State or local authorities in respect of their roles in promoting public health.
- The duties are unlikely to be sufficient to ensure that tackling health inequalities is prioritised in the health system. We strongly recommend that the NHS commissioning bodies should be held to account for reducing inequalities in health outcomes.
- The proposed new system risks service fragmentation with detrimental impacts on the very areas the reforms seek to improve: quality of services, education and training, patient choice, efficiency and equity, and has the potential to exacerbate any existing postcode lottery in health services.
- The “Nuffield Intervention Ladder” should be applied to the Responsibility Deal approach. Robust, time-limited monitoring and evaluation after 12 months will be crucial to assess the effectiveness of voluntary commitments.
- There is concern that responsibility for health falls too heavily on the individual at a time of increasing economic pressure and a real reduction in the wider social and economic support networks.

3. ADDITIONAL ISSUES

Provider and Regulatory organisations

Protecting, maintaining and improving the public’s health require services to cooperate, take a population approach to identifying and addressing shared priorities to meet health needs, and making best use of all available resources. A requirement to promote competition will discourage integration and collaboration across the sectors, and should be removed from the draft Health & Social Care Bill. A duty of cooperation should be placed upon service providers and commissioners.

Public health influence within provider organisations should be extended, eg:

- a public health lead working within Foundation Trusts and community service organisations;
- provider trusts should work with LAs in improving the health of the population; and
- above a capped level of reserves, an annual proportion of Foundation Trust reserves to be spent on initiatives agreed locally as providing health gain for the population.

June 2011

Written evidence from Heart of Mersey (PH 77)

ABOUT HEART OF MERSEY

Heart of Mersey (HoM) is a cardiovascular health charity covering Cheshire and Merseyside. HoM aims to co-ordinate a strategic approach to preventing the high rates of cardiovascular disease (CVD) and associated inequalities in our region. We are jointly commissioned by the primary care trusts and local authorities in our area to deliver a population-based approach to heart disease and stroke prevention. Merseyside and Western Cheshire, in comparison with the rest of England, have long suffered disproportionately from CVD. CVD is the biggest contributor to health inequalities in our region.

Although our principal activity is to work with local organisations to achieve improved access to healthy food and a reduction in exposure to smoking, we believe that local action alone is not enough to improve the health of our population. We therefore work in partnership with national and international organisations where appropriate to advocate for healthier policy in tobacco control (such as the recent ban on point of sale tobacco advertising) and food and agricultural production (including advocating for a European Common Agricultural Policy which supports healthier nutrition).

SUMMARY

- HoM welcomes the opportunity to comment on the Government’s proposals for the establishment of a new public health system. It is important that public health is considered carefully along with other concerns about the future of the National Health Service.
- HoM broadly welcomes the responsibility for public health being shifted to local authorities and the possibilities thereby provided to integrate with services such as children’s and adult services. However this transfer should not be at the expense of any lack of independence for public health and should be a transparent process with clear accountability at all times.
- HoM has concerns about the pace of change and any possible reduction in public health capacity which should be resisted.

- As a CVD prevention charity, HoM would like to emphasise that the key risk factors for CVD and other noncommunicable diseases such as type 2 diabetes and many cancers, are a poor diet, smoking, alcohol harm and physical inactivity. The new arrangements for public health should therefore maintain a focus on making it easier for people to lead healthier lifestyles through appropriate policies and regulation at regional and national level.
- We would welcome encouragement from the Government for commissioning at a supra local level where this is appropriate and provides better value. There are many examples where work on a larger geographical footprint has been very effective such as in tobacco control (around illicit tobacco for example) and in promoting healthier eating (such as in pre-school nutrition policy).

GENERAL COMMENTS

1. HoM welcomes the opportunity to respond to the Inquiry on Public Health. We recognise that much of the recent discussions and listening exercise about the Government's Health and Social Care Bill have focused on debates around GP commissioning, competition ruling and suchlike. However it is essential in addition that there is full scrutiny of the Government's proposals for the establishment of a new public health system and it is important that this is considered carefully along with the other concerns about the future of the National Health Service.

2. HoM supports the transfer of responsibility of public health from the NHS to local authorities in England. There are clear advantages in providing opportunities with integration with children's and adult services. The Marmot Review¹ said "Give every child the best start in life" in its policy objectives to address health inequalities. By placing public health in local authorities there is a clear opportunity for example to focus on smoking prevention and cessation among the young and a healthier diet in pre-school settings. However, in a time of cutbacks in public sector spending, local authorities must give appropriate priority and resources to public health and its independence must be fiercely protected.

3. As we wrote in our response to the Government's consultation *Healthy Lives, Healthy People*, HoM supports the Government's focus on public health and preventative medicine, tackling health inequalities, and the establishment of a national Public Health Service with a ring-fenced budget to lead a cross-government, life-course approach to public health. We support the clear commitment to "improving the health of the poorest fastest", focusing on outcomes, evidence, fairness, and localism. However, whilst HoM agrees that empowering local communities to tackle health inequalities and improve outcomes is essential, we believe that national oversight and monitoring by Public Health England will be vital to maximise public health improvements.

4. We also believe that although local leadership is critical, there is still an important role for supra-local commissioning to address important prevention issues such as illicit tobacco and that there remains a need for national regulation around for example food labelling, reduction in dietary salt, saturated fats and sugars, and the elimination of industrial trans fats.

5. HoM welcomes the recognition of the important role of Directors of Public Health as strategic leaders in local public health, health inequalities and health partnerships. We recommend that Directors of Public Health must have the authority and independence to advise on policy areas that have a bearing on smoking cessation, physical activity, healthy eating and all aspects of population health and health inequalities. They should ensure that the National Institute for Health and Clinical Effectiveness (NICE) public health guidance is implemented including guidance on the prevention of cardiovascular disease, overweight and obesity, physical activity and the environment, and on reduction in smoking.²⁻⁸ They must also have their independence to comment on any problems and deficiencies and to know that when in the right, they will have the backing of Public Health England. The public health role of NICE should be enhanced and the reviews halted in 2010 should be reactivated.

6. HoM believes that transparency and accountability are essential components in public health delivery. We therefore have some concerns around perceived reliance on voluntary agreements with the commercial sector through the Responsibility Deal. The role of the commercial sector must be clearly identified and should not include any involvement in public health policy development.

7. HoM is concerned about the speed and scale of reorganisation and change and the impact this is likely to have on public health capacity.

8. We believe that third sector organisations make an important commitment to public health⁹ in demonstrating and sharing good public health practice, in providing independent scrutiny, in a key advocacy role, in engaging local communities and helping to provide an evidence basis to support public health policy. The role of the third sector should be explicitly laid out wherever possible in the new public health system and be seen as key and active partners in shaping the proposed new structures given the sector's expertise in public health. Further, the role of the academic sector should be recognised particularly in the development and dissemination of data and evidence to support decision-making.

9. As a heart health charity, we are concerned principally about how the two key risk factors of tobacco and poor nutrition are addressed.

10. The Committee has said it will consider specific issues in its Inquiry:

RESPONSES TO SPECIFIC ISSUES

The creation of Public Health England within the Department of Health

The abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse

11. We have concern around both the abolition of the Health Protection Agency and its absorption within Public Health England, which itself will be established within the Department of Health. The independence of Public Health England is very important to ensure it has the authority to carry forward evidence-based policy. An independent and transparent scrutiny facility is also necessary. For these reasons we would support the establishment of Public Health England at “arm’s length” from the Department of Health as a Special Health Authority for example.

The public health role of the Secretary of State

12. Public health and preventative health should remain a key focus of the Secretary of State. It should also be recognised however that better public health should be a challenge for all Government’s departments; improved health leads to increased wealth and should be a key component of any economic regeneration strategy. National cross-Government arrangements should mirror what is expected at local level including a move towards a broader health and wellbeing agenda.

13. The role of the Chief Medical Officer should be maintained and kept independent.

14. As previously noted, there remains a need for national regulation around for example food labelling, reduction in dietary salt, saturated fats and sugars, and the elimination of industrial trans fats. Similarly, there must be a continued focus on smoking which is the largest cause of preventable death in England.¹⁰ HoM supports the Government’s commitment to protecting health policy from the vested interests of the tobacco industry. The forthcoming consultation on tobacco packaging must be transparent and ensure that it is not subverted by tobacco industry interests operating through “front groups” as identified by Action on Smoking and Health. The European Union has an important role in legislation and the Government should be aware how key policies such as the Common Agriculture Policy impact not only on the food we eat but our public health.

The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)

15. HoM would suggest that the remit of health and wellbeing boards includes public health improvement, health protection and healthcare service commissioning, with the Director of Public Health performing a statutory role of principal advisor.

16. We would support that health and wellbeing boards should assess the needs of the local population, taking into account the key role of the Director of Public Health, and lead joint strategic needs assessment. Tools need to be developed to enhance the local commissioning process to measure future avoidable chronic disease outcomes and cost effectiveness. Governance arrangements for local agencies with lead responsibilities for public health should be required to include representatives with population health experience as well as representatives able to engage civil society and the voluntary sector, to feed into strategic decision making.

17. The boards should be responsible for scrutinising and signing off local commissioning plans. There are existing arrangements to work across local authority areas—such as in Liverpool City Region—which should be supported. This is particularly important when considering upstream population based approaches to address obesity, cardiovascular disease etc. Local Transport Plans are excellent examples of working together to offer a collective strategy. The health and wellbeing boards should include representatives from the local authority (including directors of adult social services, children’s services, environmental health, planning etc) in addition to voluntary sector representatives, GPs and service providers. Existing services in local authorities such as environmental health and trading standards have had important roles in the effective implementation of tobacco policies at local level such as in enforcing age of sale restrictions and similarly in healthier food policies around hot food takeaways for example. Their work should be supported as part of the public health function but not at the expense of the public health workforce currently placed within primary care trusts. Sufficient funds should be allocated to the ring-fenced public health budget to enable it to deliver effective services.

Arrangements for commissioning public health services

18. It is important that the localism agenda does not ignore the potential benefits of commissioning at supra-local level. There are strong advantages in supra-local co-ordination as a means of avoiding duplication of activity and resourcing. Thus upstream prevention interventions may be best addressed across local authorities and at a population level. Changes at population level with reference to cardiovascular disease has been addressed in NICE guidance² which focused on how national or regional policy and legislation can be powerful levers for behaviour change. Paid advertising is an area where national campaigns generally deliver better value for money, while unpaid media can be gained effectively at a supra local level. Examples of obtaining greater value for money include the delivery of a comprehensive cardiovascular disease (CVD) prevention programme across Cheshire and Merseyside (Heart of Mersey). This has included supra-local programmes on

tobacco control (including smokefree mental health, underage tobacco sales, illicit tobacco), and food (including takeaway food and pre-school nutrition). It is often the case that communities straddle (or move across) local government boundaries and are better served by interventions delivered at the scale of the functional urban region.

19. HoM is further concerned that public health procurement practices follow the DH Procurement Guide.¹¹ It is important that potential providers are involved in the development of service opportunities at an early stage to ensure best value and improved services. Those commissioning public health services will need support particularly where providers may be from within the voluntary and community sector.

The future of the Public Health Observatories

20. Having good public health intelligence is critical to informing both national and local work. The observatories need independence and a protected budget to continue their essential activities. Similarly, it is essential for annual surveys for the Health Survey for England to be maintained. With a focus on outcomes, we need to ensure we are in a position to effectively measure public health programmes and delivery at both national and local levels.

The structure and purpose of the Public Health Outcomes Framework

21. HoM supports the commitment to an Outcomes Framework and believes that open access to data and shared priorities will enable a common focus on health and wellbeing priorities. Effective tobacco control and improving diets are essential to reducing health inequalities and should be pivotal in data availability and focus. Cardiovascular disease is the biggest contributor to health inequalities in Cheshire and Merseyside and we welcome the commitment to health inequality reduction and advancing equality.

Arrangements for funding public health services (including the Health Premium)

22. Focusing the health premium on health gain in a recession may have the unfortunate effect of penalising the most needy in society and communities. It is often the poorest whose health suffers fastest in a recession. HoM believes that reduction in smoking prevalence, maternal smoking and smoking in mental health should be key factors in allocating the health premium.

23. We have some concern that the health premium could potentially widen inequalities between areas that do and do not receive the payment and are therefore interested in how the formula will be devised. The health premium should be based on a percentage improvement rather than a relative level as different local authorities will have different starting points. Percentage improvements will not disadvantage lower performing local authorities further as these will most likely be those with populations experiencing multiple levels of deprivation.

The future of the public health workforce (including the regulation of public health professionals)

24. All specialist public health staff should either be transferred into local authorities or retained in the NHS under the new arrangements; this is not a time to reduce public health capacity.

25. It is essential that the role of Director of Public Health (DPH) is positioned at a senior level within local authorities—ideally directly responsible to the CEO—with the professional freedom and independence to ensure effective public health delivery. The DPH's statutory responsibilities should be defined in the Health and Social Care Act. Duties should include input into major policy and planning matters; health impact assessment being an important tool. Whilst DsPH will be jointly appointed by Public Health England (PHE) and the local authority, it would be preferred that contractual arrangements should be with PHE (assuming its own independence as previously recommended) to prevent problems of dual accountability. Ring-fenced public health budgets will need to be robustly defended by DsPH and PHE. Independent annual public health reports should be produced at both local and national levels.

How the Government is responding to the Marmot Review on health inequalities

26. We agree with organisations such as the National Heart Forum that it is important that the Marmot Review is referenced in *Healthy Lives, Healthy People*. The interpretation of tackling inequalities must go beyond inequalities in access to health services and fully address inequalities in health outcomes.

June 2011

REFERENCES

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⁶ NICE (2006). *Brief interventions and referral for smoking cessation*, London: NICE.

⁷ NICE (2007). *Workplace interventions to promote smoking cessation*, London: NICE.

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⁹ ACEVO (2010). *The Organised Efforts of Society. The role of the voluntary sector in improving the health of the population*, London: ACEVO.

¹⁰ DH (2011). *Healthy Lives, Healthy People: A tobacco control plan for England*, London: DH.

¹¹ DH (2010). *Procurement guide for commissioners of NHS-funded services*, London: DH.

Written evidence from British Heart Foundation (PH 78)

1. The British Heart Foundation (BHF) is the UK's leading heart charity. Our vision is of a world where no-one dies prematurely of heart disease. Each year, heart and circulatory disease causes over 180,000 deaths,¹⁵² and costs the UK £30.7 billion.¹⁵³

2. In more than 90% of cases, the risk of a first heart attack is related to potentially modifiable risk factors, including smoking, poor diet, obesity or overweight, and insufficient physical activity.¹⁵⁴

3. We welcome the Health Select Committee's commitment to scrutinising the impact of the health reforms on public health through this Inquiry. This submission from the BHF includes recommendations for changes to the Bill, as well as for further policy development and implementation, and draws on our responses to the Public Health White Paper.

4. SUMMARY

- History shows that public health benefits and reductions in health inequalities most frequently result from timely, evidence-based legislation. To protect population health and to create an environment that supports and enables healthy choices, individual behaviour change approaches and voluntary action by industry must be part of a much wider government strategy that includes regulation and legislation.
- In particular, to protect children and young people, we are calling for plain packaging for cigarettes, for all advertisements for food and drink that is high in fat, saturated fat, sugar, and salt (HFSS food and drink) to be screened after the 9.00 pm watershed, and for the independent development of regulations for non-broadcast marketing.
- While we support local community empowerment, there must be national oversight to monitor outcomes among different population groups, and to ensure action is taken where outcomes fail to improve or unacceptable variation persists.
- Open access to independent national and local data on population health needs, behaviour and outcomes will be an important mechanism for enabling public scrutiny and democratic accountability, as well as effective evidence-based commissioning.
- Local authorities should have clear responsibility in the Bill for protecting and improving the health of their populations, supported by Public Health England.
- Public Health England must be able to provide independent advice and leadership across Government and to local commissioners and providers, and must therefore be independent of the Department of Health.
- Directors of Public Health (DsPH) must have the protected independence and authority to advocate and influence across all the local authority's policy areas and functions, and must report directly to the local authority CEO.
- Public health practice must be based on evidence and robust evaluation. To support this, the Secretary of State and all health and public health structures must have a duty to promote research, and there must be effective links between commissioners, providers and academia.
- The voluntary sector, patients, the public, academic institutions and clinical networks should be fully engaged and involved throughout the commissioning cycle.

¹⁵² www.heartstats.org

¹⁵³ NICE (2010). *Prevention of cardiovascular disease at population level*.

¹⁵⁴ NICE (2010). *Prevention of cardiovascular disease at population level*.

THE ROLE OF NATIONAL GOVERNMENT

5. We welcome the commitment in the White Paper to addressing the “*root causes of poor health and wellbeing*” and to adopting a cross-Government, life-course approach. We look forward to learning more about the mechanisms to achieve this and to enable Public Health England to work closely with other Government departments. Health Impact Assessments and Health Equity Impact Assessments should play a key role.

6. The activity and progress of local authorities in promoting health and tackling inequalities will inevitably vary. **The Government should ensure outcomes are monitored, and should take responsibility for ensuring that appropriate action is taken where unacceptable variation in outcome persists.** We would welcome more information about the process for making sure that this happens. This will be particularly important during the period of transition and financial challenge to ensure preventative activity does not suffer.

7. The BHF firmly believes that the provision of information, behaviour change (“nudging”), and voluntary action by industry will not on their own deliver the health outcomes to which we are all committed. Many aspects of the environment set the default options for behaviour and decision-making. The physical environment and commercial marketing, for example, can make positive health behaviours and healthy choices more difficult. In addition, while we recognise the importance of personal freedom and responsibility, this must be balanced with the need to protect population health, particularly among vulnerable groups including children who cannot be expected to take responsibility for their decisions.

8. History shows that public health benefits and reductions in health inequalities¹⁵⁵ most frequently result from timely, evidence-based legislation. This is shown, for example, by legislation for safe water, clean air, seat belts, and the recent Review¹⁵⁶ of smokefree laws. Upstream whole system measures are also the most cost-effective.¹⁵⁷

9. Complementary measures from different “rungs” of the Ladder of Intervention¹⁵⁸ are therefore needed—rather than starting with the least intrusive measures and progressing incrementally up the Ladder as implied in the White Paper. NICE’s role should include the review of upstream national and international public health measures.

10. We were pleased to see the Tobacco Control Plan commit to the implementation of legislation to prohibit the display of tobacco at the point of sale and to prohibit cigarette vending machines—both are vital to put tobacco out of sight and reach of children. We also welcome the Government’s commitment to consult on introducing plain packaging for cigarettes. Despite health warnings, packaging remains a “silent salesman” for tobacco brands. We firmly believe that to increase the effectiveness of health warnings and address misconceptions about the risks of smoking, legislation is needed to introduce plain packaging for cigarettes across the UK.

11. Legislation and regulation is also needed to protect children and young people from the harm caused by the marketing of HFSS food and drink. Although the advertising of these products is prohibited during children’s programming, a recent review by Ofcom¹⁵⁹ showed that just over half of children’s viewing time is in commercial adult airtime. To protect children and young people, we are calling for all advertisements for HFSS foods and drinks to be screened after the 9.00 pm watershed, and for the independent development of regulations for non-broadcast marketing (including online, in print and on product packaging).

PUBLIC HEALTH ENGLAND

12. Public Health England has great potential to tackle the wide range of social determinants of ill health and health inequalities and to drive improvement across all national and local policy areas and functions. **But to achieve this Public Health England must be able to provide independent advice and leadership, and must be independent of the Department of Health.**

DIRECTORS OF PUBLIC HEALTH IN LOCAL AUTHORITIES

13. Transferring public health functions into local authorities also has great potential to promote collaborative action to tackle the wide social determinants of health. **Local authorities should have clear responsibility for protecting and improving the health of their populations, supported by Public Health England.**

14. The transition to local authorities must be carefully managed to ensure that specialist public health expertise and experience is not lost. There must be a coordinated approach to workforce training and supply that considers not just Directors of Public Health (DsPH) but those who work in jobs that have a bearing on health (such as planning and transport).

¹⁵⁵ www.scotland.gov.uk/Publications/2008/06/09160103/2

¹⁵⁶ University of Bath (2011). *The impact of smokefree legislation in England: Evidence Review*.

¹⁵⁷ For more information, please see the evidence-based cost-effective upstream measures recommended in NICE (2010). *Prevention of cardiovascular disease at population level*.

¹⁵⁸ Nuffield Council on Bioethics (2007). *Public health: ethics issues*.

¹⁵⁹ Ofcom (2010). HFSS advertising restrictions—Final review.

15. DsPH should work to implement NICE public health guidance, including guidance on the prevention of cardiovascular disease,¹⁶⁰ prevention of overweight and obesity,¹⁶¹ and on physical activity and the environment.¹⁶²

16. DsPH will need the protected *independence*, authority, and resources to drive health improvement across all local government policy areas and functions. To achieve this, they **must be directly accountable to the CEO** (employed by local authorities with an honorary contract with Public Health England).

COMMISSIONING

17. There must be a clear, publicly accessible audit trail leading from population Joint Strategic Needs Assessment (JSNA), through to service design, service implementation, monitoring and review. The effectiveness of this process will depend on close partnership working and data-sharing between DsPH and GP commissioning consortia.

18. We would like to see guidance on the benefits of supra-local commissioning by local authorities. This is a valuable way of providing interventions for small and scattered populations that are not defined geographically, as well as a way of pooling resources for larger populations and avoiding duplication.

19. During this period of significant organisational change, the voluntary sector and academic institutions remain a constant and lasting source of expertise and evidence. As activity is increasingly devolved to a local level, national voluntary organisations also play an important role in identifying and disseminating local good practice, and exploring the needs of population groups across organisational boundaries.

20. Although the BHF does not supply services under contract to the NHS or local authorities, we are a significant contributor to the health and well-being of local populations. We have invested £9 million in our *Hearty Lives* programme which aims to reduce high levels of cardiovascular disease (CVD) in deprived communities.¹⁶³ Strategic health authorities, primary care trusts and local authorities will need to work closely with voluntary sector organisations to see co-investments, such as the BHF investment in Hearty Lives, safely through the transitional period.

21. **Charities, patients, the public and academic institutions should be fully engaged and involved throughout the commissioning cycle.** At a local level this should start with involvement in the development of the local Joint Strategic Needs Assessments, and Health and Wellbeing Boards should be responsible for ensuring that this happens.

22. National and local commissioning policy and guidance should also take better account of the role of national charities as co-commissioners. This policy and guidance should distinguish appropriately between funding from general taxation and charitable funding to ensure the latter is not subject to inappropriate bureaucratic processes which impede the speed and flexibility of response for which the voluntary sector is so valued.

23. The new public health commissioning architecture is very complex—to facilitate the engagement of the voluntary sector, we urge the Government to ensure that the different commissioning routes and opportunities for engagement are clearly communicated.

24. **Cardiac and stroke networks should also be fully engaged throughout the commissioning cycle.** Clinical networks play a vital role in supporting and coordinating an integrated pathway across both prevention and care, and in ensuring services are planned, and resources are allocated from the perspective of the whole system rather than piecemeal.

FUNDING PUBLIC HEALTH SERVICES

25. While we welcome the commitment to a ring-fenced budget, the scope of this budget needs clarification. The actual amount allocated to local authorities must be sufficient to enable DsPH to drive health improvement, and activities currently funded from NHS funds must not be simply re-badged as “public health”.

26. We have concerns that the Health Premium—which financially rewards areas that appear to be performing well—may penalise communities where need is growing fastest, thereby widening health inequalities. In addition, there can be a significant time lag between a public health intervention and its measurable outcomes, and some of the economic and environmental factors that influence health inequalities are outside the control of local authorities.

¹⁶⁰ NICE (2010). *Prevention of cardiovascular disease at population level*.

¹⁶¹ NICE (2006). *Obesity. Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children*.

¹⁶² NICE (2008). *Promoting and creating built or natural environments that encourage and support physical activity*.

¹⁶³ For more information, please see: www.bhf.org.uk/heart-health/how-we-help/in-your-area/hearty-lives.aspx

PUBLIC HEALTH RESEARCH AND DATA

27. We welcome the recognition in the White Paper that “Public health evaluation and research will be critical in enabling public health practice to develop into the future and address key challenges and opportunities”.

28. Medical research is key to preventing heart disease. The UK is a world leader in cardiovascular research. But to maintain this status, research must be valued and embedded as a core function at all levels of the new NHS landscape. To achieve this, we are calling for **the promotion of research to be a direct duty on the Secretary of State, and on all health and public health structures**, including Public Health England and commissioning consortia.

29. There is currently a gap between public health research and the provision of public health services. **Effective links will be needed between commissioners, providers, the National Institute for Health Research (NIHR) and academia, to ensure public health research can be coordinated across local structures and that public health practice is based on evidence and evaluation.**

30. Public health knowledge management systems are also crucial to ensure evidence-based practice. The roles of information officers should be protected, maintained and developed. Frameworks and guidance on the evaluation of “what works” should also be developed and disseminated.

31. Open access to independent and usefully analysed and presented data on population health needs, outcomes and behaviour is an important mechanism for enabling public scrutiny, and enabling commissioners and charities like the BHF to invest resources most effectively. This should include the Public Health Outcomes Framework, and national lifestyle surveys. We welcome the proposal to produce an update of the Local Tobacco Profiles. However, clarity is needed about the future of the valuable data collection and analysis functions currently performed by the Public Health Observatories.

32. Data must be collected in a way that allows variations in outcomes to be compared between different population groups (including socio-economic, geographical, gender, and ethnic background)—focusing only on averages can hide persistent or worsening inequalities.

THE PUBLIC HEALTH OUTCOMES FRAMEWORK

33. We welcome the Government’s focus on public health outcomes. However, it is important that process measures that tell us whether we are *on track* to achieve those outcomes are also maintained at a national and local level as some outcomes may not be identifiable until many years after an intervention.

34. We are also concerned that limiting the indicators to those with short time lags for data and those that are meaningful at a local level, as proposed in the consultation on the Outcomes Framework, may exclude valuable indicators for chronic disease prevention. Indicators on second-hand smoke exposure among children for example, may be most meaningful at a national or sub-national level.

35. We welcome the inclusion of indicators covering a wide range of determinants of health, and believe that this breadth should be maintained. As heart disease is the single biggest killer in the UK, indicators on the prevalence of cardiovascular disease and risk factors for cardiovascular disease must be included.¹⁶⁴ The “national ambitions” in the Tobacco Plan and other forthcoming plans should also be included in the Framework.

FORTHCOMING PUBLIC HEALTH PLANS AND POLICY

36. We look forward to learning more about the strategies for tackling particular public health challenges. Clear visions for social marketing, for promoting physical activity, and for tackling obesity are needed and we hope to see this detail provided in national plans.

Obesity and physical activity

37. **We strongly agree with the White Paper that active travel and physical activity must become the norm in communities.** We now hope to see more detail on how this will be achieved. Access to local parks and safe outside space and a reduction in the speed limit to 20 miles per hour in residential areas are key to enabling people to build physical activity into their daily lives.

¹⁶⁴ As well as those in the consultation document, we propose that the Framework should include indicators on:

- Smoking prevalence in children and young people.
- Children exposed to second-hand smoke.
- Successful 4-week smoking quits.
- Healthy diets among children and adults (there are no indicators on diet and nutrition that are not obesity-related—healthy eating, in normal weight children and adults, is also needed to keep down cholesterol and blood pressure, key risk factors for heart disease).
- Walking (in addition to cycling).
- Proportion of children meeting the recommended guidelines on physical activity.
- Deaths attributable to smoking.
- Cardiovascular disease morbidity.

38. Information about the nutritional content of food is also crucial to create an environment that enables consumers to make healthy choices. Research has shown that front of pack (FOP) labels including traffic light colours, the words “high”, “medium” and “low”, and percentage guideline daily amounts help consumers tell at-a-glance what’s in the food they’re buying.¹⁶⁵

39. Developments concerning food labelling at European Union level will allow continued use of additional forms of expressions (AFEs) already in the marketplace. **We are calling on the UK Government to support AFEs and FOP labelling which include information on energy, fat, saturated fat, sugar and salt. The Government should strongly support and encourage the use of the Food Standards Agency’s Multiple Traffic Light FOP labelling system** within the UK. Those companies choosing to use their own labelling schemes should provide independent and transparent evidence to demonstrate that these are effective.

40. We are pleased that work is underway on the provision of nutritional information at the point where decisions are made in cafes and restaurants, and hope to see this extended to give consumers more comprehensive information about the nutritional content of foods rather than just the energy content.

41. To eliminate industrial trans fats, action will be needed across small and medium-sized catering businesses, as well as large suppliers, manufacturers and providers. If voluntary action is unsuccessful, the Government must take legislative action to remove trans fats. Additional work is also urgently needed to substantially reduce saturated fat consumption and replace with unsaturated fats.

42. We understand that the Responsibility Deal targets for salt reduction are equivalent to the FSA 2012 targets. However, further ongoing action by manufacturers, retailers and caterers will be essential to reduce salt consumption to recommended levels.

43. A key aspect of a life-course approach to public health should be the promotion of healthy eating and physical activity from a young age including during the early years and at school. The White Paper gives helpful indications of what “good schools” will do to promote health, but monitoring must be in place to identify schools that are not meeting expectations and these should be offered high quality, evidence-based support and guidance.

44. We understand that there will cease to be a nationally recognised Healthy School Status and urge the Government to ensure that the necessary infrastructure and support is made available so schools can protect the health of children and young people.

Social marketing

45. We look forward to reading more in the forthcoming Social Marketing Plan about how healthy diets, physical activity, smoking cessation and smoke-free homes and cars will be promoted. The Plan must give particular consideration to the need for dedicated interventions for groups that suffer disproportionately from cardiovascular disease, including some black and minority ethnic groups.

Congenital and inherited heart conditions

46. Throughout the White Paper consultations, there is an absence of reference to inherited cardiac conditions, such as familial hypercholesterolaemia (FH) which causes high blood cholesterol levels and a greatly heightened risk of heart disease. NICE has recommended the implementation of cascade screening whereby first degree relatives of known FH sufferers are screened for the genetic defect and managed appropriately if found to be affected.

47. There is also a lack of reference to congenital heart disease, despite this being the most commonly occurring major congenital abnormality affecting one in every 145 babies.¹⁶⁶ Effective routine screening antenatally and post-partum is crucial, and audit and specialist professional training are needed to support this.

48. The BHF would welcome the opportunity to provide additional information on any of the points in this submission.

June 2011

¹⁶⁵ <http://www.food.gov.uk/news/newsarchive/2009/may/pmp>

¹⁶⁶ Petersen S., Peto V., and Rayner M. (2003). *Congenital heart disease statistics*.

Written evidence from the Royal College of Physicians of Edinburgh (PH 79)

1. The Royal College of Physicians of Edinburgh (RCPE) has as many Fellows and members working in England as in Scotland, and its content will therefore be of interest to many. In addition, several public health measures contained in the public health strategy proposed by the Government are reserved matters and therefore affect the whole of the UK. RCPE is also a parent College of the Faculty of Public Health and endorses the advocacy and the concern of the Faculty that has been represented to Government on the subject of the strategy. The following comments are edited extracts from our response to Healthy lives—healthy people: the strategy for Public Health in England and are relevant to this inquiry.

2. The public health strategy proposes a radical departure from previous approaches. It addresses many current public health challenges and shifts the balance of emphasis towards individuals and communities, a crucial element of any public health strategy. However, the strategy must recognise the leadership role of Government, and of political will, in facilitating change and improving health and the social determinants of health. Therefore, while the general direction of the strategy is welcome, a number of questions are left unanswered.

- The RCPE strongly welcomes the cross-Government, life-course approach to public health and the establishment of a Public Health Service with a ring-fenced budget.
- It supports the commitment to improving the health of the poorest, fastest. This includes broad interventions to decrease poverty, because over 90% of ill health is attributable to factors outside the NHS. Furthermore, dedicated interventions and awareness campaigns are needed for those who suffer disproportionately from cardiovascular disease, including some black and minority ethnic groups.
- To protect population health, particularly children and young people, and to create an environment that supports and enables healthy choices, behaviour change approaches and voluntary action by industry must be part of a much wider government strategy that includes regulation and legislation.
- While the College supports the commitment to empowering communities, national oversight and accountability are essential. Independent and open access to performance data, including the Public Health Outcomes Framework, will be crucial to enabling scrutiny and accountability and facilitating the sharing of best practice and effective innovation.
- Directors of Public Health (DsPH) must have the independence, authority and resources to be effective local leaders and to drive improvement in all policy areas that have a bearing on health and health inequalities.
- It agrees that close partnership working will be essential between Public Health England and the NHS Commissioning Board, and between DsPH in local authorities and GP Commissioning Consortia.
- Patients, the public and voluntary sector organisations should be involved in needs assessment and throughout the commissioning cycle.

3. THE COLLEGE'S CONCERNS

- to what extent is the Government diminishing its own role in leadership, regulation and legislation for health?
- to what extent is it weakening the public health function by, once again, reorganising, while simultaneously highlighting the need for a strong and integrated set of arrangements?
- what is the relationship between the current strategic intentions and reduction of health and inequalities which is still a prime policy objective?

4. The strategy has not addressed these issues, while the whole breadth of Government action influences the public health of the country. This strategy does not bring together the Government's commitment to fiscal and other legislative matters that could be vital ingredients, and that are so important in this area.

5. FURTHER COMMENTS ON THE GOVERNMENT'S STRATEGIC PROPOSALS

Background

Discussion of structural changes to public health organisation in England inevitably follows the Government's proposed reforms to the rest of the NHS in England. These will generate major disruption. Some discussion of concerns regarding the wider NHS forms is therefore necessary.

History is repeating earlier mistakes

6. Early in the days of the last Labour Government, in the late 1990s, Primary Care Groups (PCGs) were established in England; these were commissioning bodies largely run by general practitioners (GPs). Very soon they were found to be too small to be able to commission effectively, as NHS hospitals were much larger and more powerful organisations. So these PCGs were amalgamated into larger PCTs in 2002, and employment of public health staff passed from health authorities (HAs) to these new PCTs. In turn, these PCTs were also

shown to be still too small, and in 2006 were amalgamated into much larger PCTs, which looked rather similar to the original HAs of the 1990s! So public health departments had to reform themselves within new organisations twice within five years. Their performance was substantially impaired on each occasion.

7. Each previous NHS reorganisation produced substantial disorganisation and demotivation that lasted at least two years. The negative effects on the organisation's efficiency and morale of the NHS were therefore considerable. The NHS is one of the most effective and efficient health care systems in the world. The idea of simultaneously trying to extract £20billion savings while uplifting the biggest reform in three decades defies logic.

8. The current coalition government intends to abolish PCTs and to devolve commissioning of most health services to consortia of GPs. These emerging consortia are already becoming recognisably similar to the PCGs of 12 years ago. We appear destined to be forced to tread the same path again, to re-learn that commissioning bodies have to be larger than is being proposed. An even earlier cycle of such reform was initiated by the Conservative Government of the early 1980s, when larger Area Health Authorities (AHAs) were abolished, to make way for very much smaller District Health Authorities (DHAs). These were in turn found to be much too small to be effective, and they were required to merge to form much larger HAs.

9. If it is now planned that PCTs should be abolished, public health departments will therefore need a new home, as "commissioning groups" will be too small to provide this (as were PCGs before them). So PCTs are to be transferred to local authorities (to the larger tier, where there are two tiers of local government), taking their budgets with them, supposedly "intact". However, various PCT chief officers are concerned that PCTs, before they give up their public health departments, will have relieved them of responsibility for as many funding streams as possible, so that these can contribute to PCT "savings". The Public Health White Paper describes how this should occur, and indicates some of the main public health challenges which the Government envisages will face the new local government-based departments, and how they might be structured to deal with these. It also indicates some of the public health solutions which the Government hopes may be adopted in the future.

Pros and Cons of Locality based Public Health

10. There are both positive and negative aspects of the proposal to move public health to local government. The positive aspects are about the advantages of a local authority base—not a new idea for public health, as this is where public health was based until 1974. NHS PCT-based public health departments had to collaborate closely with matching local authorities, as so many public health and local government services interact with each others. Indeed, several directors of public health have, for some years past, been appointed to joint posts that straddle local authorities and PCTs. Such relationships should become much easier in the future proposed arrangements, and services may be able to collaborate more efficiently than hitherto.

11. The *negative aspects* surround the *break-up of established PCT-based departments*. These departments, operating since 2006, have just begun to function effectively, and with funding increases to support adequate public health data analysis and health promotion (or health improvement, as it is often called nowadays), have become able to achieve adequate critical mass to enable them to work really well. *Their destruction will be a significant loss to effective health improvement in England.*

12. However, the change will *not* "set public health free". Public health departments in PCTs were often fairly criticised for too readily adopting NHS agendas. This was often at the expense of ignoring more major challenges outside the immediate reach of health services. If the proposals are enacted, public health departments will now inevitably be dragged into the adoption of agendas that are set in the context of local government, its problems, perceptions, and services. It will probably be no easier for directors of public health to demonstrate independence of thought and action than it was within the NHS.

The Public Health Function needs an Independent Voice

13. The White Paper proposes that they should share accountability to both the local authorities which employ them, and to the Department of Health (or perhaps to new "wholly-owned subsidiary" to be called "Public Health England"). Ironically, this is proposed by a Government supposedly supportive of the "devolution of power and authority" away from the centre! Furthermore, will DPHs (or DsPH?) be free to lead their departments in practising genuinely science-based public health? There are inconsistencies and paradoxes in this approach.

14. The current Secretary of State has stated his opposition to what he calls "nannying legislation". This is what others might call effective public health leadership. Previous impressive examples include clean drinking water, effective public sanitation, legislation to ban tobacco advertising, smoke-free indoor public areas, compulsory wearing of seatbelts, plus elimination of asbestos from workplaces, and arsenic from food etc. Health education itself was found to be largely ineffective over forty years ago (eg the people kept on smoking). It only became effective when supported by environmental changes (often legislative ones) which made healthy choices easier. However, the current Secretary of State opposes all such modifications of the physical and social environment in the interests of public health. His White Paper instead advises public health departments instead to "nudge" populations towards healthier lifestyles. On its own, this is a flawed and ineffective strategy, lacking supporting evidence and much criticised in recent papers in the BMJ and Lancet.

Conflicts of Interest

15. Another very worrying sign is the willingness of the Government to invite major food industry firms to work with the Health Department on “healthy nutrition initiatives” as part of the Responsibility Deals. There are clear worries about blatant conflicts of interest, based on past business loyalties.

Evidence Based Policy

16. The recent NICE CVD Prevention report reviewed extensive evidence. The most effective policy levers are legislation, regulation tax and subsidies.

17. These have all been explicitly ruled out as “Departmental Diktats”. Instead, voluntary agreements are being developed. These were evidently ineffective during 40 years of failed tobacco control. More recently, voluntary agreements have been proven equally ineffective in promoting healthier diets in the USA and in Europe. Public health science runs a grave risk of being left outside the new public health service in England. This is reminiscent of the Conservative Government of the early 1980s and its suppression of the Black Report that potentially exposed social inequalities in health.

18. Recent events are worryingly similar. In December 2010, the Government cancelled over a dozen ongoing and planned NICE Public Health reviews. These covered key topics such as work on obesity.

19. The UK government has also told the National Institute for Health and Clinical Excellence (NICE) to suspend its work on the prevention of obesity using a ‘whole-systems’ approach at local and community level.

20. NICE has also been told not to start work on several programmes that were being prepared, including:

- Increasing fruit and vegetable provision for disadvantaged communities.
- Identification and management of overweight and obese children in primary care.
- Developing transport policies that prioritise walking and cycling.
- Using the media to promote healthy eating: guidance for policy makers, food retailers and the media.
- Identification and weight management for overweight and obese children: community based interventions.

The Role of Government in Protecting Vulnerable Groups

21. In times of hardship, affluent communities can move ahead while those serving deprived communities will have less resilience to cope with the substantial cuts in public services. This is no time for the Health Department to neglect its Governmental role to protect the weakest in society. Furthermore, when ministers try to justify their radical reform proposals (eg in other documents supportive to the White Paper), they construct an image of poor health in England, but often using very misleading statistics. In fact, several health indicators have improved markedly over the last 10 years. Ministers alleged that the mortality rate from coronary heart disease is twice as high as in France. In fact, John Appleby of the King’s Fund has shown that, if current trends continue, England will soon have a lower coronary mortality rate than France (BMJ 2011).

Proposals for the Public Health Function

22. Service public health in UK has three main sub-specialties: health promotion, health protection, and planning and evaluation of health services. Consideration of each of these in the context of the reforms proposed:

- *Health promotion*: “health improvement” departments will move to local authority departments, and directors of public health will retain responsibility for these services; here the future seems reasonably clear.
- *Health protection (mainly environmental health and communicable diseases control)*: most of the consultants (and other staff) working in this field are employed by the HPA. This, however, is to be disbanded; how services will be reorganised accordingly is far from clear.
- *Health service planning and evaluation*: this will be the field of the new GP-led “commissioning consortia”. Will they invite the assistance of those individuals with a mass of experience and expertise: public health consultants, hospital consultants, and other stakeholders, into their work and discussions? Again, the future is far from clear.

23. CONCLUSIONS

This proposed public health strategy has some merits, but it does appear to preface:

- uncontrolled marketing and consumption of damaging amounts of junk food and sugary drinks;
- major disruption of currently effective public health departments and services;
- impoverishment of successor departments through pressure and erosion of their budgets;

- reduction of local accountability of public health departments and their directors;
- removal of parts of the scientific basis for public health practice from practical application;
- slowing the rate of improvement of health status in English communities; and
- increasing inequalities in health.

June 2011

Written evidence from Age UK (PH 80)

SUMMARY

- As our population is ageing any meaningful public health programme will have to fully incorporate the needs of those in later life. There is strong evidence that public health and prevention activities deliver clear benefits throughout the whole life course.
- Changing demographics must be reflected in the organisation of public health through its structures, funding and incentives.
 - Health and Wellbeing Boards must have representation from across all sectors of the community.
 - The Public Health Outcomes Framework must reflect outcomes that are meaningful for later life. Indicators must not in their design or data collection discriminate against older people.
 - Arrangements for funding must not act as a disincentive to improve the health of the older population.

1. BACKGROUND

1.1 The population is ageing. There are now more people in the UK aged over 60 than there are under 18.¹⁶⁷ Over 10 million people in the UK aged 65 and above¹⁶⁸ of whom 1.3 million people aged 85 or over.¹⁶⁹

1.2 It is important to be aware of the sheer diversity *within* this large group of people which affects their public health needs. The group generally referred to as “older people” encompasses several age-cohorts ranging from baby-boomers to centenarians. Older people are not just diverse in age; they are also diverse in other respects such as ethnicity, faith, sexual orientation, and whether they live in a rural or urban area. All these factors will affect their health needs and concerns and should be reflected in public health interventions.

1.3 Public Health has traditionally focussed on early intervention which often means initiatives aimed at early life. This is, of course, ideal as it can provide long-term benefits. However as the recent Public Health White Paper acknowledged, this does not preclude the need to continue to improve health along the life course.

1.4 Although healthy life expectancy at 65 is rising, it is not keeping pace with the overall increase in life expectancy.¹⁷⁰ We are living longer, but we are not living healthier for longer. Poor health and wellbeing has serious impact on older people’s overall quality of life, preventing people from participating in the activities they enjoy and limiting their ability to live independently.

1.5 It is not just imperative that we act, but there is also growing evidence that it is effective. Many of the chronic conditions which blight the lives of older people can be either prevented or the onset delayed. There is good evidence that it is never too late to improve health and wellbeing if people are given the right information, support and services and that the environment is conducive. Even when there is no longer the prospect of extending life expectancy, there is still every possibility of improving quality of life and wellbeing. Both are legitimate outcomes for public health.

1.6 Many aspects of healthy living apply to all ages; a prime example of this is physical activity. A CMO report from 2004¹⁷¹ stated the benefits of being physically active *in* later life:

- Preventing cardio-vascular disease, diabetes and obesity.
- Maintaining mobility and independent living.
- Training to increase muscle strength which is important for daily living.
- Strength, balance and coordination training to reduce the risk of falls.
- Preventing depression and aiding recovery.
- Improve cognitive function and reducing risk of cognitive impairment.

1.7 In addition to promoting healthy lifestyles throughout life, there is a need to address specific health problems that are particularly prevalent in older populations. Limiting long-term conditions are particularly

¹⁶⁷ *Mid-2009 Population Estimates UK*. ONS, 2010.

¹⁶⁸ *Mid-2009 Population Estimates UK*. ONS, 2010.

¹⁶⁹ *Mid-2009 Population Estimates UK*. ONS, 2010.

¹⁷⁰ *Healthy Life Expectancy at 65 2006–08*. ONS, 2010.

¹⁷¹ *At least five a week: Evidence of impact of physical activity and its relationship to health*. DH, 2004.

prevalent in older age groups. Social isolation in later life must now be recognised as an important public health issue.

1.8 Falls are a major cause of injury among older people. About a third of all people aged over 65 fall each year.¹⁷² Falls represent over half of hospital admissions for accidental injury¹⁷³ at a total cost of about £2.3 billion a year.¹⁷⁴ Yet, there is good evidence of effective action that can prevent falls and falls injury such as NICE guidance.¹⁷⁵ The recent Audit of Falls and Bone Health in Older People by the Royal College of Physicians has revealed enormous scope for improvement in this area.¹⁷⁶

1.9 The public health community is largely concerned about the obesity epidemic but there is scant recognition that malnutrition is serious and prevalent among older people living in the community. Malnourished individuals are less likely to recover from illness or injury, more susceptible to infection, experience increased ill health and have an increased risk of mortality. In addition, they have longer stays in hospital and are more likely to be readmitted. Age UK estimates that around 1 million older people—around 1:10 of people over 65—are malnourished.¹⁷⁷

2. THE CREATION OF PUBLIC HEALTH ENGLAND (PHE)

2.1 While many public health problems are best solved locally, there remains a clear leadership role for central government in providing the right drivers for local change and removing any obstacles.

2.2 Some issues that have implications for public health need to be addressed nationally such as banning advertising of certain products. There is a clear role for PHE to spot emerging health trends including health inequalities between groups of people and between different parts of the country.

2.3 There is a role for a central body like the PHE to:

- take responsibility for collecting and disseminating good practice and evidence for effective public health interventions;
- identify and fund research in public health; and
- to identify and address needs of small groups of disadvantaged people who are geographically dispersed and would therefore not register on the horizon of local authorities e.g. Gypsy Travellers.

2.4 Furthermore, PHE will be in a position to identify the health impact of government decisions for example around welfare benefits and to recommend that guidance from government is issued for example in relation to reducing speed limits.

2.5 As a result, in addition to its role in providing support and guidance to local public health organisation, it is essential that Public Health England has cross-governmental membership including representation from Departments for Work and Pensions, Communities and Local Government, and Transport.

3. THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

3.1 We welcome the transfer of health improvement responsibilities to local government as it presents an opportunity to address the complex needs of older people in a holistic way. However, the transfer of the responsibility for health improvement to local government should not simply move functions from PCTs to local government. For this to work, all the levers for change must be aligned across NHS acute and primary care, mental health services, and public health.

3.2 Local authorities are in a better position to address many of the wider determinants of health, driving the creation of healthy neighbourhoods that allow people of all ages to thrive by providing the right support and infrastructure services, for example:

- Provision of public toilets in combination with medical treatment and access to continence products will help make life for people with bladder problems less limiting and allow them to remain active and engaged.
- Local transport and retail planning which makes food shopping easier as well as the provision of meals and other services that help people with shopping and cooking helps reduce the risk of malnutrition.

¹⁷² *Epidemiology of falls*. Masud T, Morris RO., Age and Ageing, 30-S4:3–7, 2001.

¹⁷³ London Health Observatory. Accessed 05/10/10, at http://www.lho.org.uk/LHO_Topics/Health_Topics/Diseases/AccidentsInjury.aspx

¹⁷⁴ Estimate by National Osteoporosis Society, fact sheet <http://www.nos.org.uk/NetCommunity/Page.aspx?pid=328&srcid=312>, 2009 update

¹⁷⁵ *The assessment and prevention of falls in older people*. CG21. NICE, 2004.

¹⁷⁶ *Falling standards, broken promises: Report of the national audit of falls and bone health in older people 2010*. Royal College of Physicians, 2011.

¹⁷⁷ Calculation based on 1 in 7 prevalence of high or medium risk for those aged 65+ in the community (MUST report, BAPEN 2003), 27% of patients aged 65+ in hospital and 42% in care homes (65+ component) (Nutritional Screening Survey in the UK in 2008, BAPEN 2009). The estimate is a cautious one, as it is itself based on several rough estimates.

- Decent housing and support to escape fuel poverty will have an impact on respiratory diseases and ultimately on winter deaths.

3.3 The increasing decentralisation of powers to local government should result in communities that meet the needs of everyone in later life. However while the new powers are welcome, Government must address the risk of unintended consequences:

- The whole community needs to be represented in shaping the neighbourhood and services that they rely on. This is particularly important for those who are most isolated and excluded. Older people are a diverse group, and engaging all sections of the community is not achieved just by making things “accessible”. There needs to be an assertive drive to reach into communities where there is deprivation, or which are disenfranchised for whatever reason, and to actively target and work with them.
- There needs to be reassurance that people will have the tools to maintain accountability. With more powers for local government and more organisations involved in running services, older people need access to data and information that will allow them to challenge decision-makers if they are not receiving quality services.

3.4 Localism needs to have its limits, and there has been little opportunity for debate on where the boundaries should lie. The Government should review the impact of these proposed changes regularly, to understand how the powers for local government and communities are being executed and the effect they have on public health and community empowerment.

3.5 Health and Wellbeing Boards will have as important role to play in embedding health improvement into the work of local agencies. However, there is a need to ensure that the public and service users are fully engaged in the public health agenda. Health and Wellbeing Boards will have a duty of patient and public involvement. It is vital that they have representation from groups stemming from different sections of the local community. Voluntary and community groups have knowledge about, and access to, seldom-heard groups and can make a valuable contribution to the assessment and analysis of public health needs.

3.6 It will be essential to make sure the needs of disadvantaged group are identified if we are to achieve a real reduction in health inequalities. Joint Strategic Needs Assessments and Health and Wellbeing Strategies must reflect the needs of all sectors of the community.

3.7 Health and Wellbeing Boards must ensure that all aspects of public health, including the wider determinants of health, are incorporated into their plans. They must also ensure the full engagement of those whose responsibility lies in related areas of services such as planning, environment, and transport.

4. STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

4.1 The Public Health Outcomes Framework must reflect the reality of an ageing population. It is essential that it effectively factors older people into the benefits it sets out to achieve. The Framework must incorporate what is important to older people and the full set of outcomes and indicators must reflect later life proportionately.

4.2 It is essential that the outcome measures and underpinning indicators serve the whole population, including people in later life. All indicators should be disaggregated by age unless it clearly does not make sense to do so.

4.3 We are particularly concerned about the proposed indicators for Domain 5: “Healthy Life Expectancy and preventable mortality” in the draft Outcomes Framework. The proposed indicators exclude deaths in people over the age of 75 from cardiovascular disease, cancer, liver disease and chronic respiratory disease.

4.4 We are deeply concerned that limiting these vital indicators by age will compound ageist practice and send a message that older people do not matter. We fully understand that mortality is higher for older ages and that it is not meaningful to make comparisons of mortality between different age groups. As an alternative to the proposed indicators, we suggest that data is collected and reported (separately) for additional age bands “75–84” and “85 and over”.

4.5 The manner in which indicators are measured must not discriminate against older people either. For example, assessment and outcomes measures must include people living in institutions such as care homes and prisons whose residents are often excluded from health surveys. Most older people live in their own homes but nearly 400,000 people over 65 live in care homes.¹⁷⁸ Care home residents are among those people in the poorest health.

4.6 We can only assess and reduce health inequalities if we measure all groups in the population. All data relating to indicators should be collected and disaggregated according to protected equality characteristics as a matter of course. Progress against indicators should also be routinely reported by population groups. We need to ensure that headline progress does not obscure persistent failure to make improvement in relation to specific groups.

¹⁷⁸ Estimate based on Laing and Buisson *Care of Elderly People UK Market Survey 2009*.

5. ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES

5.1 The recent consultation paper, *Healthy lives, healthy people: consultation on the funding and commissioning routes for public health*¹⁷⁹ set out a proposal for a target allocation of funding to each local authority.

5.2 We suggest that the allocation is developed to reflect the five “life stages” identified in the Public Health White Paper: “Starting Well”, “Developing Well”, “Living Well”, “Working Well”, and “Ageing Well”. There would be an allocation to reflect the needs of the local population in each of these strands. The total grant for a local authority would then be the combination of all these strands. For example, using this method local authorities with particularly high existing and projected needs due to an ageing population would be able to better focus on the promotion of “Ageing Well” activities and initiatives, whereas other local authorities with a relative high proportion of young families might dedicate more resources to “Starting Well” or “Developing Well”.

5.3 It should be an essential condition for the grant that money is spent on activities that directly contribute to improving health and wellbeing.

5.4 There is a need for clarification for how public health funding relates to other local government funding such as Supporting People and Disabled Facilities Grant.

6. THE HEALTH PREMIUM

6.1 It is clear that the Health Premium will be a key driver for activity, especially during the coming years of reduced public budgets. It is therefore particularly important that the Premium is not attached to outcomes in a manner that would, perversely, increase health inequalities.

6.2 The Health Premium must not in its design or allocation discriminate against public health activities that will benefit older people. This makes it imperative that the Health Premium is designed and allocated in a manner that incentivises outcomes that will have an impact on health and wellbeing in later life as well as in earlier life equally.

6.3 As a result, we suggest that indicators that benefit the whole population should be selected in the first round. For example physical activity which has enormous potential to improve physical and mental health throughout the life course. We also know that there is room for improvement across the whole life course as only a minority of older adults are active at the recommended level.

6.4 The development of the Public Health Outcomes Framework and the Premium provides a good opportunity to incentivise activity in areas that have previously been neglected by public health. For example, we would suggest a mental health indicator is selected—such as self-reported wellbeing—as mental health is often the poor relation in public health.

6.5 The Public Health White Paper has taken into account the findings of the Marmot Review. The Review concluded that health inequalities stem from social inequalities, and that action on health inequalities requires action across all the social determinants of health.¹⁸⁰ The findings of the report should be reflected in the allocation of the Health Premium. It would be of huge benefit to incentivise local authorities to improve the local environment through attaching a Premium to a healthy locality measure and to improvements in housing. These are both areas which are already within local authority responsibility.

6.6 In order to ensure that the Premium does not inadvertently increase inequalities, there should be a requirement for recipients to report on improvement against each equality strand (or to justify objectively otherwise). For example, if unemployment becomes one of the incentivised indicators, recipient authorities would need to demonstrate decreased unemployment rate not just in the general population but also in specific subgroups such as Black and Minority Ethnic groups or older workers.

6.7 We also suggest that outcomes resulting in cost savings in the NHS in the short term, such as alcohol related hospital admissions, are not given additional financial incentives. Similarly, any indicators that are based on the Quality and Outcomes Framework for GPs should not have a Health Premium attached as they are per definition incentivised.

June 2011

¹⁷⁹ *Healthy lives, healthy people: consultation on the funding and commissioning routes for public health*. DH. 2010.

¹⁸⁰ *Fair Society, Healthy Lives: the Marmot Review*. 2010.

Written evidence from Sense (PH 81)

SUMMARY OF EVIDENCE

- Responsibilities for eliminating rubella and congenital rubella syndrome must be co-ordinated by one overarching body.
- The needs of people with sensory impairments, including deafblind people must be recognised in national and local public health strategies, activities and information.
- Initiatives to promote physical activities, including walking, and to tackle social isolation should address the needs of deafblind people.
- Routine and emergency public health information must be disseminated in an accessible format.
- Public health needs of deafblind people can only be met through the adequate provision of health and social care services.

1. INTRODUCTION

1.1 *Sense*

1.1.1 With over 50 years of experience, Sense is the leading national charity working with, and campaigning for, children and adults who are deafblind. Sense provides expert advice, support, and services for deafblind people, their families and professionals.

1.2 *About deafblindness*

1.2.1 Deafblindness is a combination of both sight *and* hearing difficulties. The complex impact of dual sensory loss means that it is a unique disability. Deafblind people face barriers with communication, access to information and mobility. There are an estimated 365,000 deafblind people in the UK, of whom the largest group are people over 70 with acquired dual sensory loss.¹⁸¹

1.2.2 There are many causes of deafblindness. These include premature birth, birth trauma and rubella during pregnancy, which can cause babies to be born deafblind. Some genetic conditions also result in deafblindness. And any of us can become deafblind at any time through illness, accident or as we grow older. People who are born deafblind often have additional disabilities, including learning and physical disabilities.

2. THE ABOLITION OF THE HEALTH PROTECTION AGENCY

2.1 *Immunisation*

2.1.1 Over the last 13 years or more uptake of the MMR immunisation has been lower than needed thanks to the very public debate about the vaccine's safety. As a result, many hundreds of thousands of children are likely to be unprotected against measles, mumps and rubella. Over recent years, and even weeks, there have been measles outbreaks, putting unprotected children at risk of serious illness, disability and death.

2.1.2 Eliminating rubella and congenital rubella syndrome as a result of a universal two dose vaccine strategy remains both possible and desirable, but only if there is a co-ordinated focus on addressing inequalities in immunisation uptake, promotion of information about immunisation that addresses the concerns and questions of parents and professionals, commissioning and purchasing, delivery and uptake, and monitoring and surveillance. Responsibilities for achieving this will sit across Public Health England, the national commissioning board, local authorities, GPs, the Department of Health and the Joint Committee on Vaccination and Information. The responsibilities of all these agencies must be coordinated by an overarching body, which has a clear duty to do this.

3. THE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

3.1 *Access to public health information*

3.1.1 Given the barriers that deafblind people face in accessing information, it is vital that routine and emergency public health information is disseminated in an accessible way. This will include a range of accessible formats, as well as communicating face-to-face.

3.1.2 Case study

3.1.3 A.D. is fully deafblind and uses hands-on signing to communicate. One day she read in a newsletter from Deafblind UK that her drinking water had been contaminated for several days. She found out later that residents in the affected area were advised over radio broadcasts not to drink the water for the first two days and boil for a few days thereafter. A.D. had been drinking the water the whole time. Fortunately, she did not suffer any health problems from drinking the water.

¹⁸¹ Robertson, J, and Emerson, E, Centre for Disability Research, 2010, Estimating the Number of People with Co-occurring Vision and Hearing Impairments in the UK.

3.1.4 Many deafblind people are reliant on a communicator guide to provide practical help with everyday tasks such as dealing with mail. A communicator guide may only work a few hours every week, so in the case above, the deafblind person may have to wait several days before somebody can relay the message to them, by which point it may be too late. Therefore, it should be the role of local government to ensure that public health information is disseminated in an accessible way. Local authorities are already obliged by statutory guidance to keep a record of the deafblind people living in their area. Therefore, they should be aware of who would need to receive information in an accessible format.

3.2 *The role of the Health and Wellbeing Boards*

3.2.1 The boards will join up commissioning across the NHS, public health, social care and other services. To ensure that this is joined up, the local authorities and GP consortia will have an obligation to undertake the Joint Strategic Needs Assessment through the Health and Wellbeing Boards. Using the strategic needs assessment, the Health and Wellbeing Boards will have to develop a high-level joint health and wellbeing strategy that spans the NHS, social care and public health. For deafblind people there is an inextricable link between public health and social care.

3.2.2 We know that deafblind people experience difficulty in maintaining good health. There are several key factors that can impact on their health including social isolation and difficulty accessing physical activity, open spaces, transport and good quality fresh food. As the case studies below show, deafblind people need support with communication and mobility which can enable them take part in physical exercise, go shopping regularly for fresh food and maintain social contacts. This proves that there is a need for the provision of support from health and social care services to ensure the public health needs of deafblind people are met.

4. THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

4.1 *Access to physical activity*

4.1.1 The percentage of adults meeting recommended guidelines of physical activity is a public health indicator. Deafblind people may be willing to take part in physical activity but it can be difficult for deafblind people to access such activities for various reasons. For example, classes often depend on being able to watch and copy a tutor and being able to go at a pace that may be too fast for people with communication difficulties. Also, hearing aids can fall out during some activities, induction loops may be unavailable or instructors and other participants could have a low level of deafblind awareness. And for many deafblind people, accessing such activities requires human communication and guiding support.

4.1.2 Case study

4.1.3 P is a deafblind man who wants to take part in physical exercise. He would need a communicator guide to assist him with this. When he mentions this as part of his social care assessment, he is told that this is a health need so he will not receive support from social care for this. When he asks his GP about this, he is told that there is no way health services will meet this need. He is supported by social care services to meet basic needs only, such as shopping trips, but this does not include any meaningful physical activity. He therefore remains at home all day for most days of the week—inactive and isolated.

4.1.4 The data for physical activity will derive from Sport England's Active People Survey. This survey examines the amount and types of exercise people participate in, as well as breaking down the statistics into key demographic groups, including disability. However, it does not consider the support people with disabilities may need in order to access physical activity.

4.1.5 One of the public health indicators will be to measure the access and utilisation of green spaces. It is recognised that access to green spaces has a positive impact on mental health wellbeing and cognitive function through physical access and usage. This is also true for deafblind people; however, they may need support from another person to guide them to and around the green space. There are significant barriers to deafblind people taking part in a brisk walk related both to lack of human support, as well as inaccessible streets and other walking routes.

4.1.6 Case study

4.1.7 R.L. is a 71 year old man who has become deafblind. He was born with a moderate hearing loss which has increased and was diagnosed with retinitis pigmentosa, a progressive eye disease, in his thirties. He is now almost totally blind. He had an assessment ten years ago and was told he did not qualify for any social care provision as he lives with his sister who can support his social care needs. R.L. used to live an active life, but now he cannot take part in any physical exercise at all. He lives a five minute walk away from a forest and he would love to go for regular walks there, but he is not able to go without support from another person as he could easily fall over objects on the ground which he is unable to see. R.L. enjoys walking in the forest as he likes to hear different sounds and feel the different textures underfoot. He also likes the opportunities to greet other walkers. Overall, R.L. feels happy, although worn out, after going for a walk in the fresh air. R.L. has been looking for a volunteer who could take him out for some exercise once a week, without success.

4.2 Older people

4.2.1 Older people with dual sensory loss make up the largest group of deafblind people. Evidence highlights that older people with dual sensory loss are more likely to develop certain additional health conditions such as stroke, arthritis, heart disease, hypertension and depressive symptoms. They are also more likely to have falls.¹⁸² Initiatives to promote physical activities, as well as prevent the conditions above should address the needs of older deafblind people. Falls prevention services are also vital to older people with dual sensory loss. However, without the right support from communicator guides, deafblind people are not able to access appointments at falls prevention clinics. Group exercise classes are a good method of preventing falls, as well as overcoming social isolation, but again older people with dual sensory loss will need support to take part in these activities.

4.3 Social isolation

4.3.1 Deafblind people all too easily become lonely and socially isolated; this affects deafblind people of all ages. Additionally, assumptions are frequently made that deafblind older people are considered to be “safe” in their favourite chair at home resulting in little other support or intervention. Without support, deafblind people become prisoners in their own home, isolated from friends and family with a lifestyle that threatens their physical and mental health. Action should be taken to ensure that people with sensory impairments can be involved in social inclusion activities. For example, community agents linking in with older people are bound to come across people with sensory impairments. Therefore they must be aware of the needs of older people with sensory impairments and use relevant communication skills.

4.3.2 Case study

4.3.3 B.J. lost her sight as a teenager and soon after she lost her hearing. She also now has severe mental health problems. She did receive a few hours support from the mental health team for a few hours a fortnight; however, this has now been cut. She says that a lot of mental health problems are due to social isolation. For B.J., it is not a question of thinking that she’ll see her friends or work colleagues next week and she cannot consider picking up the phone to give a relative a call. She often finds that she is stuck in her home for weeks on end without the possibility of going out to see somebody or even having anybody to visit her. If she does go out, she cannot chat to people as they are unable to communicate with her. B.J. feels that priority is given to washing and dressing, but the need for social interaction is completely ignored. B.J. is able to get herself washed and dressed; however, her mental wellbeing has deteriorated as a result of social isolation. Although she has had volunteers to support her in the past, she finds they are not always properly trained in the same way a specialist support worker would be.

5. CONCLUSION

5.1 Sense is happy to try and find deafblind people who can meet informally with members of the Committee and talk about some of the issues mentioned in this submission.

June 2011

Written evidence from Dr Sue Gordon, Executive Director of Public Health, NHS North of Tyne (PH82)

1. INTRODUCTION

1.1 NHS North of Tyne is a PCT cluster which has been in place since 2007–08. The cluster has an integrated public health team working across three PCOs and in partnership with three local authorities covering Newcastle, North Tyneside and Northumberland. This allows public health skills and expertise to be applied to: health improvement programmes; activities intended to reduce health inequalities; health protection and emergency preparedness; and commissioning for quality and equity of healthcare services.

1.2 Major strengths of these arrangements have been the ability to develop links between public health, planning, commissioning and performance management and the ability to influence commissioning along whole pathways of care. My comments are made based on my experience of leading a team working across all three domains of public health from a single team covering multiple PCOs.

2. EXECUTIVE SUMMARY

2.1 There is a significant lack of detail in the public health policy. This, coupled with imprecise use of language, has led to confusion and omission of a whole domain of public health activity from the policy. The dislocation of public health policy and reform from NHS policy and reform means that the role of public health within the new NHS commissioning landscape is not adequately addressed in either.

¹⁸² Crews J E, Campbell V A, 2004, Vision impairment and hearing loss among community-dwelling older Americans: implications for health and functioning. *American Journal of Public Health*; 94 (5); 823–9.

2.2 All three domains of public health need to be addressed in policy and legislation if the public's health and wellbeing are to be effectively protected and improved.

2.3 Healthcare public health—which is *not* limited to preventive interventions, but covers the whole range of healthcare services—focuses on the commissioning of healthcare services to meet local population needs. The importance of healthcare public health is its contribution to more effective and efficient commissioning and improved health equity.

2.4 The public health workforce is large and diverse, and should be led by suitably trained and qualified public health specialists. Uncertainty about future roles and employment prospects for specialist staff risks fragmentation and loss of capacity during the transition.

2.5 The role of Director of Public Health needs to be clarified in relation to its seniority and scope, particularly in championing the wider determinants of health across the breadth of local authority functions as recommended by *Marmot*.¹ Only suitably qualified public health specialists should be able to be appointed as Directors of Public Health.

2.6 Access to the profession should be through the specialty training scheme as the single route of entry. Regulation of all public health specialists should be placed on a statutory footing to ensure consistent approaches irrespective of professional background.

3. INFORMATION

3.1 *Imprecise language and dislocation between public health and NHS policy and reform*

3.1.1 Within *Healthy Lives, Healthy People*² and its accompanying consultation documents the term “public health” is used variously to mean: the health of the public, the specialty of public health, staff employed in public health teams, the director of public health, health improvement, or prevention activity.

3.1.2 Within *Healthy Lives, Healthy People* and *Liberating the NHS*³ and their accompanying consultation documents the term “inequalities” is used variously to mean: any unfair differences, differences in health status arising from lifestyle factors and the wider social determinants of health, differences in ability to access healthcare services, or differences in the outcomes arising from healthcare services. I would recommend making the distinction between:

- “health inequalities”—used for differences in health status arising from lifestyle factors and the wider social determinants of health—ie, the *Marmot* agenda¹; and
- “health equity”—used for the drive to remove or minimise differences in access to and outcomes arising from healthcare services—ie, part of the healthcare public health agenda.

3.1.3 The significant lack of detail in the presented policy coupled with this imprecise use of language, means that the omission of a whole domain of public health activity was not immediately apparent. The dislocation of public health policy and reform from NHS policy and reform has further compounded the problem.

3.1.4 As a result, the role of public health in improving health service quality and supporting healthcare commissioning is largely absent from both *Liberating the NHS* and *Healthy Lives, Healthy People*. The consequence of this absence is a lack of any detail about where qualified public health specialist staff will be located in the system to adequately support these functions and how the NHS Commissioning Board and GP Consortia will access public health advice. The resulting uncertainty creates a real risk that specialist workforce will be lost during the transition.⁴

3.2 *Three domains of public health*

3.2.1 There are three domains of public health:

- health improvement—including people's lifestyles and inequalities in the wider social determinants of health;
- health protection—including infectious diseases, environmental hazards and emergency preparedness; and
- healthcare public health—including service planning, efficiency, audit, evaluation and equity of access to and outcomes from health services.

3.2.2. *Healthy Lives, Healthy People* proposes that, subject to the passage of the *Health and Social Care Bill*,⁵ responsibility for health improvement functions and health inequalities will transfer to local government from April 2013 and Directors of Public Health will be employed by upper tier local authorities to act as the strategic leaders for public health and health inequalities in local communities. The main justification for this, given in the *impact assessments*,⁶ is that the Government has already announced that PCTs will be abolished and their commissioning functions therefore need to move elsewhere. The *impact assessments* are clear that there is “limited evidence” that transferring these responsibilities to local government will serve to improve the health and wellbeing of the population. The possibility of making these improvements is described as “plausible” at best. Improvements in health outcomes will only be realised where the Director of Public Health

is in a position to take control of levers relevant to the wider social determinants of health;⁶ this is likely to pose a significant challenge for areas where local government is arranged in two tiers and many of the critical functions that link to the social determinants of health are delivered at lower tier. The Improvement and Development Agency has recently highlighted areas of local government activity that have the potential to impact on the social determinants of health.⁷

3.2.3 Within *Healthy Lives, Healthy People*, Public Health England is described as having a mission across the whole of public health. Despite this apparently broad remit, it is clear that the key driver for the establishment of Public Health England is the perceived need to strengthen the national response on emergency preparedness and health protection.^{2, 6} There is some detail about how Public Health England will, subject to the passage of the *Health and Social Care Bill*, take on functions currently provided by the Health Protection Agency. There is little reference to Public Health England's role in relation to health improvement, health inequalities, improvement of health service quality or public health support to healthcare commissioning.

3.2.4 *Healthy Lives, Healthy People* makes a case for GPs and their practices to play a more active “public health” role through primary and secondary prevention, and referral to targeted services. In relation to tackling health inequalities, *the Marmot Review*¹ sets out specific roles for GPs and their practices as providers of care and for GP Consortia as commissioners of care. The *Royal College Of Physicians' policy statement*⁸ goes further and outlines specific roles for all doctors, but recognises that a significant cultural shift would be required to refocus beyond the immediate needs of individual patients and towards a population health perspective.

3.2.5 *Healthy Lives, Healthy People* suggests that GP Consortia will access public health expertise from the Director of Public Health (employed by the local authority) via the health and wellbeing board; however, this is unlikely to provide the necessary level of support for GP Consortia or allow them to play a full, equal and active part in their new duties for Joint Strategic Needs Assessment and production of Joint Health and Wellbeing Strategies.⁹ At local level, GP consortia will need public health advice on a range of issues, such as:

- Profiling the local practice and resident population and identifying those at greatest risk.
- Technical input into some areas of commissioning.
- Prioritisation and areas for disinvestment.
- Using evidence on cost and clinical effectiveness to challenge secondary care clinicians.
- Advising on the evidence base for patient pathways.
- Evaluation of services.

3.2.6 I believe that having qualified public health specialist support directly available to GP Consortia is likely to be more effective in supporting these new duties and in mitigating the risk that public health skills and evidence will not be an intrinsic part of commissioning appropriate healthcare interventions.⁶ There is recognition by GPs that they need the expert input of their public health colleagues to support commissioning of health services¹⁰ and there is a strong view from the public health profession that expert public health input must be “embedded in the fabric of GP and NHS Commissioning Board commissioning”.¹¹ At least some of this advice will be highly specialist and therefore an expensive and relatively scarce resource which will need to be concentrated and shared across a number of consortia.

3.2.7 *Healthy Lives, Healthy People* recognises that public health functions need to be included in the NHS Commissioning Board's mandate. The following NHS Commissioning Board functions are likely to require expertise from qualified public health specialists:

- Leading the achievement of health outcomes.
- Allocation of NHS resources.
- Leading on quality improvement.
- Translating NICE quality standards into commissioning guidance.
- Promoting equity in access to and outcomes of healthcare.
- Implementation, management and quality assurance of screening programmes.

3.2.8 I believe that, unless professional specialist public health support is directly available to the NHS Commissioning Board, there is a risk that public health skills and evidence will not be an intrinsic part of commissioning appropriate healthcare interventions.⁶

3.2.9 Despite recognition that there is a need for public health support for NHS commissioning both nationally and locally, the role of public health within the new commissioning landscape is not adequately addressed in *Healthy Lives, Healthy People*. Additionally, there is no detail about where qualified public health specialist staff will be located in the system to adequately support these functions.

3.3 *The importance of healthcare public health*

3.3.1 Healthcare public health focuses on the effective commissioning (or decommissioning, where appropriate) and delivery of healthcare services to meet local population needs, secure equitable access to

healthcare services, and deliver better fairer outcomes from those services. Qualified public health specialists working in this field provide critical expertise, skills and knowledge in:

- interpreting large volumes of information and data received on their local population, their health needs, and the various services provided for them;
- understanding the geography of health needs in order to direct the planning and commissioning of services to meet those needs;
- applying evidence of cost and clinical effectiveness to transform services; and
- leading and delivering change in systems and organisations.

3.3.2 The importance of healthcare public health and its contribution to more effective commissioning is outlined in the *Right Care programme*¹² which aims to improve outcomes of healthcare services, increase the use of higher value interventions, and reduce unwarranted variations.

3.3.3 Analyses by both the Department of Health¹³ and the former Health Inequalities National Support Team¹⁴ have shown that, whilst tackling health inequalities successfully and sustainably requires partnership working to address the wider social determinants of health over the longer term, the biggest improvements over the short term will be derived from preventing the early deaths of people who already have disease or are at high risk of developing disease.

3.3.4 The effective management of chronic diseases in primary care using a population based approach will therefore be critical in reducing health inequalities and improving health equity.

3.4. *The need for a suitably trained and qualified specialist workforce*

3.4.1 The public health workforce is large and diverse made up of specialists and a wide range of professional practitioner groups. To ensure that expert support is available for all those concerned with protecting and improving the public's health, specialist public health should be maintained and developed as a respected, resilient, multidisciplinary profession working across all three domains of public health.¹¹ Appointment to senior public health roles should only be available to suitably qualified specialist public health staff (i.e., those on a specialist register of the General Medical Council, General Dental Council or the UK Public Health Register). The titles "Consultant in Public Health" and "Public Health Specialist" should be protected for such individuals.

3.4.2 Other than for Directors of Public Health—who are to be employed by the local authority—there is little detail about where qualified public health specialist staff will be located in the system. The uncertainty that this creates about future roles and employment leads to a risk of losing specialist workforce during the transition. Coupled with the significant cost savings to be achieved by both NHS employers and local authorities, there is a risk that qualified staff will be replaced by cheaper unqualified staff.

3.4.3 Systems for workforce development, education, training and regulation of qualified public health specialist and public health professional practitioner groups are still unclear. A workforce strategy for public health has been promised for autumn 2011.^{2, 15}

3.5. *The role and status of Directors of Public Health*

3.5.1 The Director of Public Health is the only public health role for which there is clarity about future employment. As has already been stated the "plausible" improvements in health outcomes will only be realised where the Director of Public Health is appointed in a sufficiently senior position and with sufficient authority within the local authority to deliver against the expectation of their new role.

3.5.2 In addition, appointment to Director of Public Health roles should only be available to suitably qualified specialist public health staff (ie, those on a specialist register). As currently drafted, *Healthy Lives, Healthy People*² and the *Health and Social Care Bill*⁵ would allow someone without the relevant training or qualification to be appointed as a Director of Public Health. The title "Director of Public Health" should be protected for such individuals; if this is not possible, then an alternative mechanism should be enacted to ensure that only individuals on the specialist register could occupy such posts.

3.5.3 The vision for the Director of Public Health role as set out in Annex A of *Healthy Lives, Healthy People*² is too broad and is likely unachievable. I would agree with the oral evidence given to the Committee by Professor David Hunter¹⁶ that the role of Directors of Public Health should focus on health protection, health improvement and tackling health inequalities in the local authority setting, whilst healthcare public health would be better placed with qualified public health specialists embedded within the new NHS commissioning landscape.

3.6. *Implications for regulation of the public health profession*

3.6.1 Regulation of public health professionals is focused on assuring consistent quality and safety of practice of qualified specialist public health staff (ie, those on a specialist register). At the present time, there are concerns about:

- inconsistency in the regulation of different groups of specialist staff, with a mixture of statutory and voluntary approaches; and
- the large and growing number of routes to specialty registration.

3.6.2 The *Review of the Regulation of Public Health Professionals*¹⁷ makes a compelling case for placing regulation of all public health specialists on a statutory footing. I agree with the recommendations and particularly:

- “Defined Specialists” should not be considered as being equivalent to “General Specialists”, since they have not been able to demonstrate competence across the full range of public health professional standards.
- There should be a single route of entry into the profession through a single training pathway. The Faculty of Public Health should carry out the central role in relation to education and standard setting.
- Approaches to professional development and revalidation should be consistent for *all* public health specialists on the specialist registers. The Faculty of Public Health should have a central role in producing common revalidation frameworks.

4. RECOMMENDATIONS FOR ACTION

4.1 Significantly more detail is required within the policy on public health. Additional detail should be more precise in its use of language to improve clarity and support implementation. This will help to reduce variation in interpretation by different stakeholders.

4.2 All three domains of public health need to be addressed in the policy and legislation.

4.3 The importance and scope of healthcare public health needs to be recognised within the policy. How specialist public health input is positioned within the new NHS commissioning landscape needs to be addressed. It would be useful to reconnect public health policy and reform with NHS policy and reform and to reconsider whether PCT cluster type arrangements should be retained as a viable option for linking healthcare public health functions and commissioning support at an appropriate population size.

4.4 There is an urgent need to clarify systems for workforce development, education, and training for the public health workforce. Clarity is needed about future roles and employment prospects for specialist public health staff other than Directors of Public Health.

4.5 The role of Director of Public Health needs to be clarified in relation to its scope and its seniority. Only suitably qualified public health specialists should be able to be appointed as Director of Public Health. The Director of Public Health may not be best placed to provide leadership for healthcare public health.

4.6 Regulation of all public health specialists should be placed on a statutory footing with consistent approaches irrespective of professional background. Access to the profession should be through a single route of entry.

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June 2011

Written evidence from the College of Occupational Therapists (PH 83)

SUMMARY

- The College of Occupational Therapists (COT) believe that an Allied Health Professions Director in Public Health England is needed as occupational therapists and other Allied Health Professionals make a significant contribution to public health.
- COT believe that the proposed increase in competition in the Health and Social Care Bill will reduce collaborative commissioning for public health and exacerbate health inequalities.
- COT think that Allied Health Professionals should be represented in commissioning decisions about public health. It is also unclear how “hard to reach” patient groups will be able to contribute to local decisions about public health.
- COT think that the Public Health Outcomes Framework needs to consider overall lifestyle and reasons for health behaviour rather than just focus on discrete parts of a person’s life such as obesity.
- COT would like to see rates of violence against disabled people added to the Public Health Outcomes Framework as it is a risk to the health and wellbeing of people with disabilities.
- The future of the public health workforce is at risk by lack of understanding of professional roles by commissioners, by fragmentation of education and training and by localised workforce decisions which will marginalise smaller professional groups.
- COT would like to see more qualitative evidence being considered as part of the evidence for public health interventions.

1.0 INTRODUCTION

1.1 The College of Occupational Therapists is pleased to provide a response to the Health Committee’s Enquiry into Public Health. The College of Occupational Therapists is the professional body for occupational therapists and represents about 28,000 occupational therapists, support workers and students from across the United Kingdom. Occupational therapists work in local authority social services, the NHS, housing, schools, prisons, voluntary and independent sectors, and vocational and employment rehabilitation services. Occupational therapists are one of the Allied Health Professions, the second largest staff group after nursing which consists of 12 professions including physiotherapists, speech and language therapists, podiatrists, radiographers, dieticians and art therapists (for more information please go to www.ahpf.org.uk).

1.2 Occupational therapists are regulated by the Health Professions Council, and work with people of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties.

1.3 The philosophy of occupational therapy is founded on the knowledge that occupation is essential to human existence and good health and wellbeing. Occupation includes all the things that people do or participate in. For example, caring for themselves and others, working, learning, playing and interacting with others. Being deprived of or having limited access to occupation affects physical and psychological health.

1.4 The daily patterns of activities chosen by individuals can either create a balanced or imbalanced lifestyle which will influence their state of health. Many public health issues which are predicted to consume the majority of health resources in the near future are attributed to modern lifestyle and activity choices. These would include obesity, cardiovascular disease, chronic obstructive pulmonary disease, work related stress, anxiety, depression and sexually transmitted diseases. Tackling the public health challenges of the future will therefore require an understanding of how and why people choose certain activities and how to engage in the correct balance of health promoting activity. This is the speciality area of occupational therapy (Christiansen and Matuska 2006).

1.5 Occupational therapists can contribute to primary, secondary and tertiary levels of public health. Primary public health occupational therapy interventions (upstream activities for the well population to prevent ill

health) are described by NICE (2008) in *Occupational therapy interventions and physical activity interventions to promote the mental well being of older people*. These NICE guidelines clearly show that occupational therapists have a key role in promoting the importance of activity, health and wellbeing among older people. Leisure activities that provide intellectual and social stimulation protect against dementia. Occupational therapists coordinating and delivering mentally, socially and physically stimulating activities may postpone the onset of dementia (Fratiglioni *et al* 2007).

1.6 Secondary public health occupational therapy interventions (to target at risk groups to prevent chronic health problems) would include falls prevention programmes for the elderly which can significantly reduce the rates of falls and increase levels of independence (Logan *et al* 2010). Indeed, a single visit by an occupational therapist reduces the risk of falling after hip fracture (Monaco *et al* 2008). Occupational therapists also offer return to work schemes for adults and for example, can get people with mental health problems into employment faster and working for longer hours than other interventions (Schene *et al* 2007). Occupational therapy interventions for children who are at risk academically, economically and socially can significantly improve hand writing skills and improve academic outcomes for this group (Peterson *et al* 2003).

1.7 Tertiary public health interventions (targeting those with chronic health problems to make the most improvements in health that are possible) would be for example, occupational therapy rehabilitation programmes that include provision of assistive technology and adaptive equipment to enable independence (Scriven and Atwal 2004). Occupational therapists can provide programmes to reduce obesity in schools and for those with mental health problems (Cahill and Suarez-Balcazar 2009, Ormston 2007). Occupational therapy led lifestyle treatment can lead to significantly reduced rates of anxiety for those in primary care (Lambert *et al* 2006).

2.0 CREATION OF PUBLIC HEALTH ENGLAND

2.1 COT believe that there is a need for an Allied Health Professions Director in Public Health England as interventions provided by Allied Health Professionals such as occupational therapists make a significant contribution to public health. Too often Allied Health Professions are represented by nurses or doctors and this is inappropriate as nursing, medical and Allied Health Professional roles can be very different. The sheer volume of nursing related activity means this could inadvertently take priority over Allied Health Professional public health initiatives.

3.0 ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

3.1 Collaborative commissioning for public health will be required that can reach across health, social care, justice and education. This kind of collaboration has developed in some areas and occupational therapists who are trained to work across these areas can be key to developing collaborative working practices. For example, occupational therapists working across health and social care in reablement services can demonstrate faster access to care services and significant reductions in dependence. However, COT believe that the increased emphasis on competition in the Health and Social Care Bill will reduce the ability to commission collaboratively leaving it harder to effectively plan public health services. There will also be less willingness to share good or innovative public health practice.

3.2 COT believe that the current commissioning plans for public health do not include enough clinical engagement from Allied Health Professions including occupational therapists. We believe that there should be Allied Health Profession representation at every level of decision making, commissioning and providing public health. The Department of Health will strengthen the role and incentives for GPs in preventative services both as primary care professionals and as commissioners but this cannot happen in isolation from other professionals. Although the Government suggests GPs need to work with Allied Health Professionals to improve the health and wellbeing of the local population as a whole, there is little evidence of this happening.

4.0 THE PUBLIC HEALTH OUTCOMES FRAMEWORK

4.1 COT welcome the development of the Public Health Outcomes Framework but hope that this will not be at the cost of interventions that consider all the inter-related factors than effect public health rather than focus on discrete interventions. It is well recognised that health is influenced by activity patterns, culture, economy and the environment. Rather than trying to target specific problems overall patterns of living that promote physical, social, emotional and economic wellbeing should be developed.

4.2 COT believe that the most important indicators in the Public Health Outcomes Framework will be employment, settled accommodation, social connectedness, physical activity levels, self reported wellbeing, quality of life for older people, acute admissions due to falls and children/families in poverty. Some screening for children has been removed and the return of these would facilitate early diagnosis and more effective treatment eg spinal scoliosis, eye tests, dental checks.

4.3 COT believe that given the increase in violence against disabled people (particularly see Mencap's campaign about hate crime against people with learning disabilities www.mencap.org.uk/campaigns/learning-disability-week), that this should be measured and reported as a subset of violent crime. The effect of violent crime against people with disabilities is an underestimated risk to their health and wellbeing.

5.0 THE FUTURE OF THE PUBLIC HEALTH WORKFORCE

5.1 COT has concerns about the future of occupational therapists ability to deliver public health interventions. This is for several reasons: firstly current commissioners of public health do not understand the role that occupational therapists have in public health. As a result of this for example, the NICE guidelines for occupational therapy to promote the mental wellbeing of older adults are not commissioned and people are denied these evidence based interventions.

5.2 Secondly, the proposed changes to education, training and workforce decisions which will rely on local networks and planning, will mean that smaller professional groups such as occupational therapists or other Allied Health Professionals will lose out and our voices will be marginalised in workforce planning.

6.0 GOVERNMENT RESPONSE TO THE MARMOT REVIEW ON HEALTH INEQUALITIES

6.1 The Marmot review was clear that health inequalities result from social inequalities and that there is a need for action to tackle the social determinants of health inequalities. COT does not believe that the Government proposals in the Health and Social Care Bill will improve health inequalities.

6.2 The proposal to remove the cap on the level of income that Foundation Trusts can generate from private patients will create less choice and access for poorer patients and will acerbate health inequalities.

6.3 The Any Qualified Provider model will allow private providers to cherry pick the straight forward lucrative parts of care pathways. Patients with multiple needs who require complex interventions (who occupational therapists frequently work with) and who are usually the most socially deprived will get less choice. Smaller, localised providers will be unable to compete with much larger providers.

6.4 How commissioning decisions will include Allied Health Professionals or patients from “hard to reach” groups is unclear meaning that decisions about public health will be made by those with the strongest voice rather than include those with the most health inequalities.

6.5 COT is aware that in the consultation for *Healthy Lives, Health People; Our Strategy for Public Health in England*, there was an emphasis on how to best develop and use evidence to improve public health commissioning and interventions. Qualitative research is particularly relevant in public health where an individual's health and behaviour change is affected by many inter-related factors. Evidence about a discrete intervention such as obesity or smoking, may be almost irrelevant to a person leading a complex and ever-changing life, whereas evidence about whole care packages and programmes is more likely to be useful when helping an individual to engage with health improvement activities.

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June 2011

Written evidence from the National Heart Forum (PH 84)

ABOUT THE NATIONAL HEART FORUM (NHF)

The NHF is a charitable alliance of 70 national organisations working to reduce the risk of avoidable chronic diseases including coronary heart disease, stroke, cancer and diabetes. Our members include medical professional organisations, charities concerned with health, welfare and social policy as well as many individuals distinguished in the fields of disease prevention and public health.

The following remarks draw on consensus-based responses submitted by the National Heart Forum to the Government's consultation on the public health white paper—*Healthy Lives, Healthy People*.

SUMMARY POINTS

- The primary concern of the NHF is that the new arrangements proposed for public health should not lead to any weakening of the public health function, or any loss of expertise or momentum in tackling the major burdens of ill-health in the UK caused by largely avoidable risk factors of poor diet and poor living conditions, smoking, alcohol harm and sedentary behaviours.
- NHF is, in principle, broadly supportive of the direction of change; shifting the locus of public health from the health services to local authorities, but we have significant, specific concerns about aspects of the process involved, including the scale and pace of change, and how it may impact on the independence, accountability and prioritisation of public health.
- We welcome the Committee's inquiry into public health. We believe that it will be a timely and helpful interrogation of the Government's plans and an opportunity for the Government to respond to the contentious issues and clarify areas of uncertainty about the mechanisms of the new arrangements.

RECOMMENDATIONS THAT THE NHF WOULD LIKE THE COMMITTEE TO CONSIDER

1. *Independence of public health advice*

- The role of the **Chief Medical Officer (CMO) must be kept as an independent adviser** to Government, across all departments, not just health. The CMO must have experience in public health and needs to be free to speak out about all public health issues. The position of CMO should be a full time commitment in view of the high demands of the role.
- **Directors of public health (DsPH) should have protected independence and be recognised as principal adviser on all health matters to their local authority**, the NHS and their local Health and Wellbeing Board. To ensure this, we recommend that DsPH should be appointed as a second tier officer accountable to the CEO of the local authority and their statutory responsibilities should be defined in the Health and Social Care Act. This is not unprecedented within Local Authorities; the solicitor role has a similar independence under the section 151 legislation. These duties should include statutory consultation input in all major policy and planning matters across local authorities to take into account the protection and promotion of population health. **We also recommend that DsPH should have a formal relationship with GP consortia** to help ensure that consortia decision-making is underpinned by expert, professional public health advice. The objective is to ensure co-terminosity between the NHS and local authorities on public health matters and to safeguard the important role of the NHS in delivering public health.

2. *Public accountability in the public health system*

- We recommend that a **new Public Health Act** or provision is introduced to enshrine the Government's duties of state and capacity to protect the population's health and to have reserve powers that would enable legislators to introduce health protection measures as and when necessary to reduce the risk of chronic diseases as well as communicable health threats. A broader perspective on health protection is needed as the boundaries with health improvement increasingly overlap.
- Under the proposed new arrangements, the public health system will, in effect, sit within the political system. This raises significant concerns about a lack of independent scrutiny of public health across government. If this arrangement is to be enacted then in addition to protected roles for the CMO and DsPH, we would recommend the establishment of a **new independent Office of Public Responsibility** to act in a complementary role to the health service and social care remit of the Care Quality Commission.

- We also propose that **Public Health England becomes an arms length Executive Agency or non-departmental public body (NDPB)** with an independent public interest governance structure to ensure public health science and policy analysis is properly independent of vested and ideological interests. This will separate scientific risk assessments and policy advice from political decision making on risk management and it will be transparent. Public Health England should be a “whole government” resource. Such considerations are normal in other areas of Government such as economic and fiscal advice, and have proven essential components of effective public health organisations in the UK and elsewhere in the world.
- To protect the independence of DsPH and to ensure rights of access to both the health service and local authority we recommend that while jointly appointed by the local authority and Public Health England (PHE), **DsPH should have their contractual arrangements with PHE if it becomes an executive agency or NDPB.** Depending on the eventual status of PHE and its relationship with the NHS, it may be necessary to strengthen the links within the public health system—between PHE, the NHS and local authorities by giving DsPH and their specialist staff honorary contracts with the NHS. In theory and practice, dual accountability is not recommended.
- The reliance on voluntary agreements with the commercial sector through the Responsibility Deal for public health raises issues of accountability which require clarification. The consideration of “attributable risk” is currently absent from Government thinking in regard to food, drink and associated marketing industries. Specifically, **the role of the commercial sector must be clearly delineated and should not include any involvement in public health policy development.** Independent monitoring of the pledges and robust **evaluation of the public health outcomes of the Responsibility Deal should involve public interest organisations and the Government.**
- We **support the principle of an outcomes-focused approach to public health.** With the right indicators and with clear leadership from DsPH, DH Policy, Public Health England and NICE, we believe this approach has the potential to improve transparency and accountability and to support a common focus and prioritisation of public health resources, at both national and local level, on tackling the major causes and determinants of ill-health.
- The **prevention components of Quality, Innovation, Productivity and Prevention (QIPP) need to be considerably strengthened** and the purpose of the exercise framed as contributing to long term reductions in health service burdens, not just short term efficiency savings.
- We recommend that **consortia commissioning plans should be formally signed off by Health and Wellbeing Boards.**
- There should be a mandatory requirement to produce **independent annual reports** on public health at both national and local levels by the CMO and DsPH respectively. The reports should include a declaration of the resources available to the public health department.

3. The role of central Government in public health

- There is a significant risk that the shift of responsibility for aspects of public health to local authorities under the localism agenda will create gaps in the public health system and loss of expertise. The health care system also needs dedicated public health expertise, outcome targets and other incentives. **Public health expertise is needed at the NHS commissioning executive and in DH policy** and to strengthen cross-government arrangements and co-ordination. We are concerned about the loss of public health expertise and capacity in DH policy and in other Government Departments especially with respect to health improvement and the prevention of avoidable chronic conditions. As the main driver of health and social care costs, this should be a public health priority.
- There must be leadership from central Government to develop and deliver **robust national and international level public health strategies** that tackle the major risk factors of poor diet, inactivity, smoking and alcohol harm. Local authorities cannot address the upstream policy challenges of tackling price and availability of tobacco and alcohol for example, controls on HFSS food marketing to children or the introduction of effective and consistent nutritional labelling on food products.
- The role of central Government in **setting minimum national standards** (for school food and public procurement policies, for example) must be safeguarded. Evidence shows that the major population-wide public health gains are delivered by upstream policy actions (legislation for smoke-free public places, energy-efficient homes, seat-belts and a ban on tobacco advertising, for example). Evidence to support the effectiveness of “nudging” individuals as a means to improve population health and reduce health inequalities, on the other hand, is weak.¹⁸³ Indeed the evidence base supports measures which stop or re-engineer potentially harmful modern marketing nudges. Upstream measures need public acceptance and this should be an important aspect of social marketing initiatives. Upstream measures also efficiently and proportionately reduce health inequalities.

¹⁸³ BMJ 2011; 342: d228.

- We recommend that there must be a continuing **role for the “centre” to support and resource ideas, research, evidence and information.** Operational functions should be contracted out to expert providers. The way in which new arrangements will maintain the **public health observatory function** requires urgent clarification as well as confirmation that vital **national surveys**,¹⁸⁴ data collection and surveillance mechanisms, and the analysis of the data into useful information, continue so that the evidence gathered is used to underpin effective public health practice. The UK is recognised to be a world leader in such public health systems and it is vital to maintain this position.
- The centre has a **key role to play in the development of effective public health practice** and this should be identified as a function which is properly resourced within the new system.
- The importance of the cross-Government role in public health is fundamental to the success of the new arrangements. **The new public health arrangements need to be strengthened across government and public health should be a feature of all Government policy making.** For example, to be sustainable, any national economic plan must include measures to tackle the unsustainable, demand side pressures on health and social care services caused by escalating burdens of chronic but mostly preventable conditions. The national cross-Government arrangements need to mirror and connect with what is expected at local level: local authority governance and the policy shift to a broader health and wellbeing agenda. Local Authorities and DsPH need defined mechanisms to be able collectively to inform Government about the support they need at local level from Government departments.
- Increasingly there are many significant international determinants (eg EU directives or trade agreements) of health and disease and the Government needs to strengthen its capacity and capability to work on such issues with the EU, UN and Bretton Woods organisations.
- Government should make health impact assessments (HIA), which include an equity focus, a statutory requirement in all policy processes at national and local levels as part of the integrated impact assessment process, applied both prospectively and as a three to five year follow up assessment.

4. Public health expertise and resources

- We recommend that DsPH and consultant specialist appointments should be individuals who are trained, accredited and registered in specialist public health.
- There are worrying signs that the changes to the new arrangements are already leading to public health professionals losing their jobs and services being reduced or lost such as National Support Teams, Public Health Observatories and regional offices. We recommend that **local authorities should be obliged to transfer all specialist public health** staff or that they be retained in the NHS under the new arrangements. Temporary transition funding should be made available to avoid redundancies.
- We recommend that the scope of the ring-fenced public health budgets for public health is clearly defined and the size of the budget calculated from a realistic baseline that is taken before the implementation of efficiency savings. Traditional health protection measures for infectious and communicable disease and emergency preparedness will take up the lion’s share of the proposed £4bn allocation, so it will be essential that other budgets and local authority resources from transport, planning, education and environment are unlocked and accessible for public health purposes as part of a wider cross-government approach. There is a real danger that health improvement budgets will be squeezed at national and local levels. This is short-sighted as the main drivers of cost in the health and social care systems are now preventable chronic diseases. It is also essential that any public health funds are not utilised by local authorities to underpin existing services, such as leisure services, which in theory could be justified to have a public health function.
- As resources inevitably become scarcer, policy makers, planners and commissioners need to understand what the current distributions of avoidable chronic diseases are, among whom, and how they are likely to develop in the future, particularly their impact on different population. **It is essential that the centre—either Department of Health or Public Health England—makes sure that those involved in commissioning have the right tools available to them.** An example is the public health micro-simulation the National Heart Forum developed for the Foresight Tackling Obesity enquiry and which is now able to provide valuable insights and potential information on future outcomes and cost effectiveness.

¹⁸⁴ Such as Health Survey for England, National Diet and Nutrition Survey, Low Income Diet and Nutrition Survey.

- The new arrangements do not fully acknowledge the potential role and contributions of the voluntary and the academic sectors. We recommend that the Department of Health establishes **statutory expert groups, drawn from the voluntary sector and academia, for key public health areas**—particularly nutrition, tobacco, physical activity and alcohol harm—under the auspices of an independent Public Health England and DH Public Health Policy. The DH strategic partnership arrangements with the voluntary sector need strengthening and **the role of the voluntary and community sector as both advocates and providers of public health services should be realised**. We refer the Committee to the report of the Association of Chief Executives of Voluntary Organisations (ACEVO) for examples.¹⁸⁵
- The portfolio of work on public health guidance produced by the National Institute for Health and Clinical Excellence (NICE) has been an invaluable resource in recent years. Many important NICE reviews—on obesity, inequalities and child health—were halted in late 2010 with damaging consequences. We recommend that these should be reactivated as a matter of urgency. We recommend that **the functions of NICE should be enhanced and its focus broadened to include the review and evaluation of national and international public health measures as well as local level interventions**.
- **There is a need for a public health repository**, a digital knowledge management system, which provides public health resources at the point of need. Charities, community groups and the voluntary sector generate and publish valuable resources that need to be seen as valuable resources contributing to the evidence-based and deposited in the public health repository for knowledge sharing.
- The framing of public health as “everybody’s business” needs to be practically supported. **Public health should have an input into medical education and training**. This would support the ambition for a public health-led NHS that is primarily focused on the cost-effective prevention of disease rather than treatment. Public Health England and NICE should be part of the new Health Education England arrangements.
- The Government should give **clearer encouragement for bodies to commission jointly** on a larger geographical footprint where this provides better value for money.
- **Integration with children’s services** could strengthen the potential to achieve the Government’s ambition to take a “life course” approach to public health. An example might be smoking prevention and cessation among the young.

5. Tackling health inequalities

- We welcome the referencing of the Marmot Review¹⁸⁶ in the public white paper but recommend that the interpretation of tackling inequalities must go beyond inequalities in access to health services and fully address inequalities in health outcomes.
- The mechanisms for tackling inequalities such as the proposed Health Premium need to be more carefully thought through. Without care, for example, the Health Premium could have the perverse effect of penalising communities where need is growing fastest.

June 2011

Written evidence from the British Retail Consortium (PH 85)

1.0 INTRODUCTION

1.1 The British Retail Consortium (BRC) is the trade association of the retail sector and is the authoritative voice of the industry to policy makers and to the media. The BRC brings together the whole range of retailers across the UK, from independents to large multiples and department stores, selling a wide selection of products through centre of town, out of town, rural and online stores.

1.2 Our membership includes all the major food retailers, who between them account for over 90% of the UK’s grocery sales.

1.3 The BRC and its members have worked closely with Government and stakeholders throughout the UK to help consumers to make healthier choices and live healthier lives. BRC members have led the food industry in terms of clear labelling, reformulation and offering healthier alternatives and dedicated healthy ranges. Similarly in alcohol, BRC members were the first to rollout the Department of Health’s (DH) label promoting unit awareness on their own brand products as well as supporting the Drinkaware Trust and the creation of Community Alcohol Partnerships (CAPs). BRC members have given full support to the DH Responsibility Deal on public health as well as working closely with colleagues in Scotland on their alcohol industry partnership and the development of their obesity route map.

¹⁸⁵ ACEVO (2010). The Organised Efforts of Society. The role of the voluntary sector in improving the health of the population. A report by the ACEVO Commission on Public Health.

¹⁸⁶ Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post-2010.

1.4 Our members also have a strong interest in the Health Protection Agency (HPA). Its role in public health incidents is important to all food businesses; we also worked closely with the Agency in preparation for the threats from pandemic flu.

1.5 We have restricted our comments to those issues which affect retail businesses, which are our relationship with Government to deliver public health policy and the role of the HPA.

2.0 THE PUBLIC HEALTH ROLE OF THE SECRETARY OF STATE

2.1 We believe public health should be a key role for the Secretary of State. This ensures both it receives sufficient recognition of importance within DH and that there is engagement with stakeholders, such as retailers, to deliver public health policy.

2.2 We have been impressed by the current Secretary of State's approach to public health. He made it clear that public health was a key priority for the Department and demonstrated that in his leadership of the Responsibility Deal. By taking such a prominent role in the development of the Deal, the Secretary of State has signalled its importance to Government policy and ensured maximum participation from industry partners.

2.3 We also believe the decision to incorporate nutrition policy within DH was correct. This should ensure it is fully integrated into public health policy as a whole and that there is co-ordination across other Government departments.

3.0 RETAIL ENGAGEMENT ON PUBLIC HEALTH

3.1 Retailers have been very active in key areas of public health for many years. They have provided customers with reformulated products, reducing fats, sugars and salts, they have provided clear nutrition and alcohol labelling, raised awareness of issues with consumers through a number of communication methods and promoted healthier choices in store. This ensures we are all able to enjoy a healthy, balanced, affordable diet.

3.2 All of the work on public health has been shared with the Government, demonstrating the value of responsible companies working with consumers and the market to deliver key goals. The partnership with Government has been demonstrated through progress in salt reduction plans and the commitment to all the key pledges in the Responsibility Deal.

3.3 We understand the reasoning behind increasing local input and focus on public health initiatives but this could present challenges to businesses, such as retailers, that operate at a UK level.

3.4 Although retailers are extremely active in the community through their individual stores, many of their initiatives in public health are co-ordinated at a national level. As UK businesses they make changes to products and labelling at a national level and, similarly they run campaigns such as promotions and information on healthy menus and cooking from scratch across all their stores.

3.5 Whilst retailers have operated a number of initiatives at a local level, including bringing working with consumers in store to improve nutrition understanding and promoting key public health themes with their colleagues, families and communities, their core business, including promotions and campaigns are run nationally. Our preference would be national agreement on the key priorities in public health, allowing for some variation in delivery at the local level.

4.0 THE ABOLITION OF THE HEALTH PROTECTION AGENCY

4.1 We have two concerns regarding the proposal to include the functions of the HPA within DH. The first is retaining the resource and experience currently within the HPA. It performs a crucial role in terms of monitoring potential risks and reacting to emerging issues in both informing businesses and reinforcing consumer confidence. The HPA and its predecessors have established a strong reputation with businesses and earned recognition around the world and we would caution against any changes that could damage that.

4.2 The second point is partly linked to the first, which is the benefit of independence from central government. Similarly to the Food Standards Agency, this gives the HPA enhanced credibility which is important in conveying messages to consumers.

4.3 Whatever changes are made to the HPA we would reinforce the need to ensure good co-ordination with other organisations such as the FSA; the recent problems with E.Coli in Germany have highlighted how public health issues can span several organisations and countries.

Written evidence from Dr John Tomlinson (PH 86)

1. SUMMARY

I am submitting this paper in my capacity as East Midlands Representative of the Faculty of Public Health National Board. In this role I am the elected representative of all Directors and Consultants in Public Health across the East Midlands.

The inquiry into Public Health by the Health Select Committee is most welcome. The NHS White paper and Bill are being actively debated. However the Bill and subsequent Public Health White paper has little detail or clarification with respect to a number of really important Public Health (PH) issues.

The information below utilises the Faculty of Public Health (FPH) response to the PH white paper. The response has been produced following a series of national and regional meetings including the East Midlands. Importantly I and others in the East Midlands are fully supportive of the FPH response.

2. WHAT IS PUBLIC HEALTH

Recommendations

2.1 To ensure that expert support is available for all those concerned with protecting and improving the public's health, public health should be maintained and developed as a respected, resilient, multidisciplinary profession working across the three domains of health protection, health improvement and healthcare services.

Comments

2.2 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.

2.3 There are three domains of public health: health improvement (including people's lifestyles as well— 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 if the public's health and wellbeing are to be protected and improved.

2.4 The public health white paper, Healthy Lives, Healthy People, focuses on prevention and protection, making limited mention of the health service domain of public health practice and apparently fails to recognise the importance to health of effective, equitable, accessible and appropriate health services.

3. RESPONSIBILITY FOR PROTECTING AND PROMOTING THE HEALTH OF THE LOCAL POPULATION

Recommendations

3.1 Local authorities should be accountable for protecting and improving the health of their populations at all times, including outbreak and emergency situations.

3.2 Public Health England should support local authorities in doing this. Local authorities should be required to use the skills and expertise of public health specialists to deliver health and wellbeing for their local population.

Comments

3.3 Neither the Health and Social Care Bill nor the public health white paper articulates these responsibilities clearly. This puts the public at serious risk, particularly in emergency or epidemic situations.

3.4 The wider determinants of health (employment, education, transport, environment, housing etc) are not under the control of the NHS. Local government can directly and indirectly make a substantial difference in these areas and thus public health staff have always worked closely with local authorities to improve health through influencing the wider determinants of health. Organisational boundaries have sometimes got in the way and thus having senior public health staff working within or seconded to local authorities would enhance our capabilities to improve health. This will be supported still further by the need to develop joint health & wellbeing strategies supported by clear outcome frameworks.

4. PUBLIC HEALTH ENGLAND—THE NEW PUBLIC HEALTH SERVICE SHOULD

Recommendations

4.1 Be able to offer independent advice to national and local government, the NHS and the public on all matters relating to the maintenance, improvement and protection of health.

4.2 Provide effective, expert and adequately resourced local teams, supporting and working closely with local services, including the director of public health (DPH), on all three domains of public health.

4.3 Be able to provide advice and guidance to the devolved nations where they are unable to access this locally.

4.4 Be established as a special health authority or, if it must be part of the Department of Health, as an executive agency.

Comments

4.5 It is unlikely that these aims can be achieved if Public Health England (PHE) becomes a fully-integrated part of the Department of Health. As currently proposed this agency will be part of the Department of Health, and its employees will become civil servants. This is inappropriate as many of its functions (eg those currently performed by the Health Protection Agency) are direct services provided to the NHS and other agencies, rather than the formation of policy. Establishing PHE as a special health authority or as a distinct executive agency of the Department of Health would offer a more practical and acceptable way forward. There are three domains to public health practice: health improvement, health protection and healthcare public health. Currently, most public health consultants have expertise in defined areas but their work encompasses aspects of all three domains. This allows for an integrated approach to tackling public health issues and problems. This integration of work would be lost if only some public health consultants were employed by Public Health England. By employing consultants and specialists in all three domains of public health and, where appropriate, seconding them to support local organisations—including as part of the DPH's local team—PHE will be able to ensure that scarce specialist resources are used and developed to best effect. This could also enable consultants and specialists to remain on NHS terms and conditions of service.

Further detail is offered in a recent Lancet Publication (*PH in England*).

5. THE JOINT DIRECTOR OF PUBLIC HEALTH (DPH) POST

Recommendations

A DPH must:

5.1 Be trained and registered to specialist level in public health.

5.2 Be required to produce an independent, public annual report on the health and health needs of their population.

5.3 Be a statutory member of the Health and Wellbeing Board.

5.4 Be directly accountable to the local authority CEO.

5.5 Have responsibility for managing the ring-fenced public health budget and public health staff.

5.6 Provide strategic leadership for all three domains of public health at local level.

5.7 Have direct access to the local authority's cabinet and councillors.

5.8 Not be sacked for any reason without the approval of both the local authority and the Secretary of State.

5.9 Have a contractual relationship—which could be honorary—with PHE.

5.10 Be appointed jointly by the local authority and PHE, through a statutory appointments process which mirrors the existing process for DPHs and consultants/specialists in public health—and which is accredited by FPH (as is currently the case).

Comments

5.11 We welcome the proposal to make joint appointments of directors of public health mandatory, although of course many areas already have joint appointments. 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 and credible independent professional advice. To be credible with the public, the DPH needs to have an element of independence from local government; to be able to constructively criticise the policies of their local authority where such policies harm the health of the population. It is worth noting that when medical officers of health (the predecessors of directors of public health) were employed by local authorities their contracts specifically allowed them such a degree of independence.

5.12 As currently drafted, both the public health white paper and the Health and Social Care Bill would allow someone without the relevant training or qualification to be appointed as a DPH. We therefore believe that it should be mandatory for directors of public health to be on the GMC Specialist Register or the United Kingdom Public Health Register. There is no requirement in either the Bill or Public Health White papers for the DPH to have direct access to the cabinet, councillors or to the CEO. The relationship of the DPH with PHE is unclear, and the DPH could have their employment terminated without the approval of either PHE or the Secretary of State for Health.

6. REGULATION OF SPECIALIST PH WORKFORCE

Recommendations

6.1 FPH should be the standard setter for all public health practice in the UK.

6.2 The title “Specialist in Public Health” should be a protected title, required by statute to be registered.

Comments

6.3 Consultants and specialists in public health, including DPHs, give advice and take decisions which have a major impact on the lives of many thousands of people. Although doctors and dentists working at this level must have statutory registration, this is not required for those from backgrounds other than medicine, although their responsibilities are often identical. It is therefore important that statutory regulation applies to all Consultants and Specialists in Public Health.

7. PUBLIC HEALTH TRAINING

Recommendations

7.1 Should be organised and provided alongside training on other medical specialties with similar routes of access, standard setting and quality assurance.

Comments

7.2 Public health training is currently organised and funded in this way. It 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. The range of training placements will, however, need to be increased to ensure trainees gain experience in all relevant settings.

7.3 The training programme for public health consultants is designed to be equivalent, as far as is practicable, to hospital specialities. Entrants have to be medically qualified, or have a good degree and relevant postgraduate experience. The training programme lasts for at least five years, and progression requires trainees to pass a two part exam and to complete defined work-based learning outcomes. At the end of this programme, employers and the public can be confident that public health consultants will have been trained to the highest possible standards.

7.4 Once the training programme has been completed, medically qualified trainees are eligible to be on the Specialist Register, and are regulated (like all doctors) by the General Medical Council (GMC). Action can therefore be taken to deal with poor performance or misconduct.

7.5 Non-medically qualified trainees are eligible to be included on the United Kingdom Public Health Register. But this body is much more limited in its powers than the GMC.

7.6 We believe that all public health specialists, doctors and non-medically qualified practitioners, should be subject to the same degree of regulation and by the same body, to protect employers and the public from poor performance and misconduct.

8. WORKFORCE CAPACITY

Recommendations

8.1 Measures should be taken to preserve public health capacity at this crucial time.

Comments

8.2 Previous NHS reorganisations have led to a substantial drop in the number of public health consultants. The uncertainties in employment prospects caused by the current reorganisation, and financial restraints, are already leading to some public health consultants seeking voluntary redundancy or early retirement. A further reduction in what is already a very small profession (there are only around 1,000 public health consultants in total) will threaten our ability to improve the health of the population, to contribute our part in the commissioning of health services, and to deliver our input to the response to major incidents and emergencies.

9. GP COMMISSIONING AND SPECIALISED COMMISSIONING

Recommendations

9.1 GP consortia and their teams should be required to work with DPHs and, through them and their teams ensure that commissioning decisions made by GPs are underpinned by expert PH advice. One way of achieving this would be for the DPH or representative to be a formal member of local GP Consortia Boards.

9.2 Those involved in specialised commissioning should be supported by expert PH advice.

Comments

9.3 The population perspective brought by public health experts and the patient-focused perspective of GPs are complementary. Both are needed for successful commissioning. The engagement of the local DPH and their team will facilitate a strategic approach, rooted in the needs of the local communities.

9.4 Currently, public health consultants play a crucial role in the commissioning of healthcare. We contribute our skills and expertise in health needs assessment, critical appraisal of published evidence of effectiveness, leading the production and implementation of care pathways, and as credible leaders who can “hold the ring” between primary, secondary care and community service clinicians and providers.

9.5 The Public Health input to commissioning is therefore crucial to improving the effectiveness and the efficiency of health services. The NHS and Public Health White Papers have failed to understand the vital role that public health specialists play in commissioning. We are particularly concerned at the failure to ensure a future role for public health specialists in the commissioning of specialised services. We believe that it is vital that all GP Commissioning Consortia should have ready access to public health advice and support. This would be best provided from a single agency which employed all public health consultants.

10. INFORMATION

Recommendations

10.1 The new system must ensure that all those working in public health have access to timely, comprehensive and appropriate data and analysis to inform their decisions and advice.

10.2 Arrangements for maintenance of the public health observatory function and cancer registries for ensuring access to health service data need urgent clarification.

Comments

10.3 Reliable data and information are essential to the understanding of health needs, modelling of future scenarios and assessment of impact and efficacy. This is relevant both for service planning and design and for the recognition of and response to hazards and outbreaks. Public health professionals need a comprehensive and intimate understanding of their local population if they are to identify the need for—and to effect—change in any one of the three public health domains. The implementation of Healthy People, Healthy Lives, could result in disruption of existing flows of data and the loss of analytical expertise.

10.4 Public Health Observatories and Cancer Registers have played a vital role in enhancing our knowledge of health needs, in particular by providing us with comparative data. In each locality we need to know how our needs compare to other areas, and it is impractical and inefficient for analysts in each area to attempt to replicate this work. The role of public health observatories should be maintained and strengthened.

11. TEACHING AND RESEARCH

Recommendations

11.1 High quality public health teaching and research, addressing all three public health domains, are crucial to the success of the new system. They must be closely engaged with all levels of public health service and with undergraduate, postgraduate and continuing professional development in all relevant disciplines.

Comments

11.2 Healthy Lives, Healthy People acknowledges the importance of research and the establishment of the NIHR School of Public Health is encouraging. However, local authorities do not have the strong research 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. 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. The new system offers an opportunity to build and strengthen relationships. This will require active support from universities and clarity on the relevant contractual frameworks.

12. FUNDING

Recommendations

12.1 The scope of the ring-fenced budget must be defined clearly.

12.2 The funds available in the ring-fenced budget must be sufficient to meet the needs for which that budget is intended.

Comments

12.3 There is a risk that the existence of a ring-fenced budget for “public health” will be expected to cover “all” public health interventions when many of these are, and will continue to be, the responsibility of other

organisations. 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.

12.4 We are pleased that public health will have a ring fenced budget but are concerned that local authorities may seek to use this budget to prop up their statutory services rather than spend this money on true public health services. It is essential that legislation is very clear on what the ring fenced public health budget should be used for.

13. GOVERNMENT RESPONSE TO THE MARMOT REVIEW

Recommendations

13.1 PHE and Health and Wellbeing Boards should as a key function actively support implementation of the Marmot review recommendation.

Comments

13.2 We are encouraged by the Coalition Government's support for the Marmot Review and would encourage active support for ongoing implementation of their recommendations. This should be a key function for Public Health England and a requirement for Health and Wellbeing Boards to progress.

June 2011

Written evidence from UK Public Health Register (PH 87)

The following response addresses specifically the future of the public health workforce (including the regulation of public health professionals) in the context of the proposed system Reforms

SUMMARY

The focus of this submission from UK Public Health Register (UKPHR) is on the public health workforce and is a response to the inquiry on the regulation of that workforce.

The concern of the UKPHR is to ensure that there is a robust and effective regulatory mechanism to ensure that all public health professionals, both Specialists (Generalist and Defined) and Practitioners maintain high standards of practice, underpinning the delivery of public health goals and maintaining the confidence and safety of the public. To achieve these objectives, they will need to be well trained, competent, committed to improving the health and well being of the communities that they serve, and demonstrating the highest levels of professional conduct in whatever context they are working.

The regulatory infrastructure must support this vision for the workforce, whilst not producing unnecessary regulatory hurdles to development and professional flexibility.

The UKPHR does not think that the Review of the Regulation of Public Health Professionals (November 2010) comprehensively took these issues into account in reaching its conclusions and recommendations.

ISSUES

1. The case for regulation of public health practice remains compelling. Real risk to the public arises from public health practice at the level of populations and individuals, for example from poor practice in smoking cessation, sexual health and nutrition advice or in not securing good take up of childhood immunisation programmes or providing poor advice on communicable disease control.

2. Since it was established in 2003 the UKPHR has pursued its aim of promoting public confidence in specialist public health practice in the UK through independent regulation. Our primary objective is to provide public protection by ensuring that only competent public health professionals are registered and that high standards of practice are maintained.

3. The Register regulates Public Health Specialists (both Generalist and Defined) and Practitioners, working in the three domains of public health as described by the Faculty of Public Health (FPH):

- Health improvement.
- Improving services.
- Health protection.

4. The vision for public health expressed in the White Paper is properly ambitious. We welcome this. In particular we welcome the recognition that, among the many prerequisites for realising the vision and the desired outcomes, is the need to ensure the workforce is fit for purpose, is safe, suitably trained, professional, committed and flexible. The UKPHR supports the achievement of these aims through independent, dedicated regulation of this workforce.

5. The Public Health workforce is both numerous and diverse. It is not confined to health services but also includes those working in local government, the third or voluntary sector and those working for any willing provider of public health services. However, no matter how the public health workforce is defined, the public are entitled to be assured that those working in public health are suitably trained and as professional, committed and flexible as the White Paper demands.

6. The prime purpose of regulation of the public health workforce is to provide the public with confidence that they (the public) are protected against poor practice and misconduct. Although focussing in general terms on the professional workforce, the recent Command Paper *Enabling Excellence: Autonomy and accountability for health and social care staff* sums this up well:

Delivering safe and effective care will continue to be the driving principle behind professional regulation. Further, in the context of “any willing provider” being able to provide services to the NHS in England, the role of professional regulation, providing a set of standards which apply to all aspects of a health or social care professional’s work, whether within the NHS, a local authority, or in a self-employed setting, will become all the more important in future, in most sectors of care.

7. As NHS structures continue to diverge between the four countries of the UK, the broad thrust of the argument—that increasing diversity of service provision makes effective professional regulation even more important—is increasingly real. And the point made by *Enabling Excellence* applies directly to the regulation of public health professionals, in the context of the widening public health role for local authorities.

8. The challenge to regulators, set out compellingly in *Enabling Excellence*, is to provide effective regulation in ways which are increasingly efficient, minimising the burden which regulation imposes on individuals, employers and commissioners. To that end, *Enabling Excellence* gives powerful backing to the concept of “right touch” regulation, which is being championed by the Council for Healthcare Regulatory Excellence (CHRE).

9. The paper also quotes with approval the application of the subsidiarity principle to professional regulation, arguing that the most intrusive and burdensome forms of regulation (including statutory restrictions) should be kept in reserve for the mitigation of risks which cannot safely or effectively be managed at a lower level. We agree and support that approach.

10. As already highlighted, the Register exists to protect the public, to ensure that they have confidence in public health professionals, to drive up standards in public health practice and ensure consistency across the profession. Those overriding aims are fundamental. The precise details of a registration scheme ie whether it is voluntary or statutory or falls under more than one organisation, is a second order issue.

11. There has on occasion been an assumption that only statutory registration can be ultimate guarantor of standards. Yet seen in the light of the contemporary public policy agenda around regulation, an approach which builds on the current significant success of the voluntary register, would in our view be equally, indeed more, effective. A model based on the UKPHR, as a prototype of quality assured voluntary regulation, working in partnership with CHRE offers the prospect of maintaining an effective means of regulation for public health practice (at all levels) without the need for the additional burden of statutory regulation.

12. In order to protect the public as the public health workforce moves to local government, there is a clear need to have the existing requirement on the NHS to appoint only Public Health Specialists who are registered with an appropriate regulator—primarily General Medical Council (GMC), General Dental Council (GDC) or UKPHR—extended to local government appointments.

13. The UKPHR does not support a number of key assertions made within the Review of the Regulation of Public Health Professionals (November 2010), in particular the view that Defined Specialists present less risk than General Specialists. We note with dismay that none of the options in the review took explicit account of the likely impact of their professional failure on public health service delivery. In response to the review the UKPHR commissioned an independent enhanced risk assessment, to look in particular at Defined Specialists and Practitioners. This confirmed that the risk presented by Defined Specialists was equal to that of Generalists. That report also commenced work with CHRE on the development of the concept of *opportunity lost* in relation to professional regulation.

14. The UKPHR supports regulation for all public health specialists and practitioners under the CHRE’s *Right-touch* approach, which can be achieved by either statutory or quality assured voluntary regulation. The assessment of risk posed by practitioners suggested that the result of poor practice was likely to be less severe in consequence to populations but may have significant impact on individuals.

15. These risks cannot be satisfactorily eliminated by reliance purely upon employers, particularly in the light of the increasingly diverse types of organisations likely to be employing public health professionals in the future, with the majority likely to be employed in local government. Employers clearly have their part to play in the regulatory process; but it is unlikely that employers, working alone and in their own separate ways, can of themselves offer the kind of assured regulation that the public has a right to expect and requires.

16. Regulation—professionally informed, independently led and demonstrably free of sectoral interests, continues to be essential, in the interests of the public, the public sector and public health professionals. Such regulation must include the classic components of any proper system of regulation:

- clearly defined entry standards;

- published standards of competence and conduct; and
- fair procedures for dealing with information raising a question about a practitioner's fitness to practise.

17. Over the past seven years the UK Public Health Register has developed independent and rigorous quality assured processes for the assessment, registration, and fitness to practise of specialists and practitioners from a wide range of disciplines working in public health at all levels.

18. UKPHR is currently working with the FPH on a programme of work funded by the Department of Health to ensure that multi-disciplinary Public Health Specialists are included in pilot programmes to ensure that revalidation of public health professionals on the General Medical Council register can apply equally to UKPHR registrants.

19. UKPHR works closely with other regulators, including the GMC, the Nursing and Midwifery Council (NMC), the GDC, and the General Pharmaceutical Council (GPC), to achieve consistency of regulation for public health professionals. UKPHR also works closely with professional bodies including the FPH, the Chartered Institute of Environmental Health (CIEH) and the Royal Society for Public Health (RSPH) to ensure equity of standards.

20. The UKPHR cannot see how the public, the public health workforce or employers would be well served by dismantling or fragmenting the present arrangements, at a likely significant cost to the public purse. Such a course of action would, at one and the same time, negate the purpose of the substantial public investment already made in the development of the Register; and create a situation in which another body would need to replicate what already exists and functions satisfactorily.

CONCLUSION

21. The concern of the UKPHR is to ensure that there is a robust and effective regulatory mechanism to ensure that all public health professionals, both Specialist (Generalist and Defined) and Practitioners maintain high standards of practice, underpinning the delivery of public health goals and maintaining the safety and confidence of the public. This means that the workforce will need to be well trained, competent in what they do, committed to improving the health and well being of the communities that they serve and demonstrating the highest levels of professional conduct in whatever context they are working.

22. The regulatory structures that are in place must support this vision for the workforce but not produce unnecessary nor burdensome regulatory hurdles to development and professional flexibility.

23. The UKPHR is not convinced that the Review of the Regulation of Public Health Professionals (November 2010) fully took these issues into account when reaching their recommendations.

24. The UKPHR sees significant advantage in having the same regulatory body cover Public Health Specialists (both Generalist and Defined) along with otherwise unregulated Public Health Practitioners (who represent a far larger number than those currently subject to professional registration). We believe the UKPHR is well placed to provide this regulatory framework.

25. The UKPHR is already working closely with CHRE regarding external quality assurance and we continue to work very closely with the FPH, particularly around the development of revalidation and the quality assurance of training. The RSPH is also an important partner for us in terms of public health practitioner registration, as is the CIEH. We have benefited from the extensive expertise of other regulators such as the GMC, GDC, NMC, CIEH and GPC who are all represented on the UKPHR Board and who work collaboratively with the UKPHR to set the strategic direction and promote the highest professional standards for Public Health. The UKPHR already has a good reputation and has a robust base on which to build.

June 2011

Written evidence from Homeless Link (PH 88)

SUMMARY

This submission comes from Homeless Link, the national membership organisation for agencies working with people who are homeless. Our particular interest is the way that proposed arrangements for public health will impact on homeless people and the agencies which work with them.

The health of homeless people is significantly worse than the general population. High levels poor physical and mental ill health contribute to and are caused by a person's homelessness, resulting in high levels of working age mortality, a higher level of long term conditions and increased rates of multiple needs.

We believe more needs to be done to ensure the proposals for Public Health will improve the health of the most vulnerable:

- Closer integration with the wider NHS outcomes framework.

- Greater accountability at a national and local level for reducing health inequalities, both for public health directors but also for Consortia and local government through health and wellbeing boards.
- Closer integration and joint working arrangements at a local level between Directors of Public Health (DoPH), housing and other related services provided by, upon which achieving public health outcomes are dependent.

CONTEXT FOR OUR SUBMISSION

1.1 Homeless people experience many of the health and wellbeing needs covered by the new Public Health framework at a rate far higher than the general population. Because of their higher levels of need, homeless people use acute health services disproportionately to the general population, at 4 times the amount for hospital services, rising to 8 times as much for inpatient care.¹⁸⁷ We believe improving preventative and public health services can go a long way to reducing both the ill health of homeless people and the wider costs on the NHS and wider community.

	<i>% who smoke</i>	<i>% who eat 5 or more fruit a day</i>	<i>% with mental health need</i>	<i>% use drugs</i>
General population ¹⁸⁸	21%	29%	30 %	10% (one or more illicit drug in last year)
Homeless population ¹⁸⁹	77%	7%	72%	52%

1.2 The new Public Health strategy for England rightly states that good public health is strongly linked to appropriate housing and other wider determinants of health. We agree that only by integrating health with housing and social care can better health outcomes be achieved. However, despite some progress in recent years on tackling the root causes of ill health, homeless people still experience some of the most persistent health inequalities in our communities. The new role for public health provides an opportunity to change this.

KEY MESSAGES FOR THE COMMITTEE

We have outlined our key points for the Committee to consider under the issues they will be reviewing for this inquiry. With the outcomes of the Listening Exercise expected shortly, we hope the opportunity will be taken to strengthen the current proposals for Public Health.

2. *The creation of Public Health England within the Department of Health*

2.1 Health policy has persistently failed to make real inroads in reducing health inequalities among homeless people and other disadvantaged groups. The creation of Public Health England offers the opportunity to step up efforts to tackle health inequalities and put preventative health services at the heart of local provision.

2.2 However the creation of a separate stream for public health must not relegate preventative and holistic models of health to the sole domain of Public Health. An approach which values earlier intervention, and takes into account the wider determinants of health, must also drive the wider NHS. Public Health England must therefore be closely aligned to the wider NHS framework and the lines of accountability between these bodies needs to be more clearly articulated. We would welcome clarity on this during the Committee's inquiry.

3. *The abolition of the Health Protection Agency (HPA) and the National Treatment Agency (NTA) for Substance Misuse*

3.1 The health needs which fall within the remit of the HPA and NTA are some of those most prevalent among the homeless population. For example rough sleepers experience TB at 200 times that of the known rate among the general population.¹⁹⁰ Research shows that nearly half of homeless day centre users (47%) have drug problems, and 52% alcohol problems.¹⁹¹

3.2 We are concerned that the abolition of the HPA will see key areas of their remit unaccounted for. While this is proposed to fall within Public Health England and their Health Protection Units we recommend the Committee seeks further clarity about how this duty will be discharged. This should include clear indicators for vaccination, screening and treatment completion rates for infectious diseases in the outcomes framework for at-risk populations. Without this we face not only increased need among individuals but wider public health risks.

¹⁸⁷ Healthcare for Single Homeless people, (DH, 2010)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114250

¹⁸⁸ Taken from ONS and NHS data.

¹⁸⁹ Data from Homeless Health Needs Audit, www.homeless.org.uk/health-needs-audit, 2010.

¹⁹⁰ See Inclusion Health: Evidence Pack (March 2010)
www.cabinetoffice.gov.uk/media/346574/inclusion-health-evidencepack.pdf

¹⁹¹ Homeless Link Survey of Needs and Provision 2011, www.homeless.org.uk/snap

3.3 Bringing the NTA under Public Health may present opportunities for locally developed preventative and early intervention work around drug and alcohol treatment. However these services will need to be integrated into those commissioned by Consortia in the new NHS arrangements (for example acute services, dual diagnosis services). Public Health England will need to engage closely with the Department of Health to ensure the integration of outcomes framework and clinical standards; and local DoPH will need to have a clear remit to work with Consortia and other local services, such as housing, and employment via the health and wellbeing board, which are needed to sustain drug related outcomes.

4. *The public health role of the Secretary of State*

4.1 We note that the Health Bill [as amended in Public Bill committee] has made provision for the Secretary of State's duty as to reduce inequalities "to have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service." [section 3, 1B]

4.2 We call on the Committee to seek further clarity during their inquiry as to how the Secretary of State will discharge this duty, particularly with regard to how they will hold the NHS Commissioning board to account for reducing inequalities alongside Public Health England. The relationship between these bodies is at best vague in the current proposals yet it is within the prescribed remit of both to reduce inequalities.

4.3 The Secretary of State should consider appointing an Inclusion Board to guide the discharge of the public health role. They must ensure the outcomes framework incentivises targeted action to improve the health of the most vulnerable, and report annually on progress made by local public health directors and Consortia to improve services for those with the poorest health.

5. *The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)*

5.1 Local government are well placed to co-ordinate much of their proposed work for public health, however we have some concerns for the Committee to consider about how they will discharge their duties.

5.2 There need to be stronger mechanisms for the involvement of key stakeholders—not just local government—in the arrangements for Health and wellbeing boards and the JSNA. For example housing is an important determinant of health, yet its role is underplayed in the current proposals. Health and Wellbeing Boards would be strengthened if their membership included more routine involvement from housing and voluntary sector providers. We hope the guidance for the early implementer programme of Health and Wellbeing boards will encourage this approach.

5.3 The current expertise held by public health teams needs to be protected amidst the transfer of responsibility to Local Government. We are concerned that the pace of change risks losing some of this.

5.4 We think the accountability arrangements for local government need to be strengthened. Currently there is little means for wider stakeholders to hold local government, or DoPH, to account if they feel the JSNA or Joint health and Wellbeing strategies fail to identify and respond to health needs within the community. We would like to see an expectation for more transparent reporting on how commissioning has acted on the priorities identified in the JSNA, and for HealthWatch to have a far greater authority to hold local government to account for improving the public's health (eg to scrutinise health improvement plans).

6. *Arrangements for public health involvement in the commissioning of NHS services*

6.1 We think these arrangements need to be strengthened. It is vital Public Health Directors are involved in commissioning processes for wider NHS services so that these are fully integrated.

6.2 Public Health services are not prioritised in many mainstream services, despite evidence that they are the most effective in preventing more acute health conditions. We would like to see a strong duty for Consortia to engage with Directors of Public Health when drawing up commissioning plans. There should also be a clearer link for how the NHS Commissioning Board will work with Public Health England in the fulfilment of its responsibilities.

7. *Arrangements for commissioning public health services*

7.1 As we understand the primary commissioning arrangements will be from priorities identified in the JSNA and Joint Health and wellbeing strategies. We believe current arrangements could do more to draw on the expertise of voluntary sector partners who often play a key role in both delivering public health services, and engaging those with the most acute inequalities. There are no clear mechanisms for how agencies not formally part of this structure can both help determine commissioning priorities and in the delivery of services.

7.2 We suggest there is a clearer process for stakeholders to feed into health improvement plans, including a mechanism for routinely inviting voluntary and community sector (VCS) agencies to participate on areas relevant to their areas of expertise.

7.3 The new commissioning arrangements may open up opportunities for a wider range of providers to deliver health and wellbeing services. Many small, local agencies currently provide very effective and targeted services which fall into the remit of Public Health. However, they often deliver low volume services to very complex client groups where outcomes can be harder to achieve, and require a “spend to save” investment which commissioners can be unwilling to take.

7.4 This means that commissioning may favour larger providers who can carry this risk. Their capture of the market could stifle innovation and prevent the necessary transfer of resources into primary and community care. To mitigate against this the re-design of tariffs should reflect the complexity—and length of time—of treatment for some patient groups, and ensure that all providers are paid fair prices for their services. Alternative providers must demonstrate and be assessed on how they collaborate with other services as part of meeting their quality standard.

8. The structure and purpose of the Public Health Outcomes Framework

8.1 We welcome the focus the new Public Health Framework will place on preventative services and shared responsibility with other services for reducing health inequalities. Many of the complex health needs experienced by homeless people can be improved through more targeted and earlier interventions which the new public health framework could drive forward.

8.2 It is essential, however, that the existence of a separate framework for public health does not prevent other key players in the health system for taking responsibility for preventative approaches to health. The proposed framework for the NHS is a far more clinically driven framework. However we know that a holistic approach more often championed in public health is often most effective to improve people’s health.

8.3 To be a success therefore, we think greater steps are needed to align the Public Health Outcomes Framework with the NHS Outcomes Framework and the proposed social care outcomes measures. They must be understood and shared across each function. Each must take responsibility for preventative services and have an appreciation of the wider determinants of health, rather than this be the sole domain of Public Health.

8.4 We welcome much of the proposed domains and indicators. However, to capture reduction in inequalities the framework must measure outcomes of more vulnerable and ‘hard to reach’ population groups. There must be provision to disaggregate this information by at-risk groups who are known to experience poorer health. A flag in the data systems to record homelessness would help provide this analysis.

9. Arrangements for funding public health services (including the Health Premium)

9.1 The health premium should not be viewed as the sole incentive for reducing inequalities which is a fundamental aim of public health. As such, the health premium should be designed to encourage local authorities and their partners to address areas of more acute inequality which may require additional resources or more targeted interventions. It should not be designed as a proxy for reducing inequalities across all areas of health improvement.

9.2 The formula should consider the variation in the “baseline” of need in an area: levels of need vary and change depending on the wider determinants (levels of unemployment, levels of affordable accommodation, etc) and these changes must be considered and reconsidered when measuring progress over time; and the longer term nature of progress for some public health improvement areas. Areas should not be punished or disincentivised for offering services which do not offer a quick fix but instead achieve outcomes over a longer period of time.

June 2011

Written evidence from Pharmacy Voice (PH 89)

INTRODUCTION

Pharmacy Voice (PV) represents community pharmacy owners. Its founder members are the Association of Independent Multiple pharmacies (AIMp), the Company Chemists’ Association (CCA) and the National Pharmacy Association (NPA). The principal aim of Pharmacy Voice is to enable community pharmacy to fulfil its potential and play an expanded role as a healthcare provider of choice in the new NHS, offering unrivalled accessibility, value and quality for patients and driving forward the medicines optimisation, public health and long term conditions agendas.

Pharmacy Voice creates a stronger, unified voice for community pharmacy. We are pleased to have the opportunity to provide written evidence on the Public Health Inquiry.

SUMMARY

1. Community pharmacies are increasingly delivering a range of public health services that are producing positive outcomes, notably for people in deprived or vulnerable circumstances. Well established services include harm reduction programmes for substance misusers, stop smoking, sexual health, weight management,

NHS Health Checks and flu vaccinations. The Department of Health recently recognised pharmacists as “a valuable and trusted public health resource.”¹⁹²

2. The transition to new commissioning arrangements in England inevitably brings a level of disruption to the management of health and social care. It is important that there is at this time robust monitoring and holding to account of PCTs and local government responsible for the commissioning and decommissioning of public health services. Particular attention should be paid to community pharmacy with a successful track record of providing public health services.

3. Whilst we support the Government’s aim of shifting powers to local communities in order to reduce health inequalities we are concerned there may arise a lack of strategic planning for populations which will lead to fragmentation of provision and a reduced service offering.

CREATION OF PUBLIC HEALTH ENGLAND

4. The relationships and responsibilities of Public Health England (PHE), NHS Commissioning Board (NHSCB), Local Authorities and Commissioning Consortia in the planning and implementation of public health services are unclear. Clarity is required, to allow health and social care providers to fully engage with this emerging system.

5. Public Health England will have the ability to spread health improvement services that are of proven benefit. This should include community pharmacy based services. The evidence for selecting pharmacy based public health services is included as Appendix A.

6. In our recently published *Community Pharmacy: a blueprint for better health*¹⁹³ we called for strategic advice on pharmacy to be provided to the NHS Commissioning Board through a Director of Pharmacy and Medicines. There should be a similar facility for strategic advice on pharmacy led- public health services within Public Health England and Health and Wellbeing Boards.

7. Pharmacy Voice, the Royal Pharmaceutical Society and Pharmaceutical Services Negotiating Committee are submitting a joint response to UK Influenza Pandemic Preparedness Strategy 2011 Strategy for consultation.

8. Community pharmacy traditionally rises to the challenge of emergencies and will do its utmost to help out in times of need. The flu pandemic 2009/10 was no exception and at national, regional and local levels, the pharmacy profession; pharmacy member organisations, pharmacy owners, local pharmaceutical committees and individual pharmacy team responded rapidly to support the public and primary care organisations, (PCOs), across the UK.

9. It is essential that shared knowledge, capability, capacity and experience of community pharmacy are not lost as reforms of public services take shape.

FUTURE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

10. Plans to transfer certain responsibilities for public health into local government, and possible new arrangements for local authority oversight of health commissioning, mean that ties between councils and healthcare professionals such as community pharmacists are set to grow.

11. Whilst we in principle support the Government’s aim of shifting powers to local communities, we are concerned that there will be a lack of strategic planning for populations which could lead to greater fragmentation of provision and a reduced service offering.

12. Community pharmacies already straddle the ground where the local authority and NHS worlds meet. They are “an integral part of the NHS”, a “vital local service” and a “community facility.” Nonetheless, many of the local authority commissioners of public health will be unfamiliar with the attributes and potential contribution of health service providers including community pharmacies. There is an urgent need for the development of national core service specifications and national recognition of training competences and frameworks to give commissioners assurance that service specifications are robust.

13. Local Government and Improvement and Development published “JSNA best practice guide” in April 2011 but there is no guidance on the types of groups who should be consulted. The Minister should clarify the types of groups, such as pharmacists, that local authorities should be consulting with when developing their JSNAs to ensure that they consult as widely as possible.

14. Community pharmacy teams and pharmacies are important and substantial “health assets”.

15. In addition to being responsible for Joint Strategic Needs Assessments (JSNAs) the responsibility for Pharmaceutical Needs Assessments (PNAs) is proposed to lie with Health and Wellbeing Boards (HWBs). HWBs will have little or no experience of community pharmacy and the understanding of the importance of a robust and accurate PNA yet they must ensure that it is an effective document which is reviewed and updated at regular intervals to inform commissioning decisions.

¹⁹² Healthy lives, healthy people: Our strategy for public health in England White Paper. DH 2010.

¹⁹³ *Community Pharmacy: a blueprint for better health*. Pharmacy Voice 2011
www.pharmacyvoice.com

16. Guidance should be developed by the NHS Commissioning Board to assist HWBs to carry out PNAs, to ensure that they are getting the maximum benefit from community pharmacy services in their area.

17. In the formation of HWBs, as too with commissioning consortia, there must be inclusive and transparent processes of appointment to governing and advisory positions.

18. Legislation should provide for a clear link between the HWBs and the pharmacy sector, either through a nominated individual or a duty to consult.

ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

19. Pharmacists work in the “medicines space” as the experts on medicines. Pharmacy Voice’s vision for the future proposes solutions related to the current issues within the medicines space, ie wastage, poor adherence, medicines-mismatches occurring across interfaces such as admission to hospital and poor discharge planning, and emerging evidence of widespread medicines management and administration errors in residential care.

20. The safe management of medicines has significant public health and patient safety implications and these interactions provide opportunities for public health interventions. We are concerned this aspect of pharmaceutical care should not be overlooked in these changes.

21. Pharmacy Voice understands that the Local Government Association have mixed views on introducing competition into the public sector market which could lead to tension between policy makers, Monitor, commissioners and Any Willing Provider (AWP). Public health services should be open to Any Qualified Provider and decisions should be made on the basis of “best qualified provider”.

22. Community pharmacy could be an example of an AWP model that generates genuine benefits to the community. An estimated 1.6 million people choose to visit a pharmacy each day, of which 1.2 million do so for health-related reasons. People are not constrained by registered lists, geography and the majority receive NHS services free at the point of use yet positive competition operates among community pharmacy where excellence in customer service determines a person’s choice of provider.

THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

23. We are concerned that despite the government’s public recognition of the role of community pharmacy in supporting the public health agenda there is no role for community pharmacy, or eye care providers in contributing to the proposed public health outcomes framework, *Healthy Lives, Healthy People*, consultation, December 2010.

24. Safe use of medicines is an additional domain which is crucial in keeping people healthy and in preventing poisonings, adverse effects and hospital readmissions.

25. We supported the approach to align across the NHS, Adult Social Care and Public Health frameworks but highlighted some of the difficulties in achieving this. As each of these stakeholders uses information on quality and outcomes for different purposes, they require different types of information and different presentation formats. The selection and design of indicators, and their presentation, must be tailored to the different requirements of these stakeholders. The government will need to ensure:

- (a) agreement of shared purpose and goals at a national level of stakeholders;
- (b) alignment of public sector policies of health and local government;
- (c) national frameworks for commissioning outputs, outcomes and costs are comprehensive by incorporating a holistic approach to the public’s health and wellbeing; and
- (d) effective information and communications plans are in place. Enabling IT across organisations is essential and must support data input analysis and outputs which are meaningful, timely and robust.

ARRANGEMENT FOR FUNDING PUBLIC HEALTH SERVICES (INCLUDING THE HEALTH PREMIUM)

26. The proposal that health premiums will incentivise action to reduce health inequalities from funding within the ring-fenced budget will be very difficult to achieve. This is because it is unclear where the monies will come from when other priorities such as efficiency savings and reductions in local authority budgets of up 25% take hold.

27. Structures need to be put in place to ensure that local authorities use ring fenced money appropriately, and not merely to substitute for funds withdrawn from education, leisure amenities or public spaces. These are important wide determinants of public health, but have access to existing funding streams.

28. We support the ring-fencing of funding for public health but there is a need to ensure that ring-fencing occurs nationally as well as locally to support appropriate public health services to all age groups and to those with the greatest need.

29. Capturing outcome data for the unregistered population (ie those not on GP lists) is currently problematic. Services which have the potential to improve the long term health of this population should not be penalized

for lack of outcome data. Evidence of service delivery, of target populations accessing support, and possibly patient reported outcome measures should be regarded as legitimate markers in such circumstances.

FUTURE OF PUBLIC HEALTH WORKFORCE INCLUDING REGULATION OF PUBLIC HEALTH PROFESSIONALS

30. Currently there are no nationally recognised points of reference for training and accreditation. PCTs develop service specifications and training requirements for the most part in isolation, based on the service specification they have developed. Core national service frameworks would enable competencies and training frameworks to be mapped to service specifications.

31. Ensuring that all pharmacists working in a pharmacy are accredited to provide a particular service is currently problematic as pharmacists may live and work in different PCTs, indeed locum pharmacists frequently work in several PCTs. The majority of PCTs do not recognise training delivered/accredited by other PCTs. This situation is likely to be exacerbated if NHS structural reforms lead to smaller commissioning units and new commissioners who are unfamiliar with the attributes of community pharmacy.

TRANSITION PERIOD

32. The transition to new commissioning arrangements in England inevitably brings a level of disruption to the management of health and social care. It is important that there is at this time robust monitoring and holding to account of PCTs and local government responsible for the commissioning and decommissioning of public health services. Particular attention should be paid to community pharmacy with a successful track record of providing public health services.

33. Pharmacy Voice seeks early discussion with emerging organisations to show how we can deliver scalable, sustainable, quality services that meet the needs of people locally and quality assure safe, effective services that people value through national contracts, national frameworks and local relationships.

OTHER REFERENCES

A vision for Pharmacy in the new NHS DH 2003.

Planning for town centres The Office of the Deputy Prime Minister 2003.

Health and Social Care Bill 2011 Part 6 paragraph 190.

June 2011

APPENDIX A

EVIDENCE OF COMMUNITY PHARMACY PUBLIC HEALTH SERVICES

Many locally commissioned pharmacy enhanced services are directly aligned with the Government's policy emphasis on public health and preventative healthcare:

- **Stop Smoking services** have shown very good results in pharmacy. In 2009–10, 140,000 people chose community pharmacy to set a quit date and 62,000 had successfully quit by week 4, a 13% increase on the previous year.
- **NHS Health Checks.** Birmingham South PCT commissioned a "Heart MOT" pilot, a cardiovascular risk-based assessment, in 30 community pharmacies in Birmingham. The results of the pilot show that males who would not normally see a GP access the pharmacy led- services. In addition those individuals from deprived areas and with a minority ethnic background also accessed this service from community pharmacy.
Of those assessed, 60% were male, 65% were from the average, less deprived, and most deprived quintiles, and 7.4% and 24.8% were from Black and Asian communities respectively. Importantly, it highlights that a significant number of individuals can be identified for whom intervention for vascular disease risk or other risk factors is required.
- **Alcohol intervention** In the North West of England pharmacy is playing a key role in the provision of alcohol intervention and brief advice (IBA). Around 125 pharmacies across Wirral, Blackpool, Knowsley, Oldham, Liverpool and Warrington are involved in service provision. The service can be targeted to those who may be at high risk such as those who present for treatment of hangovers, gastric problems and falls. Pharmacy sees a different demographic of people from those who may visit a GP practice, especially in areas of health inequality.

Examples of the benefits are as follows:

- Members of the general public chose community pharmacies in NHS Knowsley pilot to seek out advice concerning their alcohol use. The outcome was that 1165 interventions were carried out and 26% of people who participated were identified as having an increased risk and 6% at high risk of alcohol misuse.
- Based on these results the potential cost savings could be significantly greater than those estimated by the Department of Health, which makes an assumption that only one in four people would be identified at increasing or high risk.

- Directors of Public Health increased their capability and capacity to access people in the community by integrating community pharmacy into their implementations plans.
- **Sexual Health screening and treatment:** Pharmacy has become an increasingly important venue for community sexual health services. Access to emergency hormonal contraception (EHC) is a common enhanced pharmacy service as pharmacies are open in the evenings and at weekends, with no need to book an appointment.

In the first year of the service, it was found that 50% of women accessed the service at the weekend or on Mondays, when it can be difficult to obtain appointments at family planning clinics or GP, now in some localities; pharmacies are the largest providers of EHC to women.
- **Weight management services** evaluated by the University of Central Lancashire showed statistically significant results for agreed weight maintained for 12 months. The service was more cost effective than prescribing Orlistat over 12 months (£160 per patient vs £419.51). People liked the informal pharmacy environment, the accessibility and the flexibility.
- **Healthy Living Pharmacies (HLP).** Figures from the Portsmouth pilot project showed that 30% of patients seen for a Medication Use Review (MUR) had not seen their GP or practice nurse in the previous 12 months. Research also shows HLP had a 36% increase in the number of people who quit smoking and approximately a quarter women who were provided with EHC were also offered Chlamydia screening and almost half (46.4%) of all those accepted a screening kit. A total of 264 who accepted a kit returned a sample, of whom 24 (9.1%) tested positive, concluding that Chlamydia screening for EHC pharmacy patients was warranted.
- **Isle of Wight community pharmacy seasonal flu vaccination report.** Community pharmacists have an important role to play in the delivery of many services commissioned by public health whether these are health promotion services to raise awareness, services offering health prevention or services offering protection. Top-line results indicate significant success:
 - Total vaccinated: 2903 (approx. 10% of total vaccinated through all services).
 - Under-65s with co-morbidities: 36.3% of cohort vaccinated (Other providers: 17.1%).
 - Percentage Rating Service OK or Excellent: 99.6% (90.9% Excellent).
 - Percentage receiving flu vaccination for first time: 8.2%.
 - Percentage for whom vaccination unlikely without pharmacy access: 6.2%.
 - Percentage indicating they would use community pharmacy again: 98.4%.
 - Percentage indicating they found the service more accessible: 92.8%.
- **Minor Ailment schemes.** It is estimated that some 57 million GP consultations each year involve minor ailments, which could in most case be dealt with at a pharmacy. The average cost of a pharmacy consultation (£17.75) relative to an average GP consultation (£32) is £14.25 less expensive. If all patients with minor ailments were to receive pharmacy consultations, then over £812 million could potentially be saved from the NHS budget. This equates to just over 4% of the Government's pledged £20 billion target for efficiency savings.

Written evidence from UK Drug Policy Commission (PH 90)

SUMMARY

- The UK Drug Policy Commission broadly welcomes the renewed focus on Public Health and the proposals within the health reforms that place drug misuse and dependence in a Public Health context, recognising the role of inequality and disadvantage, and a range of social, environmental and economic factors in promoting and sustaining poor health outcomes.
- However, we also have a number of concerns about the arrangements outlined in the Healthy Lives Healthy People white paper that are being legislated for in the Health and Social Care Bill that specifically relate to the provision of services for people with drug problems.
- The white paper and associated documents contain very few references to drug dependence and related services despite the fact that the current drug treatment budget will make up a significant part of the total budget for Public Health (about a quarter of it). Although we recognise the need for flexibility to enable local areas to meet local needs we are concerned that, for a range of reasons that include the widespread stigma attached to drug users even when they are trying to address their problems, there may be significant reduction in investment in drugs interventions.

- The strategy is largely silent with respect to the important “harm-reduction” services, such as needle exchanges and vaccination programmes, which have been largely responsible for the comparatively low rates of HIV infection among injecting drug users (IDUs) in the UK. If these services are not protected there is a danger that they will be neglected and rates of infection will increase.¹⁹⁴
- As mental health services are to be commissioned through GP consortia while drug treatment services will be within the Public Health remit, there is a danger that the difficulties already encountered by people with mental health and substance misuse dual diagnosis will be exacerbated, and they will increasingly suffer from the gap between services.
- The National Treatment Agency for Substance Misuse (NTA) and the Health Protection Agency (HPA) have provided the drive and focus for the development of services and the associated health and social gains resulting from these. They have also developed information systems which are the foundation for monitoring levels and quality of provision and the outcomes of treatment and harm reduction services. It is essential that these monitoring capabilities are retained and adequately resourced within Public Health England as local areas would not have the capacity to undertake the work to the same standard.

Background considerations

1. There are a number of contextual factors that need to be borne in mind when looking at the likely impact of the proposed NHS reforms and the greater focus on public health for people with problems relating to illicit drug use and dependence.

2. Firstly, it should be noted that drug problems are often, although not exclusively, associated with disadvantage, and there are disproportionate numbers of people with drug problems in deprived areas. The prevalence of drug problems is comparatively small when considered alongside some other public health problems, such as hazardous alcohol use,¹⁹⁵ but drug-related harms are extensive and wide-ranging. The most recent estimates of the costs of Class A drug use estimated them as £15 billion, with crime costs being the biggest contributor (90% of the total).¹⁹⁶

3. The Drug Strategies over the past decade have therefore recognised that drug interventions are a cross-departmental responsibility and that partnership approaches are necessary at all levels for efficient and effective delivery. There has been a considerable investment in increased drug treatment provision over this period, which has been overseen and co-ordinated by the NTA.

4. As our recent research has highlighted, people with a history of drug problems and their families are a highly stigmatised group. At one level the general public recognise that being part of the community is important to recovery from drug problems. Yet people also express reluctance to live near or work with people with a history of drug problems and are fearful of having services in their neighbourhood.¹⁹⁷

Maintaining adequate investment in drug treatment and related services

5. In the past, drug treatment funding has come from a range of sources in addition to the pooled treatment budget distributed by the NTA. As well as funding for the Drug Intervention Programme, in many areas there has been funding from Primary Care Trusts, and local authority Social Care budgets have been used to fund residential rehabilitation. There is a danger that, in this period of reorganisation when local budgets are being squeezed, such spending by other departments will reduce or cease altogether, particularly if it is felt that that is the remit of the Public Health function. It is important therefore that there is clarity about what has been included within the Public Health ring-fenced budget, and what is not covered.

¹⁹⁴ The UN Commission on Narcotic Drugs has just adopted a resolution calling for scaled-up HIV prevention activities for injecting drug users worldwide:
<http://www.unaids.org/en/resources/presscentre/featurestories/2011/march/20110328cnd/>. The UK has been in the forefront of such provision in the past and as a result has a comparatively low level of HIV among injecting drug users. It is important that this is maintained under the new arrangements.

¹⁹⁵ It is estimated that about 1% of people aged 15 to 64 in England are problematic opiate or crack users (see Hay et al (2010) “Opiate and crack cocaine use: A new understanding of prevalence”. *Drugs-Education Prevention and Policy*. 17, 135–147) and that about 3% of adults aged 16 to 59 in the household population had used illicit drugs at least once a month in the past year (Hoare & Moon (eds) (2010) *Drug Misuse Declared: Findings from the 2009/10 British Crime Survey*). By comparison, in 2007, 33% of men and 16% of women (24% of adults) were classified as hazardous drinkers. This includes 6% of men and 2% of women estimated to be harmful drinkers, the most serious form of hazardous drinking, which means that damage to health is likely (The Health and Social Care Information Centre (2010) *Statistics on alcohol: England, 2010*, London, Health and Social Care Information Centre).

¹⁹⁶ Gordon L et al (2006) “The economic and social costs of Class A drug use in England and Wales, 2003/04” in Singleton et al (eds) *Measuring different aspects of problem drug use: methodological developments*. Home Office Online Report 16/06. London: Home Office.

¹⁹⁷ Singleton, N. (2010). *Attitudes to Drug Dependence: Results from a Survey of People Living in Private Households in the UK*. London: UK Drug Policy Commission. (Available at:
http://www.ukdpc.org.uk/publications.shtml#Stigma_reports)

6. As mentioned above, recently published UKDPC research shows that there is widespread stigma directed at drug users in recovery and their families.¹⁹⁸ There is a concern that if budgets are tight, these groups will be seen as relatively undeserving and the money currently spent on well-evidenced interventions will be diverted to other areas. This would have severe consequences for the individuals concerned (including families of people with drug problems) and society as a whole.

7. The current pooled treatment budget will make up a substantial portion of the new Public Health budget (probably around a quarter) but there is currently only one outcome measure associated with drugs proposed. The experience from the Total Place pilots¹⁹⁹ suggests that local authorities may well transfer spending from drugs to other areas within the Public Health remit. This is likely to be exacerbated by the stigma directed at drug users and their families, who are already an excluded and vulnerable group.

8. The development of more integrated services for drug and alcohol problems and a greater focus on prevention (in those programmes where there is evidence of effectiveness) that might result from a prioritisation of Public Health may be beneficial but may take some time to realise. If what does occur is simply a shift of funding away from drug interventions then the hidden nature of drug problems and the lack of outcome indicators in these areas may mean that problems arising from such disinvestment may not be picked up quickly but the impacts on communities and individuals may be severe and wide-ranging.

9. It is important that the full range of drug treatment and support services are available in all areas, including harm-reduction services such as needle exchange and hepatitis B vaccinations for injecting drug users, through to the support services necessary for sustaining recovery. It is also essential that support for family members/carers of people with drug problems is available. At present, since there are no outcome measures associated with such services in the proposed framework there is a danger that these will be neglected unless mandated in some way. At the very least they should be an explicit component of the Joint Strategic Needs Assessments.

Arrangements for commissioning drug services.

10. We are concerned that, since mental health service funding is to be undertaken by GP consortia while drug treatment services will be within the Public Health remit, there is a danger that provision for people with dual diagnoses of mental health and substance misuse problems may become even more fractured. The danger that such people are simply passed back and forth between services or fall into the gap between is well recognised²⁰⁰ and it is important that safeguards are put in place to prevent this occurring.

11. It is proposed that that some drug treatment services (in prisons) will be commissioned through the NHS Commissioning Board, some may still be commissioned through local authority social care budgets, and GPs will also be undertaking some provision. It is important that the Health and Well-being Boards are able to take responsibility for co-ordination and ensuring that the whole range of provision is adequately provided and cost shifting does not occur.

12. At the local level, commissioning of drug treatment services has in the past been undertaken by Drug (and Alcohol) Action Teams, many of which have been situated in PCTs. Within the organisational changes underway we are concerned that there is a danger that this specific expertise will either be lost or transferred into GP consortia rather than into local authorities.

13. There are a wide range of interventions aimed at tackling drug problems at a local level so co-ordination of activities is essential. The criminal justice system is also a large consumer of drug and alcohol treatment through programmes such as the Drugs Intervention Programme and Drug Rehabilitation Requirements. However, as currently constituted there is no mention of having any representatives from policing or other parts of the criminal justice system on Health and Well-being Boards. This may have a negative impact on such programmes, reduce partnership working, and runs the risk of overlap or issues falling through the net between Health and Well-being Boards and Community Safety Partnerships.

14. The consultation documents suggest that there is the potential for supra-local commissioning arrangements for services that are specialised in nature. We would suggest that such arrangements might be appropriate in some cases for residential rehabilitation services, which often currently draw patients from a range of local areas, and further consideration should be given to how this might work to provide greater security to these providers.

15. The recent report by the Communities and Local Government Committee, *Localism*, pointed out some of the potential pitfalls of decentralising all aspects of services. There are other important functions that would be more appropriately managed at the national level for reason of efficiency, coherence and consistency. These include workforce development and research, as well as information systems (discussed further below).

16. Some GPs have a special interest in substance misuse and provide prescribing services within some drug treatment systems. All GPs also have an important role in providing support to family members of people with drug problems (an often overlooked group who are subject to much stigma and hence may be reluctant to seek

¹⁹⁸ *Getting Serious About Stigma: the problem with stigmatising drug users*, UK Drug Policy Commission 2010 http://www.ukdpc.org.uk/publications.shtml#Stigma_reports

¹⁹⁹ Eg *Leicester and Leicestershire Total Place Final Report* Leicester and Leicestershire Public Services Board, 2010.

²⁰⁰ *Dual Diagnosis Good Practice Guide* Department of Health, 2002.

help),²⁰¹ both directly and through signposting them to other services.²⁰² The strategy makes no mention of this work and it is not clear how the GP's role as provider will be separated from their role as commissioner of services to deal with potential conflicts of interest. It is also a concern that there are currently no outcome measures to incentivise activity in these areas. The Directors of Public Health and the Health and Well-being Boards will need to ensure that GPs are aware of the importance of providing support to these groups. The content of current GP training also needs to be reviewed to ensure it includes a focus on these issues if they are not to be sidelined.

Monitoring outcomes

17. The proposed Public Health Outcomes Framework contains only one item relating to drugs, concerning numbers in effective treatment. We are concerned that this limited representation within the outcome indicators will lead to drug services being given a low priority.

18. Because of the strict criteria applied to items for inclusion in the framework there may be a danger of focusing on what is measurable rather than what is important. It is also the case that, although there is a requirement for outcomes to have an evidenced link to interventions, it is still possible that there may be multiple factors, (such as other interventions, social and environmental influences) that play a part. Thus, not all changes in these indicators may be due to the interventions put in place under the public health programme.

19. The current requirement that indicators in the Public Health Outcomes Framework are measurable at the local authority level means that some things that are important but quite rare or difficult to measure (such as drug-related deaths and drug-use prevalence) are excluded and action in these areas is not incentivised. There is a need for methodological work looking at ways to deal with this issue, such as combining data across years or proxy measures, to overcome this problem.

20. It is also important to note that while some indicators have a short time lag between data collection and data provision there may be a much longer time lag between an intervention occurring and any impact on the indicator. There is a danger that there will be a tendency to shift focus away from interventions which may have substantial longer term pay-offs towards those that have an immediate but limited effect on outcomes.

21. Some outcomes may be difficult to measure at a local level but may be still be useful at a regional and national level. An additional range of outcome indicators could be identified at these higher levels. In the area of drugs, it is important that major surveys, such as the British Crime Survey and Smoking, Drinking and Drug Use among Schoolchildren continue to be funded to allow monitoring of drug prevalence nationally.

22. There should be some recognition within the outcomes framework of the importance for Public Health of some of the harm-reduction programmes for drug users, particularly injecting drug users. These could be in line with some of those already included, eg rates of new HIV infection acquired through injecting drug use, uptake of hepatitis B and C immunisation.

23. Drug-related death rates should also be considered. Although the instability of single-year data and delays in registration of deaths are an issue, they are probably not insurmountable and there are a number of programmes to address drug-related deaths, such as take-home naloxone, for which there is a growing evidence base.

24. The National Treatment Agency for Substance Misuse (NTA) and the Health Protection Agency (HPA) have in recent years provided the drive and focus for the development of services and the associated health and social gains resulting from these. They have also developed information systems which are the foundation for monitoring levels and quality of provision, and the outcomes of treatment and harm-reduction services. It is essential that these capabilities are retained and adequately resourced within Public Health England as local areas would not have the capacity to undertake the work to the same standard.

25. The new National Institute for Health Research (NIHR) School for Public Health Research provides an excellent opportunity for the development of the evidence base and in addition to the work it funds itself, it could play a pivotal role in drawing up, in consultation with all stakeholders, a broad research programme which all funders could support.

26. In addition to developing the evidence base it is important that NIHR plays a role in ensuring the continuing provision of those interventions for which there is already a strong evidence base, for example substitute prescribing and some harm-reduction initiatives such as needle exchange.

27. It is also important there is national leadership in developing multi-site evaluations, since local areas will not have the capacity or through-put to mount such studies.

²⁰¹ *Getting Serious About Stigma: the problem with stigmatising drug users*, UK Drug Policy Commission, 2010
http://www.ukdpc.org.uk/publications.shtml#Stigma_reports

²⁰² *Supporting the Supporters: families of drug misusers*, UK Drug Policy Commission, 2009
http://www.ukdpc.org.uk/publications.shtml#Families_report

Incentivising improved outcomes

28. Payment by results (PbR) is seen as mechanism for incentivising improved outcomes and on the face of it seems very sensible. However, at a recent expert seminar organised by UKDPC, a number of concerns were raised about the model being proposed for the PbR for recovery pilot schemes. These concerns included: the complexity of the model with outcomes across multiple domains; the risks to service providers, particularly small voluntary sector providers, from the full outcomes payment model proposed; the potential for “gaming” given the complexity of the proposed system; and the unrealistic timescales.²⁰³

29. These concerns remain, and it is notable that the model proposed for the PbR for recovery pilot schemes is far more radical than any being operated or developed elsewhere in the public sector. This could be perceived as experimentation on a vulnerable group and raises ethical concerns.

30. Many of the concerns identified with respect to PbR would also apply to the idea of incentivising local areas’ performance through a health premium. The potential for perverse incentives and other unintended consequences are considerable. An approach that takes account of health inequalities is very welcome but it is not clear how this would work. If it does not recognise the additional difficulties that might be encountered in disadvantaged areas that might make progress there slower, it is possible that the incentives would end up entrenching rather than improving inequalities.

June 2011

Written evidence from Action on Hearing Loss (PH 91)

1. Action on Hearing Loss is the new name for RNID. We're the charity working for a world where hearing loss doesn't limit or label people, where tinnitus is silenced—and where people value and look after their hearing.

We want:

- people to acknowledge their hearing loss and take action;
- more support for people with hearing loss;
- no one to be isolated through their hearing loss;
- people to protect themselves against hearing loss and tinnitus; and
- to cure hearing loss and tinnitus.

SUMMARY

- Hearing loss is widespread, and demands urgent action.
- Hearing loss can impact on health, wellbeing and employment.
- Noise induced hearing loss is preventable.
- On average, there is a 10-year delay in people seeking help with their hearing loss.
- Diagnosis of hearing loss in adults is opportunistic and ad hoc.
- There is a lack of integration between health and social care for hearing loss.
- Poor access to health services for people with hearing loss causes health inequalities.

WE ARE CALLING FOR:

- Hearing loss to be put on the public health agenda of Public Health England, Health and Wellbeing boards, joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies.
- Public Health England to consider a strategy to encourage people to take steps to protect their hearing.
- Early diagnosis and management of hearing loss to be actively encouraged and promoted.
- JSNAs to be refreshed to recognise and tackle the high levels of unmet need around hearing loss.
- A full range of clinical expertise to be integrated into the commissioning process for hearing services.
- Best practice in hearing service provision to be promoted and publicised.
- Health services to improve accessibility for people with hearing loss.
- A duty on local authorities to tackle inequalities.
- Common boundaries between consortia and local authorities.
- An efficient and effective local public health intelligence network.

²⁰³ *By their fruits: Applying payment by results to drug recovery*, UK Drug Policy Commission, 2011
<http://www.ukdpc.org.uk/publications.shtml#Localism>

HEARING LOSS IS WIDESPREAD, AND DEMANDS URGENT ACTION

2. Hearing loss is widespread. It currently affects more than 10 million people in the UK—or one in six of the population. Because of the ageing population, the number of people with hearing loss is set to grow by 14% every 10 years and by 2031 there will be approximately 14.5 million people with hearing loss in the UK. As such, it is a major and growing public health issue.

HEARING LOSS CAN IMPACT ON HEALTH, WELLBEING AND EMPLOYMENT

3. People with hearing loss frequently suffer from other additional disabilities or long term health condition that limits their daily activities, such as arthritis and mobility problems. This includes around half of all people with age-related hearing loss.²⁰⁴ This often compounds barriers to inclusion and feelings of isolation, and means that managing hearing loss can be fundamental to effective management of other conditions.

4. Research reveals that people with hearing loss have a higher prevalence of depression, anxiety and stress. A recent study shows that older people with hearing loss are 2.45 times more likely to develop depression than those without hearing loss.²⁰⁵

5. Recent research also shows that people with mild hearing loss have nearly twice the chance of developing dementia compared to people with normal hearing. The risk increases threefold for those with moderate and fivefold for severe hearing loss.²⁰⁶

6. Research we conducted in 2007 into the employment experiences of severely and profoundly deaf people, found that at a time of near full employment, deaf people were four times more likely to be unemployed than the general population, with negative attitudes from employers seen as the main barrier to getting a job.²⁰⁷

NOISE-INDUCED HEARING LOSS IS PREVENTABLE

7. Noise-induced hearing loss is a preventable condition. Four million young people are putting their hearing at risk through their listening habits²⁰⁸ (including their use of MP3 players and going to music events), but the government does not provide public health information that allows audiences to make an informed choice about the dangers of overexposure to excessive noise.

ON AVERAGE, THERE IS A 10-YEAR DELAY IN PEOPLE SEEKING HELP WITH THEIR HEARING LOSS

8. Early diagnosis and intervention is fundamental to preventing and reducing the impact of hearing loss, supporting independence and wellbeing and preventing mental ill health. However, on average, there is a 10-year delay in people seeking help with their hearing loss. In a 2010 YouGov poll four in five people (79%) said that the NHS needs to make early diagnosis a priority for hearing loss.

DIAGNOSIS OF HEARING LOSS IN ADULTS IS OPPORTUNISTIC AND AD HOC

9. Evidence suggests that GPs fail to refer 45% of people reporting hearing problems for any intervention, such as a referral for a hearing test or hearing aids.²⁰⁹ This raises concerns that GPs do not have up to date information around the importance of early intervention in guaranteeing positive outcomes for patients with hearing loss.

THERE IS A LACK OF INTEGRATION BETWEEN HEALTH AND SOCIAL CARE FOR HEARING LOSS

10. Even when hearing tests and hearing aids are taken up, without the necessary ongoing social support people with hearing loss remain at risk of declining independence and wellbeing. Despite this, essential services such as lipreading classes, hearing therapy and assistive technologies for the home are under-recognised. Only one in five audiology departments provide patients with information regarding ongoing services and support.²¹⁰

POOR ACCESS TO HEALTH SERVICES FOR PEOPLE WITH HEARING LOSS CAUSES HEALTH INEQUALITIES

11. Currently many people with hearing loss experience difficulties accessing health services and public health information that could enable them to manage their health effectively. This is due to difficulties accessing appointment systems and health settings and difficulties communicating with healthcare staff. Our survey about access to GP surgeries found a third of respondents with hearing loss have been left unclear about their

²⁰⁴ RNID *Annual Survey* 2010.

²⁰⁵ Saito H, Nishiwaki Y, Michikawa T, Kikuchi Y, Mizutani K, Takebayashi T, Ogawa K “*Hearing handicap predicts the development of depressive symptoms after 3 years in older community-dwelling Japanese*” *J Am Geriatr Soc.* 58(1):93–7. 2010.

²⁰⁶ Lin, Frank, E Jeffrey Metter, Richard O’Brien, Susan Resnick, Alan Zonderman and Luigi Ferrucci “*Hearing Loss and Incident Dementia*”. *Arch Neurol* 68(2), 2011.

²⁰⁷ RNID *Opportunity Blocked* 2007,

²⁰⁸ Hughes E A, Fortnum H M, Davis A C, Haggard M, Coles R, Lutman M E “*Damage to hearing arising from leisure noise*”. *British Journal of Audiology* 20, 157–164, 1986.

²⁰⁹ Davis, A *et al* (2007) “*Acceptability, benefit and costs of early screening for hearing disability: a study of potential hearing tests and models*” (Health Technology Assessment 2007; Vol. II: No. 42).

²¹⁰ RNID *Annual Survey* 2008.

condition because of communication problems with their GP or nurse and over a quarter (28%) found it difficult to contact their GP surgery to get an appointment because of their hearing loss.²¹¹

WE ARE CALLING FOR:

Hearing loss to be put on the public health agenda of Public Health England, health and wellbeing boards, JSNAs and joint health and wellbeing strategies

12. Although it is clearly a public health issue that demands action, hearing loss is not currently on the public health agenda. We recommend that, with the creation of Public Health England, hearing loss is recognised and responded to through health and wellbeing boards, joint strategic needs assessments and joint health and wellbeing strategies.

13. A public health strategy should also take into account the effects of tinnitus (the perception of sound in the ears in the absence of external noise). Tinnitus can lead to sleep difficulties, and concentration difficulties in both social and employment situations. It also contributes to mental health issues. People with tinnitus need a range of information and support, from basic information and reassurance to intervention by clinical specialists and follow up care.

Public Health England to consider a strategy to encourage people to take steps to protect their hearing

14. Noise-induced hearing loss is preventable—Public Health England should consider a strategy to encourage people to take steps to protect their hearing.

Early diagnosis and management of hearing loss to be actively encouraged and promoted

15. As the core function of public health is to tackle determinants of health and wellbeing, people should be actively encouraged to address the onset of hearing loss, so as to avoid related conditions including depression, anxiety, dementia and social isolation.

16. We recently commissioned a cost benefit analysis of a hearing screening programme, which showed that the benefits of hearing screening for older people clearly outweigh the costs. At a cost of £255 million over 10 years, a hearing screening programme for over 65s could save £2 billion, representing a benefit cost ratio of more than eight to one.²¹²

17. As well as providing economic benefits, a screening programme would set out clear routes for referral and treatment for adults. This would ensure earlier and increased take-up of hearing aids, leading to more successful patient outcomes. It would also tackle the high level of unmet need and social stigma around hearing loss.

18. In the meantime we are calling for accessible and joined up hearing services delivered close to people's homes.

19. GPs have an important role and should recognise the importance of early intervention and provide timely referral to audiology and hearing services.

20. We are calling on health professionals to develop Quality and Outcomes Framework (QOF) indicators, to provide an incentive for promoting hearing checks, and to integrate hearing checks into other routine health assessments, particularly those targeting older people.

JSNAs to be refreshed to recognise and tackle the high levels of unmet need around hearing loss

21. The white paper envisages health and wellbeing boards developing joint strategies based on the assessment of need outlined in their Joint Strategic Needs Assessment (JSNA). Making population assessments around hearing loss is complicated by the current levels of unmet need. Issues of stigma and inbuilt barriers to services mean that one in three people who could benefit from hearing aids currently do not use them.

22. JSNAs need to account for the one in six in the population who have some level of hearing loss. They should recognise the need for accessible services that would encourage those with hearing loss to access hearing checks and hearing aids. JSNAs also need to account for those with hearing aids who may need to receive ongoing social support to ensure hearing aids are fully utilised. This could be through services such as our Hear to Help, as well as lipreading classes and hearing therapy to help maintain communication skills, independence and wellbeing.

23. We recommend that JSNAs are refreshed to help tackle unaddressed need and ensure a joined up patient journey for people, and to promote prevention, early intervention, accessible services and ongoing social support for people with hearing loss.

²¹¹ RNID *Simple Cure* 2006.

²¹² RNID and London Economics *Cost Benefit Analysis of Hearing Screening for Older People*. London: RNID, 2010.

A full range of clinical expertise to be integrated into the commissioning process for hearing services

24. It is essential that the full range of clinical expertise is integrated into the commissioning process for hearing services. This is of particular concern, as evidence suggests a lack of GP awareness around treatment options, additional services and referral criteria in audiology.

Best practice in hearing service provision to be promoted and publicised

25. We recommend audiology and hearing loss champions within each local authority, responsible for capturing relevant developments in technology, clinical procedures and models of service delivery. They would promote and publicise best practice in terms of hearing service provision and should be involved in the commissioning process.

26. We would also like to see some GP consortia becoming centres of excellence in specialised areas, including audiology and hearing loss, with the NHS Commissioning Board playing a fundamental role in identifying and disseminating good practice.

Health services to improve accessibility for people with hearing loss

27. Health services must commit to making services 100% accessible to patients with hearing loss. This means ensuring appointments can be booked not just on the phone but by email, text or text-to-speech relay services, ensuring that staff are all fully deaf aware and providing timely access to interpreters where required.

A duty on local authorities to tackle inequalities

28. Although the Health and Social Care Bill introduces important new duties on the NHS Commissioning Board and consortia to tackle inequalities in health, there are no equivalent duties on local authorities. This duty should be introduced to go along with the shift of budgets and responsibility for public health.

Common boundaries between consortia and local authorities

29. GP commissioning boundaries should, as far as possible, be aligned to local authority boundaries to support joint working between health and social care needs and to ensure population health issues are addressed, including tackling health inequalities and the needs of unregistered patients.

An efficient and effective local public health intelligence network

30. If the function of the Public Health Observatories is bought under Public Health England to save money, this should not be at the expense of a less effective local public health intelligence network, as this could result in higher overall costs. The role of the Public Health Observatories will also be complicated by the issue of co-terminosity between GP consortia and local authorities. The fact that these bodies have different catchment areas will make it more difficult to capture data to inform health and wellbeing boards.

June 2011

Written evidence from the Royal College of Paediatrics and Child Health (PH 92)

1. The RCPCH is pleased to submit written evidence to the Health Select Committee Inquiry into Public Health. As a professional body seeking to ensure the best outcomes for children, we want to highlight the particular implications for children and young people in the areas being specifically examined by the Committee. We will respond to each of the topics of enquiry in turn.

2. THE CREATION OF PUBLIC HEALTH ENGLAND (PHE) AND ABOLITION OF THE HEALTH PROTECTION AGENCY (HPA)

2.1 The creation of PHE is vital to the achievement of a joined-up, flexible and responsive public health service. However, we continue to request greater clarity on the role, structure and personnel of the new body. We also highlight the importance of the role that PHE should play in coordinating immunisation and vaccination programmes. A national service would achieve economies of scale and help to ensure safety.

2.2 RCPCH agrees with many commentators that the creation of PHE within the Department of Health has the potential to damage the independence and credibility of the organisation and by extension, the public health workforce. While we acknowledge that an entirely independent body may not be desirable in the light of the other reforms suggested by the White Paper, we believe the discrete role and relatively autonomous reputation of PHE should be preserved. To this end, we recommend that PHE should be required to comply with the Nolan principles of public life, have an established board with public meetings and publication of board papers.

2.3 The HPA is an internationally recognised body that provides high quality independent research and advice on health protection issues. Its dissolution and the integration of its functions and (presumably) workforce into the PHE will have to be carefully managed both in terms of health protection functions in the transition period, and the issues identified with independence and autonomy above.

3. THE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

3.1 RCPCH supports the transferral of public health functions to local authorities. This reform represents an opportunity to reduce silo working and increase collaboration between agencies, particularly with children's care. Their role in addressing the social determinants of health, such as housing, education or transport, cannot be understated. The Health and Wellbeing Board (H&WB) will need to play a vital role in coordinating a coherent strategic approach, and the input of community paediatricians, educational authorities and public health professionals will be essential to achieving this.

3.2 Nonetheless it is important that H&WBs, in their broad remit, do not lose focus of children's health and, in particular, child protection. It is important that Children's Trust (CT) arrangements, where still in existence, or in whichever form they have taken following abolition of statutory requirements to have a CT structure, work closely with H&WBs and provide specific focus and expertise on matters affecting children and young people. We would recommend that CT arrangements remain in form and function (if not name), and that they remain separate from the H&WBs, yet still having a shared agenda on children's matters.

3.3 It is vital that Local Safeguarding Children's Board (LSCB) functions are not subsumed into H&WBs. It is crucial that LSCBs retain independence and can properly hold local authorities, and other agencies, to account.

3.4 Clinical consortia must be actively represented and engaged on H&WBs, and schools must also be included on the membership. This is especially important given the increasing amount of schools, particularly secondary schools, applying for academy status, as well as the increase in free schools. The increased autonomy from local authorities that these schools will have means that oversight via the H&WBs is required, as well as enabling schools to access expertise and be part of the multi-agency child protection process.

3.5 Finally, we would advocate that, despite H&WBs merging adult's and children's services issues, local authority directorates should stay separate. Merging would contradict Professor Eileen Munro's review and be potentially damaging for children's outcomes.

4. PUBLIC HEALTH INVOLVEMENT IN THE COMMISSIONING OF NHS SERVICES

4.1 Public health expertise should be embedded at all levels of commissioning, from the NHS National Commissioning Board (NCB), clinical commissioning consortia, Public Health England and any supra-local or sub-national commissioning arrangements.

4.2 As outlined in the College's response to the Public Health White Paper *Healthy Lives, Healthy People*, we believe that the role of the community paediatrician will also be essential in ensuring that the various commissioning agencies take into account the health interests of children and young people. Their membership on the Health and Wellbeing Board should be mandated to ensure that a holistic view of children's services, and that links are made with Community Children's Nurses and health visitors. They will also be able to oversee safeguarding, disability services, Joint Strategic Needs Assessment, helping to develop the joint health and wellbeing strategy and navigating the sometimes complex commissioning arrangements for children's services.

5. ARRANGEMENTS OF COMMISSIONING FOR PUBLIC HEALTH SERVICES

5.1 The commissioning arrangements outlined in *Healthy Lives, Healthy People* are sensible, but need some refinement. We agree with the commissioning of children's public health under five years being directed by the National Commissioning Board, and five to 19 by Local Authorities, but caution that this separation should be based on peer group (ie September to August for the majority of children) rather than exact age. Commissioning arrangements needs to be carefully managed to ensure a natural and continuous transition into a largely school-based approach to health protection and promotion, and be consistent across boundaries between clinical consortia and local authorities.

5.2 We believe it is vital that local authorities commission school nursing. We would also make the case for some services to be commissioned nationally, for reasons of economies of scale. These might include vision services and child health mapping. There must be clear arrangements between local authorities and clinical consortia to agree contractual arrangements for healthcare for looked after children, particularly where they are placed out of area. Too often at present, children are placed without these agreements and specialist and general health support may be interrupted or inconsistent which can significantly affect wellbeing and safety of the young person and their carers. It should be clear who commissions and provides health assessments and plans for looked after children.

5.3 Some high-cost, low volume services, perhaps around health protection issues, will need to be commissioned by PHE, rather than clinical consortia. The RCPCH also supports the possibility, outlined in *Healthy Lives, Healthy People*, of sub-national or supra-local commissioning arrangements for certain specialist conditions. Many of these may be too financially risky for clinical consortia or other local agencies to commission, but arrangements may not be sensitive enough to local need if commissioned by the NCB.

5.4 RCPCH is also looking for clarity around commissioning for health service aspects of Sexual Assault Referral Centres (SARCs). We suggest that this is commissioned on a national basis, but we are happy to discuss this further with relevant partners.

6. THE FUTURE OF THE PUBLIC HEALTH OBSERVATORIES

6.1 We support the creation of the National Institute for Health Research (NIHR) and the School for Public Health Research. However, the College believe that the availability of and access to data should still be localised. However, it is vital that the knowledge and expertise amassed by Public Health Observatories, which is particularly useful in Joint Strategic Needs Assessments (JSNAs), is not lost in the new arrangements. We seek reassurance from the DH that the new system will continue to provide robust and credible local intelligence, and that the tools, data analysis and support currently provided by Child and Maternal Health Observatory (ChiMat) for maternal and child health will not be lost.

7. THE PUBLIC HEALTH OUTCOMES FRAMEWORK

7.1 The RCPCH believes the Outcomes Framework as outlined provides a robust and flexible framework for determining meaningful indicators. It pays close attention to a life course based approach, but we share concerns with other commentators that the Outcomes Framework is not sufficiently aligned with the outcomes frameworks for the NHS and social care.

7.2 Specifically, on safeguarding, we agree with our colleagues at the NHS Confederation that this area shows a particular incoherence in its approach. The proposed Public Health Outcomes Framework has a child protection element aimed specifically at children under five years, while the Social Care Outcomes Framework contains adult safeguarding elements and the NHS Outcomes Framework contains no safeguarding elements. RCPCH suggests a consistent approach that ensures adequate child protection as a key outcome for all relevant agencies.

7.3 We are encouraged that there are a number of outcomes specifically for children and young people, but similarly, these need refining if the Outcomes Framework is to drive improvements in children's health care effectively. RCPCH believes that aligning them with existing European datasets would make international comparisons easier, and avoid any duplication of effort in developing relevant indicators. The Child Health Indicators of Life and Development (CHILD) project provides an holistic set of 38 core desirable national indicators, ranging from infancy to adolescence. In terms of children's health, this is the most comprehensive range of measures identified. These form the basis of the WHO Europe Strategy for Child and Adolescent Health across over 50 countries.

8. FUNDING OF PUBLIC HEALTH SERVICES

8.1 We welcome the ring-fencing of the public health budget. In particular RCPCH highlights the importance of protecting the funding for vital health protection measures such as immunisation and vaccination, as well as full implementation of the Healthy Child programme.

8.2 We welcome the introduction of the health premium as a mechanism to address local health inequalities. However, it will need to be carefully calibrated to encourage activity that has been shown to reduce health inequalities. While it might appear sensible at first glance to simply reward achievement in reducing health inequalities, we know that the results of some interventions take many years to appear, especially in areas where such inequalities are deeply embedded. Furthermore, it may not be sensible to incentivise certain, short-term achievements in that this may encourage local authorities to focus on 'easy wins' rather than long term goals that will bring improvements in health for future generations. In short, the reward system needs to be calibrated carefully to reward tangible, measurable achievement, but in such a way that minimises the opportunity to 'game' the system and rewards a long-term and sustainable approach.

9. GOVERNMENT RESPONSE TO THE MARMOT REVIEW

9.1 The public health white paper *Healthy Lives, Healthy People* builds on the evidence presented by Sir Michael Marmot's review of health inequalities. It takes a life course approach, and pays particular attention maternal, child and adolescent health, under the 'Starting well' and 'Developing well' strands. This approach dovetails with the independent reviews led by Rt Hon Frank Field MP and Graham Allen MP, on poverty and life chances and on early intervention, respectively.

9.2 However, the Marmot review also identified poverty as a key determinant of health. The government's response to this particular aspect has been disappointing. The recently published Child Poverty Strategy marked a divergence from previous government efforts in this area, despite Johan Mackenbach's assessment that it "was the first European [attempt] to pursue a systematic policy to reduce socio-economic inequalities in health". The new Strategy rejects this approach as "exhausted" and "exacerbating the problem by weakening incentives to work".

9.3 The Institute of Fiscal Studies (IFS) recently published a review of progress on child poverty over the last 10 years. This provided evidence that whilst progress has been made, the cumulative effect of the benefit

reforms introduced by the government are likely to increase the number of children living in poverty from 2.6 million to 2.9 million by 2013–14.

9.4 The Marmot review's recommendations appear to have found traction at the Department of Health, but have failed to make an impact on other government departments. The report's recommendations covered a wide range of the social determinants of health, very many of which have a direct impact on children's health and development, and upon which the Department of Health will have little influence upon. The author of a previous report on health inequalities, Sir Donald Acheson, famously defined public health as "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society". There is little evidence that this philosophy has taken root across government departments, and without such a joined-up approach, there is little possibility of child poverty, and by extension children's health, improving.

June 2011

Written evidence from MEND (PH 93)

SUMMARY

MEND (Mind, Exercise, Nutrition... Do it!) will work with public, private, third sector and academic organisations to:

- empower children and adults to become fitter, healthier and happier and to reach or maintain a healthy weight;
- offer solutions that people can use throughout their lives to improve their fitness, health and self-esteem by providing the information and support they need to choose healthier foods and spend more time being active;
- provide the knowledge, skills, resources and training that professionals and organisations need to:
 - prevent people from becoming unhealthy as a result of inactivity, injury or poor food choices; and
 - treat people who are above a healthy weight (and therefore more at risk of developing chronic diseases including cardio-vascular disease, type 2 diabetes and some cancers).
- develop innovative ways to improve public health and encourage healthier lifestyles, using our extensive research.

Since being founded in 2004, MEND has helped more than 40,000 children and adults across the world to live fitter, healthier and happier lives. Our programmes, training and resources can be tailored to the communities where they are delivered and are developed using detailed research and evidence. We currently hold the largest volume of child weight management programme data in the world. In the UK, we have a 20-year research partnership with Great Ormond Street Hospital for Children NHS Trust and the University College London Institute of Child Health.

- GP and provider representation on Health and Wellbeing Boards will be crucial in ensuring a joined up approach to public health.
- Local Authorities are well placed to assume responsibility for commissioning obesity services but commissioners will need to be supported during the transition and thereafter to make good decisions.
- To do this, central government should do the following:
 - provide a commissioning support pack specifically for obesity services comprising high quality obesity pathways, benchmarking data, suggested proxy outcome measures and cost data;
 - provide commissioners and providers with a national set of evidence which both should be required to use;
 - produce a clear set of standards by which providers can be evaluated;
 - produce a directory of approved obesity providers;
 - incentivise good practice; and
 - make it a requirement for Local Authorities to use e-procurement.
- Children's indicators must be included in the Public Health Outcomes Framework.
- The ring fenced public health budget must be safeguarded to ensure it is translated into frontline services. What is more, budget allocations must shift to focus on targeted prevention and treatment where there is a strong evidence base, rather than traditional preventative methods with limited evidence and outcomes.
- MEND strongly supports the inclusion of recommendations made by the Marmot Review team in *Healthy People, Healthy Lives* and hopes they will infiltrate all areas of public health policy.

THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

1. We agree that Local Authorities are well placed to assume responsibility for commissioning obesity services. As the bodies responsible for many of the channels through which we can improve public health such as leisure centres, schools, housing and planning, they are well placed to formulate an all-systems strategy for tackling obesity which cross-cuts many impacting factors. This should increase their ability to improve outcomes for the population as a whole.

2. Health and wellbeing boards have the potential to provide a vital link between GP Consortia and the other various commissioners of public health interventions to achieve a joined up approach to improving public health. We hope that GP attendance will be made compulsory.

3. *Healthy Lives, Healthy People* iterates that providers may be invited to sit on the health and wellbeing board to advise on certain issues. We hope that this approach will be encouraged as providers can offer valuable advice on how to commission services effectively and efficiently.

ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

4. Commissioners, especially those who are not specialists in child and adult weight management and obesity prevention, need to be supported during the transition in making rational decisions about which interventions to purchase and to do so in a timely manner. This support must be provided immediately, to ensure that services and capacity are not lost during the transition period, as well as being embedded in the medium and long obesity strategy. MEND recommend the following steps are taken:

4.1 *Make it easy for commissioners to procure high quality interventions*

A commissioning support pack—specifically for obesity services—should be developed to support PCTs, and then local health and wellbeing boards and GP consortia, in working together to commission obesity services. The support pack should build on existing good practice and include:

- high quality obesity pathways—enabling commissioners to determine the nature of services that they may wish to commission There are many good local examples of this that can be publicised;
- benchmarking data—allowing commissioners to both assess the relative need of their population and the relative performance of existing and candidate providers (NCMP data);
- suggested proxy outcome measures—providing a framework to performance manage providers on clinically relevant indicators rather than process measures (National Obesity Observatory (NOO) Standard Evaluation Framework (SEF)); and
- cost data—setting out (in the absence of a national tariff) what would be a reasonable cost for obesity interventions, when commissioning at scale is the most cost effective option, and what that scale should be. The Department of Health can gather this information in a comparable way nationally and publicise it.

Most of this can be collated swiftly from existing sources and we are happy to contribute in any way we can.

4.2 *Ensure commissioners and providers use a national set of evidence*

It is important that commissioning decisions are made on high quality evidence. In the past we have seen tender processes drag out for up to 12 months, caused partly by commissioners developing their own set of evidence. Building on the work previously carried out by the National Obesity Observatory the evidence base should be collated and made available through the NHS Evidence website, allowing commissioners to easily access consistent, high quality, information.

4.3 *Produce a clear set of standards by which to evaluate providers*

To date, relatively few child weight management tenders have included the ability to compare value for money on a like for like basis. To ensure high quality services are commissioned and provided, both providers and commissioners must know the standards of service expected of them, and commissioners must be able to compare providers like for like.

4.4 *Produce a directory of obesity providers*

Given the developing nature of obesity intervention provision it will be important to support commissioners in identifying suitable “any willing providers”. A directory of obesity providers should be developed, encompassing NHS, private sector and social enterprise providers. This should set out which choices of interventions should be guaranteed to all patients. It should also rate interventions by categories such as cost, cost effectiveness, evidence, outcomes, impact on health inequalities and success in reaching BME groups etc. This would allow commissioners to select the best intervention for their local area, based on the resources available to them and their JSNA, but without compromising on quality.

4.5 *Incentivise good practice*

Too often in the past the obesity services have been evaluated based on process and inputs, rather than on clinical outcomes. We believe this is fundamentally wrong. The strategy should set out how services and commissioners could be rewarded on the basis of the outcomes that they deliver. This incentivisation

should be realistic and based on evidence, not, as demonstrated in one tender recently, putting a very large proportion of the contract at risk for outcomes far beyond those demonstrated anywhere in the literature. Mechanisms for achieving this could include use of the health premium, CQUINs type schemes, or the development of best practice tariffs. A NICE Quality Standard for childhood obesity should be developed, and children's indicators should be included in the new Public Health Outcomes Framework.

4.6 Use of eProcurement

The cost to providers of bidding for and winning Local Authority contracts can be considerable when the process involves a pre-qualification and full tender process. This must be addressed if the widest range of providers are to play their full part in service provision. We recommend that all Local Authorities are required to use eProcurement so that tenders can be submitted electronically and that a single (online) pre-qualification process is implemented to avoid repeatedly providing the same information for different Authorities.

THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

5. MEND strongly recommend that children's indicators are included in the Public Health Outcomes Framework so that commissioners are not incentivised to prioritise adults over children in order to grow their budgets.

ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES

6. Steps should be taken to ensure that the ring fenced public health budget is translated to frontline public health services, and is not diverted into other areas such as social care. At the national level, MEND believes that the funding imbalance between prevention and treatment requires redressing.

7. Over the past 10 years we estimate that approximately £50 million has been spent on evidence-based treatment of child obesity, while £1.5 billion has been spent on preventative measures such as trying to improve nutrition, and increase levels of physical activity. While it is widely agreed that prevention is better than treatment, there is very little evidence to suggest that many of these preventative measures work. In contrast, there is considerable evidence to support *targeted* prevention and targeted treatment such as weight management programmes. These have a direct impact on slowing, and in due course reducing, the rate of growth of chronic diseases associated with obesity such as Type 2 Diabetes, cardiovascular disease, strokes and some cancers.

8. The ring fenced public health budget presents an opportunity to redress this imbalance. While both treatment and prevention are important, in the interests of "doing what works", budget allocations should reflect a heavier focus on targeted prevention and treatment than has previously been the case.

9. The case for cost-effective evidence-based weight management programmes is far more compelling than that for many preventative measures. If the balance of spending is addressed, and some of the sums currently spent on primary prevention are reduced, then this rebalancing alone can save more than enough money to fund a long-term strategy for tackling obesity and any short-term interventions to address transition-related discontinuities—with far clearer outcomes than are currently visible. MEND is seeing increasing numbers of tenders for operating bundles of obesity prevention/wellness services, many of which appear to have a limited evidence base but are legacy services. A more rigorous case should be made for their continuation in the face of current funding pressures.

HOW THE GOVERNMENT IS RESPONDING TO THE MARMOT REVIEW ON HEALTH INEQUALITIES

10. MEND welcomes the government's inclusion of five of the six recommendations made by the Marmot Review in *Healthy People, Healthy Lives*. In order for this to translate into practical action, these principles must be embedded in each area of public health policy. MEND hopes to see this emphasis in the Government's forthcoming policy on obesity.

June 2011

Written evidence from Anna Lynch (PH 94)

1. INTRODUCTION

This submission is provided by Anna Lynch, Director of Public Health (DPH) for County Durham and is written from a personal perspective. I believe my evidence is valid, based on my experience as Director of Public Health for County Durham, jointly appointed in 2006 by County Durham PCT and Durham County Council and my former experience as Director of Public Health for Easington, County Durham, from 2002 to 2006.

2. SUMMARY

In drafting this submission I have followed the order of key points the Inquiry will consider as detailed on the Parliament website. The main concerns raised in my submission are summarised as below:

- Public Health England requires a sub-national infrastructure as close to the local level as possible.
- Great care must be taken to ensure emergency preparedness and resilience at the local level during and after transition to the new public health system with minimum disruption or change to the local health protection units which already have very effective arrangements with local systems.
- The role of DPH in local authorities needs to be able to influence across the organisation irrespective of positioning and reporting arrangements.
- Health and wellbeing boards should be authorised to sign-off commissioning plans.
- The JSNA should be monitored to ensure that it influences commissioning investments.
- All commissioners should have access to public health specialist expertise to inform decision making and prioritisation.
- The complex commissioning of public health programmes across pathways and whole systems requires oversight by the DPH to ensure quality and patient safety.
- The proposed ring-fenced public health budget is an area of immense concern and may lead to disinvestment in health improvement activity.
- The proposed health premium has the potential to perpetuate the north-south divide and widen health inequalities.
- Mandatory regulation of the public health profession is essential to safeguard the public and ensure fitness to practice.
- Government policies should be subjected to a Marmot version of health impact assessment.

Further detail is captured in the full narrative below.

3. THE CREATION OF PUBLIC HEALTH ENGLAND (PHE) WITHIN THE DEPARTMENT OF HEALTH

3.1 There is an interesting debate between public health professionals about whether PHE should be an executive arm of the DH or a special health authority. I have no strong views on this and believe that the terms of reference/constitution for PHE and its relationship as an advisory body to the DH should be spelt out clearly to afford the independence required. The relationship between PHE and the local PH system is more important and there is inadequate clarity in the proposals detailed in the PH White Paper. By subsuming the functions of the Public Health Observatories (PHO) support could be offered to the DPH and commissioners at a local level in relation to the evidence on cost effectiveness, benchmarking services, dissemination of good practice, support for joint strategic assessments and other needs assessments, use of intelligence, analysis, support in developing local indicators and outcomes, performance support etc.. There must be clarity about the role of PHE and the local interface and what can be expected as soon as possible to ensure that the transition to the new system takes this into account.

3.2 The second point relates to the sub-national infrastructure for PHE. I believe that there is a need for this to be as close to the local level as possible to enable adequate support and relationships to develop. This will be crucial if the new PH system is to work as a whole system and not be disjointed. Whilst understanding that the old strategic health authority and government offices' boundaries are unlikely to be replicated, an infrastructure echoing the four resilience hubs will not be sufficiently local enough to enable the PH system to work effectively. I understand that consideration must be given to population size when determining infrastructure but I also believe that geographical size and rurality are significant factors that should be taken into account.

4. ABOLITION OF THE HEALTH PROTECTION AGENCY (HPA) AND THE NATIONAL TREATMENT AGENCY (NTA)

4.1 I understand that the functions of both these organisations will be subsumed into PHE during 2011–12. The local Health Protection Units (HPU) should remain and there should not be a reduction in their numbers in the North of England. The HPU covering the 12 local authority/PCT areas in the north-east has very well-established and highly effective working relationships with both local DsPH and heads of environmental health services in local authorities. This arrangement and level of support has served our population well in relation to the protection of their health. I would not want to see any dilution of this level of proactive support. The risks in relation to emergency preparedness and resilience are too great to justify reducing this support to the local multi-agency system. If the role of the HPUs is extended to enable them to become the local PHE presence, this is likely to result in confusion in the local system, particularly if the NTA functions operate from the HPU together with intelligence and epidemiological support.

If this is the case then great care must be taken to ensure the local system partners understand the working arrangements and that there remains enough qualified staff to provide on the ground advice and support to

enable the discharge of robust statutory health protection functions by the DPH, GP commissioning consortia and the local authority.

4.2 I understand that the functions of the NTA as it moves into PHE are likely to incorporate a performance approach to alcohol treatment services as well as drug treatment services. I would like to see equivalent robust support from PHE in relation to all health improvement services that incorporate treatment options, eg smoking cessation services, sexual health services (including Chlamydia Screening and GUM) cervical screening services, bowel cancer screening services etc. All impact on the health of the population to a greater or lesser degree but have not been offered the same level of support from the centre.

5. THE PUBLIC HEALTH ROLE OF THE SECRETARY OF STATE (SOS)

The authority and leadership of the SoS to impact across all government departments offers real opportunities to impact on health inequalities and the health of the population. Cross-government working to tackle the root causes of poor health have not always been successful, particularly in relation to the wider determinants of health which are predominantly outside the influence of the NHS. However, the current challenge of austerity and budget constraints is likely to have a massive impact on this, both at a local and national level given the correlation between poverty and poor health status and outcomes.

6. THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

6.1 Appointment of Directors of Public Health: the proposals are for the DPH to be jointly appointed by the local authority and PHE and for the DPH to be jointly accountable to the chief executive and the Secretary of State for Health. I believe that if the role of DPH as an officer of the council is to be fully accountable to communities through elected members then the appointment process needs to be reconsidered. Localism as a concept does not involve or require central control and influence and in this context could create potential conflicts of interests for the post-holder. If the post is to be jointly appointed and have dual accountability as proposed then the parameters of this arrangement must be made absolutely clear regarding the circumstances preceding central intervention and accountability.

6.1.2 I agree that the DPH post should be a statutory requirement for upper tier local authorities and that smaller local authorities should be able to share a post where it fits local arrangements.

6.1.3 There is an interesting debate focused around the positioning of the DPH post in local authorities and whether it needs to be accountable to the chief executive.

My view is that irrespective of whether the post-holder is accountable to the chief executive or a corporate director, as long as the DPH has direct access to elected members and is not restricted to working and influencing only this one directorate but is enabled and expected to work across the organisation then the role can be effectively delivered. Realistically, in the current period of austerity and budget cuts many councils are exploring reducing their corporate management teams, not increasing their size. Localism firmly places this decision with individual councils unless legislation dictates otherwise.

6.1.4 The DPH role must have oversight and responsibility for all aspects of the health of the population thereby incorporating the three domains of health protection, health improvement and health service quality and effectiveness.

Health service quality—It is essential to ensure that GP commissioning consortia are able to make commissioning decisions based on the following with support from the DPH and public health team:

- Identified health needs utilising the joint strategic needs assessment (JSNA) and the health and wellbeing strategy.
- Robust local intelligence.
- Best practice and evidence-based interventions.
- Address and reduce health inequalities.
- Take account of health equity.
- Understanding hidden and hard to reach vulnerable patients as well as a population approach.
- Cost effectiveness and prioritisation of resource allocation.
- Health outcome measures as determined by the three national outcomes frameworks and locally agreed outcomes through the health and wellbeing board.

In the proposals for the new public health system the exclusion of this crucial domain of public health poses a risk to effective commissioning and best use of scarce resources. The DPH will in effect no longer be in the NHS and therefore there is a risk that local authorities may not consider the role should include health service quality. The role of the DPH in supporting GP commissioning consortia must be explicit in the legislation and job description so that local authorities as employers have clarity on the scope and breadth of the role and duties of the post-holder.

Health protection—the role of the DPH needs to be explicit in relation to the protection of the health of the population. The relationship and accountability arrangements with PHE and the health protection function

needs to be spelt out with great clarity in the legislation and the job description for the DPH and in the constitution of PHE. The DPH must have responsibility at a local level to work with PHE on a day to day basis in the event of healthcare acquired infections, infection control issues, communicable disease control, local outbreaks such as food poisoning, immunisation and vaccination incidents, emergency planning, major incidents, environmental hazards to health, TB and Pandemic Influenza.

Health improvement—the role of the DPH encompasses this domain and as it is very pertinent to the work of local authorities it is therefore the domain they understand the most comprehensively. It is important that health improvement programmes encompass a population health perspective, some personal health level interventions and a community health perspective. The third perspective, community health, is particularly relevant in the context of localism and democratic legitimacy for health and creates opportunities for elected members to engage and work with the DPH on local issues. Existing community development programmes led by local authorities offer great opportunities to progress health improvement in communities and reduce health inequalities. In County Durham, the existing health and wellbeing partnership is supporting and facilitating the development of community health networks, coterminous with the five shadow GP commissioning consortia, thus offering inroads to improve health at a community level.

6.2 The role of health and wellbeing boards: it is important that health and wellbeing boards have the authority to sign-off GP commissioning consortia and local authority commissioning plans to ensure that they take account of the JSNA and the local joint health and wellbeing strategy. The opportunities for improving health and reducing health inequalities are increased by the creation of these boards as long as they are given the mandate and authority to lead this agenda. Democratic leadership for health is encompassed in this approach but needs to be backed up with the appropriate authority and accountability arrangements. Further clarity is required on dispute resolution. There is potential for the role of the health and wellbeing board to include place-shaping and incorporate broader planning issues which impact on health and wellbeing in communities.

6.3 Joint strategic needs assessment: the JSNA needs to be enhanced and commissioners need to track and demonstrate how resource allocation and service developments have been shaped by the identified priorities. This has been a weakness to date. Additional support for local areas in developing and monitoring the impact of their JSNA should be provided by PHE and the intelligence functions that move from the PHOs.

6.4 Joint health and wellbeing strategy: it would be useful to have minimum guidance on the local health and wellbeing strategy but it should be flexible enough to allow for local interpretation based on population needs. The Government has decided that sustainable community strategies (SCS) are no longer required but that locally partners may determine how to develop a strategic approach to place-shaping. Currently, most health and wellbeing strategies and delivery plans will sit underneath the SCS and this has provided the accountability and mandate for partners. The accountability for the development and delivery of the joint health and wellbeing strategy will sit with the health and wellbeing board in future and the board must have the mandate to hold partners and commissioners to account for delivery and achievement of outcomes. Scarce resources will hopefully encourage cross-authority collaboration to address issues common to a number of communities.

7. ARRANGEMENTS FOR THE INVOLVEMENT OF PUBLIC HEALTH IN THE COMMISSIONING OF HEALTH SERVICES

Commissioning of all health services, whether at a national, sub-national or local level should take account of public health specialist advice. It will be necessary to ensure that appropriate public health specialist expertise is made available preferably through board level membership. This is an area of public health i.e. domain three, which is absent in the current proposals but has the most potential for short term improvement in health outcomes.

8. ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

8.1 This is a complex issue reflected well in the consultation paper on commissioning and funding routes for public health. Many health improvement programmes are commissioned across whole patient pathways and include primary prevention, early interventions, secondary prevention and treatment options. Examples of this include sexual health programmes, cervical screening, obesity and weight management programmes and services for children under five. These programmes are delivered by a range of providers in primary and secondary care and the voluntary and community sector and span patient pathways. The DPH and specialist public health staff have oversight and understanding of these complex arrangements and are able to trouble-shoot and intervene across the whole system if quality or patient safety issues arise. The proposed arrangements split the commissioning of some of these complex pathways between PHE, the NHS commissioning Board, the respective local authority and potentially GP commissioning consortia. This puts unnecessary fragmentation and risk into the system as it is difficult to see who will have complete oversight of arrangements.

8.2 I have major concerns that the ring-fenced budget for public health that will be allocated to local authorities by PHE will not be equivalent to the investment already made at a local level by PCTs and councils. If this is the case, then current commissioned public health improvement activity is likely to be unsustainable. This would be a real backward step for the population in the north east which suffers from poorer health than the rest of England and the outcome would be an increase in health inequalities for the most deprived

communities. For example, in Easington, County Durham there has been great investment in upstream prevention work based on a socio-economic model of health involving a range of partners including the shadow GP commissioning consortia (formerly Easington practice Based Commissioning Group). The allocation needs to be sufficient to enable the transfer of existing public health specialist staff to the new public health system, whether in PHE or the local authority and to maintain the level of investment in commissioned health improvement programmes. This does not mean that local authorities will not do things differently and indeed they should but the level of investment needs to be maintained or increased in real terms if improvements in health in the most deprived communities are to be the outcome of this whole system change programme.

The on-going benchmarking and public health budget data capturing exercises undertaken by the DH over the last year have been difficult to work with due to lack of guidance or adequate definitions of activity and I have major concerns that the results will culminate in a financial envelope for public health that is considerably smaller than the actual investment locally. This is a concern echoed by DsPH across England and therefore merits some focused attention to ensure it is progressed in a satisfactory way.

9. THE FUTURE OF PUBLIC HEALTH OBSERVATORIES

The proposals are to shift the functions of the PHOs to PHE. Public health intelligence and analytical skills are a specialist area and always in demand. The current capacity in PHOs must be retained in the transition and future model in PHE to ensure this resource is available to support all levels of commissioning, JSNAs and additional specialist work. PHOs have already been subjected to a 30% budget cut and this puts the resource at real risk for the future public health system.

10. THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

A move away from centrally driven targets is welcome and the breadth of domain two in the framework offers good opportunities to impact across a range of wider determinants of health. Indicators must relate to the actual activity that is being undertaken as well as focused on overall health outcomes. Some of the proposed indicators are process and output indicators which aim to measure progress towards an outcome which is acceptable as they can demonstrate movement in the right direction. The outcomes framework must be flexible and allow for an element of local input to reflect local priorities.

11. ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES (INCLUDING THE HEALTH PREMIUM)

My views on the ring-fenced budget for public health have been captured in section 8.2 of this response and the focus in this section is the health premium. There is still no clarity on how this will be allocated, how much the total funding pot will be and what the criteria for allocation will be based upon. The health premium has massive potential to worsen the north-south divide and increase health inequalities if it is focused solely on health outcomes without factoring baseline positions, distance to travel and most importantly, deprivation and poverty.

12. THE FUTURE OF THE PUBLIC HEALTH WORKFORCE (INCLUDING THE REGULATION OF PUBLIC HEALTH PROFESSIONALS)

The current requirements for public health specialists to be registered with the UKPHR should continue together with registration for those in defined groups. Registration is the safest way to ensure the public is protected by a workforce that is fit to practice. Major consideration needs to be given to the ongoing public health specialty training programme during and after the transition to the new system to ensure continuity.

13. HOW THE GOVERNMENT IS RESPONDING TO THE MARMOT REVIEW

I am not assured that there has been a robust and considered approach to the Marmot Review and its six policy recommendations. Indeed, some of the changes instigated nationally only serve to undermine these recommendations and are a retrograde step. If Government is serious about reducing health inequalities and improving health outcomes across the social spectrum then due and proper regard must be given to these six recommendations and national policy change should be subject to a Marmot version of health impact assessment.

Written evidence from Middlesbrough Health Scrutiny Panel (PH 96)

SUMMARY

- The Health Scrutiny Panel would like to see greater clarity between the role of the local Public Health teams and their relationship with, and accountability to, Public Health England.
- The “Ringfenced” Public Health Budget, allocated to each locality, must take appropriate cognisance of the locality’s need.
- Clarity is required on the relationship between the Local Health & Wellbeing Board and the GP Consortia—specifically, how the GP Commissioning Consortia will be held to account, locally, over their commissioning intentions and results.
- GP Commissioning Consortia’s impact must be partly judged on how they engage with the population wide public health agenda, as well as purely clinical interventions and primary to secondary patient pathways.
- There should be clarity about how Commissioning Consortia will be accountable for their Commissioning Strategy and there should be a requirement that Commissioning Strategy must be congruent with an area’s Joint Strategic Needs Assessment.
- It should be made explicit that the Director of Public Health has the power to “get on with the job” when responding to matters of urgent health concern. The Director of Public Health’s ability to call upon sufficient resources within the NHS to respond appropriately to any situation, should be made explicit.
- Clarity should be provided as to how Emergency Preparedness and Systemic Resilience will be provided for such things as Flu Outbreaks, when the Strategic Health Authorities (and their regional organising roles) are abolished.

DETAILED CONSIDERATION

1. The Health Scrutiny Panel welcomes the central tenet of the Public Health White Paper in placing Public Health within Local Government. A great many of the possible approaches to improving public health lie more within the gift of local government than the NHS, so the Panel sees the proposal as sensible and to be welcomed.

2. It is, however, the detail that flows from the policy direction, that the Panel would like to comment on.

3. The Panel notes that a key relationship will be between Public Health Directors/Directorates within local authorities and Public Health England. The Panel considers that urgent clarification is required as to the role of the local Public Health teams and their relationship with, and accountability to, Public Health England. Particularly, the Panel will be interested to see the size of the ring-fenced Public Health budget and how that will be divided between local authorities and Public Health England. The Panel would also take this opportunity to argue that it is absolutely essential that public health budget allocations to any given area, take appropriate cognisance of the public health profile of that area. It is the Panel’s strongly held view that those with higher levels of deprivation and “worse” public health profiles should receive appropriately weighted allocations. The Panel fears that anything else would undermine the credibility of the proposals and leave the new public health directorates with a very difficult task. The Panel looks forward to greater clarification on how the resource allocations will be weighted and the focus it will place on meeting evidenced need.

4. The Panel is conscious that whilst public health services can address problems and even prevent some problems from developing, the Panel has not seen sufficient focus, thus far, on the “causes of the causes” of ill health. It is clear that poor lifestyle choices are a fundamental cause of poor health outcomes, although there is insufficient acknowledgement in the documentation published thus far, of the reasons for some of those lifestyle related choices. Low levels of income, lack of aspiration, poor life chances and a lack of accessible information and facilities are hugely significant determinants on people’s health, which need appropriate recognition in policy.

5. The Panel recognises that under the proposals, the Director of Public Health will be the lead officer within a local authority, responsible for the deployment of Public Health resource. The Panel notes that localities will have a degree of flexibility and freedom about how they deploy those resources to meet local need. The Panel would like to highlight that localities should be able to strike a balance in public health initiatives that have strong evidential basis and services that represent something of a “leap of faith” which are less evidence based. By way of example, there is a very strong evidence base for the benefits of the *Get Active on Prescription* service, for patients identified as morbidly obese. It is clear what benefits can be delivered and why the service is being commissioned. There is less clear evidence to highlight, for instance, that free swimming for school age children, contributes to a child growing up to be a healthier, and more health conscious, adult. Still, on the balance of probabilities, this is probably the case. As such, there is a role for central Government to offer their support for such schemes, should such schemes be questioned.

6. The Panel considers it vital that the Director of Public Health is given sufficient authority to act urgently in the public interest, should it be necessary to do so. This is especially important in areas such as flu outbreaks or responding to pandemics. Whilst it is crucial that democratic oversight of Directorates of Public Health is a

strong feature of the new structures, Directors should have sufficient powers to exercise their professional judgement at times to “get things done”, when going through traditional decision making routes would create a threat to public wellbeing. The Panel considers it vital that Directors of Public Health have sufficient statutory powers to make this a reality. The Panel would also emphasise the importance that Directors of Public Health, whilst they will be local government employees, are still able to call upon NHS resources and command their utilisation should they be required in the response to a public health concern, such as a Flu Pandemic.

7. In the last two or three winter periods, the Health Scrutiny Panel has been an interested observer in our health and social care system’s resilience to associated winter pressures, such as flu. The Panel has heard from a number of senior sources that the regional planning dimension, facilitated by the Strategic Health Authority with Directors of Public Health, has been critical in co-ordinating responses to the challenges posed and ensured that spare regional capacity has been utilised in the best possible way. An example of this is the mutual assistance agreements that hospitals have had in place about bed capacity for those patients requiring inpatient treatment, due to flu. The Panel is concerned that the abolition of Strategic Health Authorities and their regional oversight role, means that the public will be less safe at times of outbreak or pandemic. It is not acceptable that such resilience in the future should have to rely upon informal networks, or good relationships between professionals to function or not. Planning for, and responding to, such regional threats requires a systematic approach, which the Panel is far from convinced is delivered by the proposed arrangements. The Panel would look to the Department to outline how this critical facilitator/convenor role will be maintained as the new structure is established. In addition, the role of SHAs and PCTs in Emergency Planning must not be forgotten. The Panel is aware that PCTs have a particular input into planning for local disasters, outbreaks and the like, through Local Resilience Forums. The Panel is far from clear who will ensure that SHAs’ and PCTs’ existing responsibilities will be picked up and carried forward. Again, the Panel would strenuously argue against a scenario where we apparently rely on informal networks of professionals to ensure an appropriate NHS contribution to Emergency Planning. The Panel has also been made aware by senior professionals that the reforms to the NHS, and particularly the challenging transitional reorganisations, could bring about the loss of important skills and knowledge. The Panel would like to know what steps are in place to ensure that organisational memory is not lost and ensure that the new arrangements are safer, or at least as safe, as what is currently in place. The Panel has also discussed these concerns with our local Emergency Planning Team, which shares the Panel’s concerns. The lack of certainty about where Health related emergency-planning expertise will come from and where it will sit, is a genuine concern. The Panel has heard a persuasive argument from our local Emergency Planning Unit, which says that it would be beneficial for the PCT emergency planner to come under the future remit of the Director of Public Health. This is a particular issue for Middlesbrough and the wider Tees area, as of the 47 COMAH (Control of Major Accident Hazards) sites in the North East, 37 are contained within the Tees area.

8. The Panel wishes to make comment on the topic of Public Health and GP Commissioning Consortia. The Panel feels it is absolutely critical that GP Commissioning Consortia have a clear and explicit methodology for taking advice on public health measures and ensuring that a fair proportion of their Commissioning activity targets public health related work. Presently, it is not clear how GP Commissioning Consortia will work with Public Health Directorates, nor whether emerging GP Commissioning Consortia see themselves as having a role in public health promotion and commissioning, as well as the Commissioning of traditional intervention based health services. The Panel would like to see the Government articulate some sort of expectation of the level or the amount of public health work that it expects GP Commissioning Consortia to become involved in. Whilst the Panel fully understands that public health initiatives will ultimately be the responsibility of Public Health Directorates and Public Health England, it is crucial that GP Commissioning Consortia are aware of the impact they could have in relation to public health and preventative services. The examples of talking therapies or debt advice are services, which are not necessarily “clinical” interventions, but could have a huge impact on people’s wellbeing and could prevent a condition worsening. The Panel feels it is essential that GP Commissioning Consortia understand this point and can actively demonstrate their understanding of how someone’s environment or position in life, influences their health outcomes.

9. It is possible that Public Health becoming a Directorate within a local authority could have one of two conclusions. Firstly, it could bring about a situation where it operates discretely within the local authority, pursuing public health goals, without ever really impacting upon the wider operation of the local authority. Alternatively, the local authority could ensure that the Directorate of Public Health becomes a crucial component of decision making, with the health impacts of proposed major decisions being taken into account before those decisions are made. In the same way as a local authority would not take a major strategic decision without seeking legal and financial advice, the public health impacts of a proposed decision could be sought from appropriate professionals before it is made. In so doing, local authorities would be genuinely ensuring that public health becomes a major component of what they do. The Health Scrutiny Panel has advocated this previously within the local authority and although the idea of health impact assessments was accepted, they have never fully been used. There is, therefore, a huge opportunity for Government to create an environment where Directors of Public Health are expected to be placed at the centre of decision making within a local authority and to be an advocate for health improvement and health protection, across all aspects of the local authority’s work.

10. The Panel wishes to make comment on the critical role of the Health & Wellbeing Boards. The Panel considers it vital that there is sufficient Elected Member representation on the Health & Wellbeing Boards to

add an appropriate degree of democratic legitimacy to their function, direction and decision making. The Panel notes that current proposals stipulate a minimum of one Elected Member on the Local Health & Wellbeing Board. The Panel is concerned that having a minimum of only one democratically elected representative on a Health & wellbeing Board is too low and the Department of Health should consider raising it to two. The Health & Wellbeing Board will perform a critical role in establishing Strategy and act as an interface/facilitator between a GP Commissioning Consortium and a Local Authority. As such, the Panel feels that there should be greater mandated political involvement and accountability in that forum, together with the local authority providing administrative support to the Board. Further, by having appropriate Executive Members heavily involved in the work of the Board, there will be appropriate political input for areas such as Children's Services, Leisure, Public Health and Social Care. The Panel understands that the Local Health & Wellbeing Board will be a critical forum where debate is held and health and wellbeing strategy for the area concerned is set. The Panel has some concerns that, under the current wording of the Health & Social Care Bill, there is only a requirement on GP Commissioning Consortia to be represented on the Local Health & Wellbeing Board, not for GPs to attend. The Panel remains concerned that if (specifically) GPs are not required to attend, the engagement of GPs in wider debate about the area's wellbeing, as opposed to commissioning priorities for a Consortia, is unlikely to happen.

11. The Panel also considers it important that further clarity should be sought about how, within the system involving Local Health & Wellbeing Boards & GP Commissioning Consortia, where the expertise of the local dental and pharmacist community will be sought. Inviting the Local Pharmacist Committee and Local Dental Committee to contribute to the ongoing debate seems eminently sensible and the Panel would call for clarity as to how that would be done.

12. In addition, the successful planning and establishment of Local Health & Wellbeing Boards, together with their accompanying Health & Wellbeing Strategy and Joint Strategic Needs Assessment, are tasks requiring a great deal of skill and judgement. This area of work requires skills and technical knowledge from local authorities, which are not necessarily the traditional domain of local government. As such, the Panel feels that the Department of Health should expect there to be a certain amount of lead in time, whilst local authorities develop or acquire the expertise to assist in the development of the new structures, ensuring a smooth transition to the new system in 2013.

13. There are a number of points to be made about the Joint Strategic Needs Assessment. Firstly, the Panel would like to draw your attention to a collaborative piece of work undertaken by all Health Scrutiny Committees in the North East, highlighting the needs of the ex-service community. It is clear that the ex-service community has not had the consideration it has warranted previously, as services have been planned and commissioned. It is of integral importance that the ex-service community is a clear and definable part of Joint Strategic Needs Assessment, to ensure that such a valued section of society has the prominence it requires, when commissioning strategies are established and enacted.

14. A second point that the Panel would like to make relating to the Joint Strategic Needs Assessment was raised by a member of the public at a recent discussion event, held by Middlesbrough Council on the Health reforms. It was described as paramount that vulnerable sections of society such as those with mental health problems, substance misuse problems, ex-offenders and asylum seekers are not "crowded out" of the priority groups within the Joint Strategic needs assessment and receive adequate attention. Such groups are some of the most vulnerable in society and do not regularly have high profile advocates "fighting their corner". It would be deeply worrying if the absence of such high profile advocates led to their absence or omission in Joint Strategic Needs Assessments.

15. In addition, the Panel would be keen to see the Department of Health stress the importance of the Health & Wellbeing Board involving itself in work around the wider determinants of health and not simply becoming a forum to discuss the commissioning of health services, aimed at addressing established health concerns. The Health & Wellbeing Board should see itself as having a critical role in influencing wider public policy, with the aim of tackling wider determinants of health such as poverty and poor life chances. It is precisely such issues as poverty and a lack of life chances that can lead to communities having poorer than normal health outcomes. It should be the job of the Health & Wellbeing Board to ensure that all parts of the new structure, particularly GP Commissioning Consortia, are fully cognisant of that and understand that poor health outcomes for a community rarely occur in a vacuum. If the Health & Wellbeing Board simply concentrates on strategies for health services and established health problems, The Panel would argue it will not be fully meeting its responsibility to the community it represents. Further, the Panel would be interested to see clarity over how Local Health & Wellbeing Boards can hold to account, or challenge, GP Commissioning Consortia, should their commissioning plans not be consistent with demonstrable local need, identified in the Joint Strategic Needs Assessment.

16. The Panel would like to express concern over the proposed arrangements for the commissioning of the children's services. Under the proposals, the Panel understands that services for children aged 0-5 will be commissioned by the NHS Commissioning Board, although the Public Health Directorate will commission services from 5-19. The Panel does not understand the rationale for that distinction and does not feel that the case for this distinction has been adequately made. It seems that Public Health Directorates are going to be inheriting responsibility for children, when they have presumably had no professional input into the services commissioned from 0-5. In addition, areas of high deprivation may require more substantial services from 0-5

than areas of affluence. Such services also need to be fully integrated with local services, particularly Children's Centres. The Panel is far from convinced that the NHS Commissioning Board has a better understanding of local need for children and families than the local authority in question and would call upon the Department to think again on this proposal.

June 2011

Written evidence from Ajinomoto (PH 97)

EXECUTIVE SUMMARY

- Levels of obesity continue to rise at an alarming rate. The health challenge posed by obesity to UK society and the NHS is enormous, not least in financial terms.
- Coalition Government action on obesity until now has been very restricted; the Public Health Outcomes Framework, which partially focuses on obesity, is too limited to help bring obesity rates down.
- Government has also yet to publish its long-awaited obesity strategy and, though Government has retained the Change4Life brand, it has significantly reduced spending on its marketing. This is despite its own figures showing that the number of people joining Change4Life dropped by 80% when it halted spending on marketing following last year's general election.
- Ajinomoto believes that the Government does not have to spend vast sums of money on tackling obesity. Small but significant steps can help to tackle the growing obesity rate. The single most effective move that Government could take to improve public health, at no cost to the Exchequer and with no need for regulation, is to issue clear and consistent messages that consumers who want to choose a sweetened beverage, should consider choosing a low-calorie option.
- We encourage a renewed sense of urgency on the part of the Government and call on it to bring forward its obesity plans as soon as possible. In this, we hope that the Health Select Committee's inquiry into public health will be of some assistance.

INTRODUCTION

1. Ajinomoto is the global leader in the science, manufacture and marketing of amino acids, nucleotides, and amino acid based ingredients, including the low-calorie sweetener AminoSweet aspartame. Our ingredients are used widely by the food and beverage industry throughout the world, to produce healthy products which are popular with consumers.

2. AminoSweet is the brand name for aspartame produced by Ajinomoto. The name was chosen to underline the fact that this low-calorie sweetener is made from two amino acids, which together result in a sweetener which tastes like sugar but is two hundred times sweeter. Being made from amino acids, the building blocks of protein which are found in many foods including meat, fish, eggs and milk, Aspartame brings nothing new to the diet and is treated by the body in exactly the same way as other foods in a person's diet.

3. Ajinomoto would like to thank the House of Commons Health Select Committee for allowing us to make a brief contribution to their inquiry into public health. Ajinomoto's contribution will focus on tackling obesity.

OBSESITY AND SUGAR INTAKE

4. Obesity levels continue to rise in England; in 2008, 66% of men and 57% of women were either overweight or obese, with 24% of all adults obese. Obesity is a risk factor associated with serious health conditions, including cardiovascular disease, diabetes and cancer. Foresight has noted that the financial cost of obesity to society and business is predicted to rise to £45.5 billion per year by 2050, in addition to a sevenfold increase in NHS costs to £6.5 billion each year.

5. There are a number of causes of obesity but it is now widely accepted that the diet of the average British adult contains too much added sugar, and that the largest single source of added sugar in the average child's diet, especially amongst children from a lower income background, is soft drinks.

FOOD AND DRINK INDUSTRY RESPONSE TO GROWING OBESITY RATES

6. The most effective means of reducing sugar consumption from beverages and other foods is to encourage the substitution of full-sugar variants by their sugar-free counterparts, as part of a balanced diet. The food and drink industry has therefore taken the responsibility for developing low and no added sugar varieties, making a significant difference to calorie intake. Some beverage brands have even reduced the added sugar to zero and the calorie content from more than 100Cal/250ml to less than 1Cal/250ml.

SUGAR SUBSTITUTION AND EFFECTIVENESS OF HELPING IN WEIGHT CONTROL

7. Sweet taste is innate and universal. Even a small level of sweetness reduction is discernable by most people and can result in reduced preference and consumption levels.

8. Because low-calorie alternatives taste as good as sugar sweetened beverages, these products have increased in sale. In addition, the success of foods and drinks sweetened with aspartame is explained by the fact that this particular low-calorie sweetener tastes most like sugar. Foods and drinks in which the sugar has been substituted with aspartame, including tea and coffee, are therefore able to deliver products which taste just as good as their sugar-sweetened alternative, but with fewer calories.

9. Meta-analyses shows that if individuals make this swap, and replace sugar-sweetened foods and drinks with their low-calorie alternative using aspartame, they can reduce their weight without any loss of palatability.²¹³ Given the ease with which such sugar substitution can take place in a wide variety of food and particularly drinks, the potential impact for weight management is significant.

RESPONSE TO THE HEALTH SELECT COMMITTEE

The structure and purpose of the Public Health Outcomes Framework

10. Ajinomoto welcomes the purpose of the Public Health Outcomes Framework, which is rightly designed to allow individuals to judge the success, or otherwise, of particular areas in tackling public health problems.

11. Despite the positive purpose of this Framework however, Ajinomoto has concerns that it is not detailed or thorough enough to enable proper comparison of outcomes. On the specific subject of obesity, the Outcomes Framework chooses to measure only the prevalence of healthy weight in a particular area: instead, it should be measuring how an area reduces its obesity rate. Through measuring this outcome, the Framework could help to highlight those areas in which innovative approaches to tackling obesity are producing results.

CONCLUSIONS

13. It is difficult to comment on the Government's proposals for combating obesity, a key public health problem that needs tackling soon to prevent the NHS being burdened with the sort of costs outlined in 2007's Foresight report.

14. This is because the Government did not address the subject at any great length in December 2010's Public Health White Paper, *Healthy Lives, Healthy People*. Although promised a separate obesity strategy in the spring of this year, at the time of writing such a strategy had not been published (though strategies for tackling smoking and alcohol abuse have been released).

15. The Government has recently published its revised social marketing strategy and committed itself to continuing with the Change4Life brand, which Ajinomoto welcomes. However, the viability of Change4Life as a tool to tackle obesity may have been damaged by the Government's withdrawal of funding for social marketing as it undertook a review into its strategy. The Government's own figures show that, following this funding cut, the numbers of people signing up for Change4Life fell by 80%.

16. The Government does not necessarily have to spend large amounts of money in tackling obesity. Small steps, such as the provision of consistent messaging encouraging people to choose low or no added sugar alternatives to their sugar sweetened products, can be undertaken at no cost to the Exchequer.

17. What is clear is that Government needs to rapidly progress with the development of the sort of comprehensive strategy needed to tackle such a significant public health problem as obesity. This is increasingly urgent; the proportion of overweight and obese people in this country continues to climb upwards yet the Government is not taking the required action. Such coordinated action at national level in turn has the potential to significantly reduce the costs associated with the treatment of obesity related diseases.

18. The Government's actions on public health have, until now, been limited and we hope that this inquiry will encourage them to do more.

June 2011

Written evidence from the NHS Information Centre for Health and Social Care (PH 98)

SUMMARY

The national reforms of the health and care system recognise the need for organisations to make better use of information to support decision-making and public accountability.

The reforms also recognise there are efficiencies to be made from managing the information flows more effectively.

The NHS Information Centre for Health and Social Care has a national role for the collection and provision of health, public health and social care data. It is our intention that the work of the NHS Information Centre will support and complement the work of Public Health England, in the same way as it will support and complement the NHS Commissioning Board, the regulators and others.

²¹³ A De la Hunty, S Gibson and M Ashwell, A review of the effectiveness of aspartame in helping with weight control, British Nutrition Foundation *Nutrition Bulletin*, 2006, 31, 115–128.

Therefore there are benefits to the system which can be derived by Public Health England taking advantage of the new role of the NHS Information Centre in respect of the centralisation of data from health care, public health and social care into the national data repository.

1. The Coalition Government recognises the important contribution that public health must make towards the strategic objectives of improving the health and wellbeing of the population. The Government's vision for public health is to protect the public and improve the healthy life expectancy of the population by improving the health of the poorest, fastest.

2. The establishment of Public Health England (PHE) should therefore be seen in the context of the Coalition Government's wider reform programme.

3. One of the key underpinning principles of the reform programme is for health and care organisations to make better use of information and intelligence.

4. The reform programme recognises there are organisational and efficiency gains to be made from the proposal to put the NHS Information Centre for Health and Social Care (NHS IC) on a firmer footing as the national repository for data relating to health care, public health and social care.

5. The scale of the organisational and structural reform risks undermining those gains if there is insufficient clarity about our organisations' roles and responsibilities. Our organisations will need to be seen to be collaborating to ensure the best use of our collective resources. In the context of information and intelligence, this should mean sharing our information assets ("collect once, use many times") and avoiding duplication of effort in regard to dissemination.

6. We know from our discussions with a range of stakeholders that the disjointed status of health care, public health and social care has been a problem in terms of information, silo-ed decision-making, reporting and accountability. The current reforms offer a significant opportunity to change that.

7. It is expected that PHE will take a lead role in prioritising public health resources across the system, such as strategic funding decisions associated with the commissioning of large-scale national health and care surveys from the NHS IC, the Office for National Statistics and other Government departments.

8. The Department of Health has an implementation programme for the transition towards and the establishment of PHE. That programme has a workstream looking specifically at information and intelligence needs and functions (known as the I & I project). The I & I project will design the future state of PHE's information and intelligence needs in line with the objectives set out in the White Paper, and developed further through the public consultations conducted earlier this year.

9. The information and intelligence function is broad, encompassing surveillance, monitoring, advice and collaboration on research. It includes:

- Drawing together the existing complex information, intelligence and surveillance functions performed by multiple organisations into a more coherent form, aimed at making evidence more easily available to those who will use it, in a form that makes it most likely to be used.
- Strengthening public health surveillance.
- Ensuring that NICE guidance is supported by authoritative, independent advice on evidence.
- Ensuring the development of the evidence base for public health, including health economics.
- Providing expertise and delivery experience to policy and strategy formulation on public health.
- Developing intelligence about relative cost effectiveness.
- Analysing and evaluating and interpreting data to assess needs, set priorities, and forecast future requirements.
- Generating, disseminating and using information and intelligence, including health statistics and research evidence.
- Providing advice to NHS and local authority commissioners nationally and locally to ensure best population health impact from public services, including addressing health inequalities.

10. The NHS IC has a national role for the collection and provision of health care, public health and social care data. It is our intention that the work of the NHS Information Centre will support and complement the work of Public Health England, in the same way as it will support and complement the NHS Commissioning Board, the regulators and others.

11. We expect that PHE will wish to take advantage of the new role of the NHS IC in respect of the centralisation of data from health care, public health and social care into the national repository. This, in turn, creates opportunities for amalgamating and linking data from different sources, which will serve to strengthen the intelligence function of PHE both nationally and locally.

12. The Health and Wellbeing Boards in local authorities provide a means for drawing together the three domains of public health, namely health protection, health improvement and health services. This requires local public health to apply information and intelligence on local population health and determinants of health into

local commissioning decisions. Underpinning this will be the routine availability and accessibility of authoritative, independent and assured national data.

13. Currently in the context of public health, information, intelligence and analysis functions are carried out nationally and locally through a range of organisations, including the NHS IC, PHE, regional public health and quality observatories, as well as other organisations such as commissioning support units.

14. We are committed to working collaboratively to ensure that we make best use of our collective resources and expertise for population health information and intelligence, and also to ensure we avoid duplication of effort and confusion over roles and responsibilities—this will require reciprocal recognition of our national mandate by our partners.

15. Many users of health-related information will not make the distinction between healthcare information and public health information. They are also likely to wish to see all related information in one place, and in a consistent format. Commonality of formats enabling comparison will need to operate within and between public health, health care and social care. Therefore it will be essential that information is disseminated and published in a way that supports collaborative working across organisations and facilitates the linking of information across topics.

16. It will be especially important that commissioners and providers of services have a shared understanding of healthcare trends. They will be working in the context of changing organisational structures and will require access to disaggregated, unit-level data to deliver statistics on the breadth of commissioning activities including:

- Measuring impacts on health over time given that the base populations will change.
- Data collections, given that the national systems and collections use different levels of detail for the purposes of aggregation.
- Presentation, reporting and time series analyses of indicators, given the variable configurations of organisations and populations.
- Allocation of resources to commissioning organisations.
- Discerning impacts associated with the health and service needs of smaller populations or harder-to-reach groups.

17. There is also a shared interest in addressing other strategic activities, including:

- Increased linkage of national datasets.
- Addressing gaps in available information.
- Improving the contextualisation of health care, public health and social care data;
- Informing population-based public health policy and action across local boundaries.

18. This requires access to data across all sectors, and the NHS IC's mandate on the centralisation and amalgamation of routine operational data from health care, public health and social care, and the linkage of that data, will serve to strengthen the intelligence function of PHE both nationally and locally.

19. It also reinforces the position of the NHS IC as the single authoritative source of national data relating to health care, public health and social care.

20. The national repository and related functions of the NHS IC will support the dissemination of these data. Equally, it will be important that the public health information requirements for NHS commissioning feed into and are met by the national repository. Collaborative partnership working with all those organisations involved in data generation, collection and analysis will be necessary to avoid duplication, and will allow those organisations to focus their efforts on areas of expertise and analysis.

21. It is possible that PHE will have greater flexibility on commissioning certain services, such as those provided through the GP contract. If this happens, there will be a need to ensure that data flows from routine practice meet nationally-agreed standards. This may need to be safeguarded through explicit contractual requirements. Otherwise it may be difficult to monitor the quality of service provided, and this may impact on the health of the population. It will be necessary therefore that data generated locally from these public health activities would also need to be fed into the national repository, so that it can be used more widely, including linkage with other datasets to deliver enhanced utility across service sectors for research and population health intelligence.

22. We believe therefore that it is in the interests of the NHS, public health and social care, as well as PHE specifically, that the establishment of PHE is founded on the principle of collaboration with the NHS IC, in regard to the use of national data resources and the population of the national repository.

Written evidence from the Centre for History in Public Health (PH 99)

SUMMARY

- This memorandum describes the history of public health within local government.
- This involvement extends back to the 19th century, when local authorities included health committees and appointed Medical Officers of Health (MOHs).
- The historical record of public health within local government is disputed. While it is important not to idealise the pre-NHS period as a “golden age” for public health, its location within local government had major advantages. Initially this facilitated sanitary reform, and subsequently aided integration of preventative and curative services.
- Successful MOHs were high profile figures in their communities and those who were skilful leaders and capable of negotiating local political realities could raise population health.
- Public health departments in local government oversaw an expanding range of health and environmental services before 1948 and were widely expected to become the lynchpin of the NHS. However this did not happen.
- Primary health care has historically been disputed territory between the general practitioner (GP) and local public health departments.
- Present proposals to reassign public health to local government cannot replicate the situation from the past, but they offer the opportunity to resume the community focus of public health prior to 1974 and to some extent prior to 1948.

INTRODUCTION: AN HISTORICAL PERSPECTIVE ON PUBLIC HEALTH

1.1 There are several aspects of current proposals for health service reorganisation which will affect public health:

- The location of public health within local government, with responsibilities for appointing a director of public health, promoting healthy living and providing preventive services.
- The allocation of responsibility for service commissioning to consortia of GPs, which will also have duties of health improvement and disease prevention.
- The appointment of local Health and Wellbeing Boards to ensure integration of local authority health work with other NHS bodies.
- The establishment of Public Health England, which will hold a ring-fenced budget to fund local government public health activities, and provide “national support for local delivery”.²¹⁴

1.2 These are not new entirely developments. Within the British health system, public health had been a local government duty since the mid-Victorian period. It was only with the 1974 NHS reorganisation that this long-standing relationship ended, presaging a period widely considered one of decline for public health. The problems of co-ordinating GP services with public health needs and of balancing central objectives with locally sensitive delivery also have a long history, long predating the inception of the NHS in 1948.

1.3 This memorandum provides an historical perspective on the Committee’s interest in the future role of public health in local government. It will discuss these earlier experiences and present the views of historians. It will show that the general verdict on the impact of public health within local government is a mixed one, but that there are aspects worthy of positive development.

2. BEFORE THE NHS: THE MEDICAL OFFICER OF HEALTH

2.1 The role of the MOH as leading local public health officer developed in Britain in the mid-19th century. Medically qualified officials were at first attached to temporary Boards of Health in periods of epidemic crisis. Their appointment became compulsory in London districts in 1855 and in all local government areas in the 1870s.

2.2 Their responsibilities were wide and included the removal of “nuisances” (ie refuse, sewerage), the regulation of overcrowded lodging houses, building standards, and monitoring of bakeries, dairies and slaughter houses. From 1889 they enforced prevention of infectious diseases through notification and isolation and by the early 1900s they increasingly supervised local services such as health visiting.

2.3 The greatest legacy of the MOHs and the health committees of Victorian and Edwardian local government was the infrastructure they built. This included drainage systems, waterworks, public baths, wash-houses and refuse collection, and a nationwide network of municipal isolation hospitals. Central government played some role in setting the policy course. Early supervisory efforts by Edwin Chadwick and the General Board of Health are well-known; the Local Government Board (the Department of Health’s distant antecedent) also issued advisory memoranda and used its loan sanction powers to influence capital projects. Ultimately though, it was local taxation and initiative which drove policy.

²¹⁴ *Health and Social Care Bill*, The Stationery Office Limited, 2011, pp.5, 6, 45, 151–2; DH, *Public Health England—A new service to get people healthy*, http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_122249

2.4 Although a postgraduate diploma (1870s) established public health as a discrete specialty, its status was low within the medical profession. It was distrusted by GPs, who feared an expanding salaried medical service would diminish opportunities for private practice, while hospital consultants considered it inferior to curative medicine for acute diseases. Nonetheless, MOHs with leadership capacity could operate effectively to enhance population health. The example of Arthur Newsholme as MOH in Brighton in the early 1900s shows how a skilful actor could negotiate local political and medical systems to improve areas like food safety and housing conditions.²¹⁵

2.5 Appraisal of the achievement prior to 1914 is broadly favourable, because from c 1870 life expectancy rose and mortality from infectious diseases fell. Historical epidemiologists caution that this was driven largely by improvements in living standards and nutritional status. However there is a consensus that public health interventions mattered too, particularly to falling mortality from cholera, typhus, typhoid and other enteric diseases.

2.6 *Conclusion:* The initial focus of public health was environmental improvement, and local government was the appropriate location for these activities. MOHs were potentially influential figures, but from the start a tension existed between private medicine and the salaried local bureaucrat.

3. BEFORE THE NHS: PUBLIC HEALTH AND HEALTH SERVICES

3.1 By 1939, the public health duties of local government had expanded far beyond the original environmental remit. Now they included maternal and child welfare services; a school medical service; dentistry; school meals and milk; tuberculosis schemes including sanatorium treatment, clinics and aftercare; health centres; “mental deficiency” (learning disability) institutions; venereal disease clinics; and regional cancer schemes. MOHs were also key figures in slum clearance and council housing programmes. From 1929 local authorities were empowered to take over the administration of Poor Law institutions, and many developed these into publicly funded general hospitals untarnished by the stigma of pauperism. In large, prosperous authorities like the London County Council this array of preventive and curative services meant local public health departments were running an embryonic NHS.

3.2 Central government now exerted policy influence through Treasury grants, initially supporting specific health services, then after 1929 through a block grant determined by local needs indicators. A new Ministry of Health (formed 1919) had principally an advisory role.

3.3 There is much historical debate about how well this system operated.²¹⁶ Many in the public health field later saw it as a “golden age”, when their powers and achievements were at their height. Infectious disease mortality was firmly in decline, with rates falling from around 350 per 100,000 in 1917, to 150 in 1937, to c 10–20 in 1957. Public health was a clearly identifiable aspect of public life, with many MOHs well-known local figures heading amply-staffed departments, including health visitors, clinicians, bacteriologists and sanitary inspectors. Their tenured appointments conferred some political independence in dealing with elected councillors and their annual public health reports presented local health statistics and helped set policy agendas.

3.4 The “golden age” interpretation is open to criticism. Despite central grants, disparities in local taxable wealth meant there was consistent variation between places in resources for health, and hence quality of services. Integrated working between the public sector and voluntary agencies was also poor in many areas.

Arguably too, public health failed to meet the challenge of the 1930s’ depression. Most MOHs were silent on poverty’s impact on ill-health, ignoring the emergent literature on malnutrition, and were conservative in their approaches to prevention, for example failing to adopt diphtheria immunisation despite international evidence of its efficacy. Tragically high levels of maternal mortality represent another failure. There were risks of “overstretch” imposed by responsibility for curative health services, and the loss of public health’s once distinctive advocacy role, as MOH activities increasingly overlapped with those of GPs.²¹⁷

3.5 More recent interpretations strike a balance between these views. Analysis of local financial statistics reveals rising real investment in public health in many areas despite national economic difficulties, albeit many poorer places remained disadvantaged.²¹⁸ Variations were not solely determined by rateable wealth, but could also reflect local expenditure choices made by council politicians working alongside MOHs. The extent to which health policy was directly determined by local electoral preferences remains uncertain.

Against the charges of “overstretch” can be set the benefits of integration of preventive and curative services, for example in the school medical service and in infant and maternal welfare. Moreover, new municipal clinics and general hospitals advanced equity of access, with health increasingly understood as a right of citizenship. Examples can be found of innovation (eg in health education), active vaccination policies, and concern for the sick poor. Often MOHs were constrained both by limited local resources, uncooperative politicians, and

²¹⁵ J.Eyler *Sir Arthur Newsholme and state medicine, 1885–1935*. Cambridge, Cambridge University Press, 1997.

²¹⁶ V.Berridge, “Public health in the twentieth century” in V Berridge, M Gorsky, A.Mold, *Public Health in History* (forthcoming 2011).

²¹⁷ C Webster, “Healthy or hungry” thirties? *History Workshop Journal*. 1982; 13: 110–129; J. Lewis, “The prevention of diphtheria in Canada and Britain 1914–1945”, *Journal of Social History*, 1986; 20 (1): 163–176.

²¹⁸ A Levene, M Powell, J Stewart, “Patterns of Municipal Health Expenditure in Interwar England and Wales”, *Bull Hist Med* 78 (2004): 635–669.

hostility from doctors in the private and voluntary sectors towards collaborative working.²¹⁹ Their failures must also be attributed to the weak Ministry of Health, which provided little vision or leadership and was “a career backwater”, unattractive to civil service high-fliers.²²⁰

3.6 The terrain of public health remained a contested one, with conflict over who had lead responsibility for primary health care, MOHs or the general practitioner. Such tensions were famously fictionalised in A.J.Cronin’s 1935 depiction of Dr. Finlay, the GP, and, Dr Snoddy, the public health doctor, later dramatised in *Dr Finlay’s Casebook*. This caricature underlines the cultural prejudices of British medicine against the doctor as “local government bureaucrat”.

3.7 *Conclusion:* The interwar period was the zenith of municipal medicine and the MOH’s public health “empire”. Historical verdicts are mixed, perhaps inevitably, since a permissive, decentralised system was bound to lead to variations in expenditure and quality. The commitment to local choice must be set against this geographical unevenness, which, in one historian’s words, “... mattered in terms of life and death”.²²¹

4. PUBLIC HEALTH AND THE NHS

4.1 In debates preceding the NHS Acts many policy-makers and politicians (particularly Labour) argued that a comprehensive, universal service could best be achieved by building on existing local government arrangements. This would have kept public health at the core of the health service. However, in 1945 Aneurin Bevan argued that most local authorities lacked the financial and managerial capacity to meet national health goals, and had a track record of uneven provision. His solution was to create separate regional bodies administering hospitals and primary care, leaving public health in local government but with drastically reduced functions. Herbert Morrison’s counter-argument, that this would instil a democratic deficit, was over-ruled. Bevan’s model was also a political compromise needed to reconcile the medical profession to the NHS.

4.2 This left public health with limited duties (maternal and child welfare, vaccination programmes, community care for older people and psychiatric patients) and administratively distinct from hospital services. Bevan initially planned a network of health centres (polyclinics) to link public health with primary care. However, economic retrenchment in the 1950s and Conservative rejection of the policy meant this did not happen.

4.3 *Conclusion:* The NHS settlement left public health in local government but with much reduced powers and responsibilities. This was due both to political expediency and legitimate concerns about the capacity of local government to meet health goals deemed nationally optimal.

5. PUBLIC HEALTH IN LOCAL GOVERNMENT, 1948–74

5.1 Public health after the war was forced to search for a new identity. Local government was rigid and unreformed and major developments in public health mostly took place away from the local level. GPs began to develop their role as providers of primary health care.

5.2 The rise of chronic disease led to an increased focus on “lifestyle” and individual behaviour as determinants of ill health. Evidence on, for example, the connection between smoking and lung cancer, brought an emphasis on “risk” and on prevention. Increasingly public health operated through national advertising campaigns, mounted by a central agency established at arms length from government. This was the Health Education Council founded in 1968, then reformed in 1973, and renamed the Health Education Authority with the advent of HIV/AIDS in the 1980s.²²²

5.3 A gulf opened up between public health as an academic, research-based, professional activity and public health in local government. Public health developed as a professional set of institutions, for example with the establishment of the Society for Social Medicine in 1956 and the Faculty of Community Medicine in 1972. The ideas of social medicine, envisaging amalgamation of preventive and curative approaches to health, developed academically but bore little relationship to practice on the ground within local government.

5.4 A key deliverer of the public health message became “single issue” groups or organisations which focussed on one public health issue. Action on Smoking and Health (ASH) founded in 1971 is a notable example. There was no representation of MOHs on the Royal College of Physicians committees on smoking in the 1960s and 70s.²²³ Such new developments in public health had little of a local dimension.

5.5 Nonetheless it would be incorrect to conclude that public health within local government achieved nothing in these years.²²⁴ A dynamic MOH with a clear vision could still achieve a great deal. For example,

²¹⁹ M Gorsky, “Local leadership in public health: the role of the medical officer of health in Britain, 1872–1974”, *Journal of Epidemiology and Community Health*, 2007, 61, 468–72; idem, “Public health in interwar Britain: did it fail?”, *Dynamis*, 2008; 28: 175–198.

²²⁰ C Webster, “Conflict and Consensus: Explaining the British Health Service”, *Twentieth Century British History* 1, 2 (1990)

²²¹ M Dupree, “The provision of social services,” in Martin Daunton ed, *The Cambridge Urban History of Britain, 1840–1950*, Cambridge: Cambridge University Press, 2001, 351–394, quotation on 391.

²²² V Berridge, *AIDS in the UK: The Making of Policy 1981-1994*, Oxford, Oxford University Press, 1996.

²²³ V Berridge, *Marketing Health: Smoking and the Discourse of Public Health in Britain, 1945–2000*, Oxford: Oxford University Press, 2007.

²²⁴ John Welshman, *Municipal Medicine: Public Health in Twentieth Century Britain*, Bern, Peter Lang, 2000.

Dr Paddy Donaldson (father of the former CMO), as MOH in Teesside in the late 1960s and early 1970s began to inaugurate screening clinics and to work closely with local G.Ps.²²⁵ Similarly, Dr Ian McQueen, MOH in Aberdeen during the 1964 typhoid outbreak, used the media in an innovative way.²²⁶

5.6 Conclusions:

- (a) Public health post war lost its local focus and emphasised the national level with advertising campaigns, mounted by a central agency, and single issue pressure groups commanding most attention.
- (b) G.P.s began to play a more prominent role in primary health care.
- (c) Nevertheless public health continued to operate at the local level and there are examples of innovative MoHs who were able to take new initiatives despite the difficulties of the post 1948 local government system.

6. PUBLIC HEALTH OUTSIDE LOCAL GOVERNMENT, 1974–PRESENT

6.1 In the 1974 NHS reorganisation public health was renamed “community medicine”, taken out of local government and integrated into the NHS. The MOH post was abolished and replaced by “community physicians”, who were intended to be both community advocate and NHS technician/manager. Other factors in this change were the desire for parity and consultant status among public health doctors, and the emergent professionalism of social work and environmental health, both of which were removed from the public health umbrella within local government.²²⁷

6.2 It is widely acknowledged that this transfer from local government was a disaster. Community physicians became preoccupied with health service matters and administration and little time was spent on prevention. The location within NHS authorities meant that they were remote from services such as housing and environment, while their population focus was at odds with the individualised interest of clinicians.

6.3 Part of the problem was the absence of a clearly articulated vision of what public health meant, and the tensions within the profession between different conceptions of their role—as technician manager or community activist.

6.4 The community physicians’ expertise in epidemiology and population health was expected to make them the lynchpin of NHS consensus management teams, at area, district and hospital level. But the advent of general management in health services in the 1980s undermined this potential public health role. Community medicine failed to achieve the promised status within the NHS and recruitment declined.²²⁸

6.5 The discipline revived only with the advent of HIV/AIDS in the mid 1980s. This led to the establishment of a committee of enquiry into the public health function chaired by the CMO, Sir Donald Acheson at the same time as he was actively involved in the fight against AIDS. The new syndrome seemed to presage a revival of epidemic disease and thus provided a model with which public health felt comfortable. The resultant report published in 1988, did not propose a return to local government, but helped to rejuvenate the profession.

6.6 Subsequent developments saw changes within the composition of the public health workforce and a greater recognition of multi disciplinary public health (MDPH).²²⁹ Further outbreaks and crisis events (BSE, 9/11, salmonella, pandemic influenza) saw parts of public health organised as an arms length agency, the Health Protection Agency, (HPA), while the mass advertising function declined and the related agency (HEA, later HDA, then NIHCE) lost this responsibility.

6.7 Conclusions:

- (a) Public health lost its local government role in 1974 and thus its contact with local communities.
- (b) The local government system replaced by the NHS consultant role was not especially vigorous but was capable of development.
- (c) Public health became remote from local communities and over dominated by the health service location.
- (d) Its ethos and workforce were both uncertain and fragmented.
- (e) Central arms length agencies assumed a key role in carrying out public health activities.

²²⁵ R J. Donaldson. *Off the cuff: reminiscences of my half century career in public health*. Richmond, Murray Print, 2000.

²²⁶ L Diack & D Smith, “The Media and the Management of a Food Crisis: Aberdeen’s typhoid outbreak in 1964”, in V Berridge and K Loughlin eds *Medicine, the Market and the Mass Media*, London, Routledge, 2005, 79–94.

²²⁷ J Lewis, *What price community medicine? The philosophy, practice and politics of public health since 1919*. Brighton, Wheatsheaf, 1986.

²²⁸ V Berridge, D Christie, E Tansey, eds *Public health in the 1980s and 1990s: decline and rise? Wellcome witnesses to twentieth century medicine*. Vol 26. London: Wellcome Trust Centre for the History of Medicine at UCL, 2006.

²²⁹ V Berridge, “Multidisciplinary public health; what sort of victory?” *Public Health* 121, (2007), 404–408.

7. OVERALL CONCLUSIONS

7.1 The historical record of public health within local government is disputed. It is important not to idealise its location there as a “golden age” but it did have major advantages. Initially it facilitated sanitary reform and subsequently aided integration of preventative and curative services.

June 2011

Written evidence from Unite the Union (PH 100)

This evidence is submitted by Unite the Union—the country’s largest trade union. The union’s members work in a range of industries including manufacturing, financial services, print, media, construction and not-for-profit sectors, local government, education and health services.

Unite represents approximately 100,000 health sector workers. This includes seven professional associations—the Community Practitioners and Health Visitors’ Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Medical Practitioners Union (MPU), Society of Sexual Health Advisors (SSHA), Hospital Physicists Association (HPA), College of Health Care Chaplains (CHCC) and the Mental Health Nurses Association (MNHA)—and members in occupations such as allied health professions, healthcare science, applied psychology, counselling and psychotherapy, dental professions, audiology, optometry, building trades, estates, craft and maintenance, administration, ICT, support services and ambulance services.

This diverse membership includes a range of members who are involved in public health functions including the professional body of health visitors, and Unite members who work in the specialist public health workforce where the Unite/MPU has public health doctors in membership and Unite is the main union for non-medical public health consultants.

EXECUTIVE SUMMARY

- Unite is extremely concerned about the impact of wider changes to the NHS on public health.
- Fragmentation of public health infrastructure and services will damage public health outcomes.
- There is insufficient information and detail on the Government’s proposals for Public Health England and the role of directors of public health. There needs to be clear systems of accountability and regulation fully integrated into this new system.
- Given the critical role of Public Health England there is a strong argument for public health consultants and specialists to continue to be employed by the NHS as Public Health England employees.
- Unite believes that several key workforce issues need to be considered in any changes. These include governance and reporting arrangements, training and professional development and terms and conditions.

1. INTRODUCTION

1.1 Unite welcomes the opportunity to submit evidence to the Health Select Committee inquiry on public health. Comments are organised under five key themes; accountability, governance and reporting; individual professional development; terms and conditions; workforce development; and future capacity. Before looking at the specific issues considered by the committee it is necessary to discuss the wider context of government health policies that will dramatically affect the public health of the population.

1.2 Firstly, the Government’s plans, as currently detailed in the Health and Social Care Bill, will cause huge upheaval for the NHS workforce. The bill will result in increased privatisation through the contracting out of health services to the private sector, which in turn will lead to further fragmentation of providers. Delivering health services is labour intensive and the drive to reduce costs to maximise profits will come at the expense of the number of staff employed and their morale. Unite has previously detailed why the Government’s plans will result in a decrease in the quality and range of health services available to people, contribute to increasing health inequality, increase healthcare costs, and reduce accountability. Unite also believes that this will lead to public health policy becoming more reactive, rather than long term and strategic. This will inevitably have a negative effect on public health.

1.3 Secondly, the agenda of deep spending cuts that the current government is implementing across public services, welfare and housing benefits run contrary to any aims to improve public health. Unite fully supports actions that improve and prioritise preventative healthcare measures, but to be effective such measures must recognise the impact of the wider social and economic determinants on health and wellbeing. These wider determinants include—but are not exclusive to—employment, the quality of that employment, employers’ duties to protect workers’ health at work, housing, local environment, the strength of civil society, facilities for active recreation and both income level and income inequality. Poverty plays a crucial role in health inequalities and a person’s health and wellbeing. In all of these areas current government actions and policies undermine progress to improving public health. This is the bleak context in which any newly created public health agency, directors of public health or public health consultants will be operating. There is a danger that the role very

quickly becomes about minimising the detrimental impacts of government actions on public health, rather than positively driving forward improvements in public health and local environments.

1.4 Unite's wider and more detailed views on the Government's strategy and plans for public health were given in the response to the Government's consultation, "*Healthy Lives, Healthy People*".²³⁰

2. ACCOUNTABILITY, GOVERNANCE AND REPORTING

2.1 At the moment there is insufficient information and detail on the Government's proposals for Public Health England, the role of directors of public health and public health consultants. The roles, responsibilities and nature of Public Health England require substantial clarification. Unite has previously pointed out that at the moment the Government's public health plans lacks specific actions and measurable targets so that the success, or otherwise, of the implementation of the Government's public health agenda can be assessed.

2.2 Directors of public health are to provide governance and professional guidance for public health staff, and there is an urgent need for the Government to provide clarity around the reporting arrangements for these roles, how they will be regulated and how they are to be held accountable.

2.3 Unite believes that the role must not be marginalised and should be given sufficient status to enable the post holder to operate strategically in promoting the public health of the local population. The role holder should therefore report directly to the local authority chief executive, have the right to put their views on health matters into the public domain, and have a right of access to elected members. The multi-agency public health challenge process must be recognised as part of the director of public health role, along side relations with communities, voluntary organisations and business. Unite public health members, who are from a multidisciplinary background, further believe that directors of public health should be statutorily regulated.

2.4 Unite agrees with the BMA that non-medical public health consultants deserve the same status and NHS terms of conditions as medical public health consultants.

2.5 While regulation of the specialist public health workforce is currently under review Unite would welcome discussion regarding the development of a regulatory structure for non-consultant level posts within public health. In particular Unite would support more flexible arrangements for progression into the specialist workforce. It is important that there are appropriate systems of career progression between specialist and non-specialist grades to prevent a replication of the medical/non-medical divide of the 1990s.

3. INDIVIDUAL PROFESSIONAL DEVELOPMENT

3.1 Unite members have strongly expressed the view that the current uncertainty around the future roles and employment arrangements will have a negative effect on the public health workforce and individual professional development within the field.

3.2 There is currently a lack of detail on future training and professional development of the public health workforce. Government proposals in the Health and Social Care Bill are also raising fears about career development and training. The fragmented commissioning arrangements in the bill are expected to create barriers between different organisations and prevent consultants and public health staff from gaining and maintaining competencies across all of the key domains in public health. In addition this will create difficulties in the identification of suitable and accredited specialist training placements. At the moment the public health workforce is relatively mobile across the public health domain which allows them to gain a wide range of experience. Unite is committed to ensuring that this system is maintained.

3.3 Local authorities currently do not have the knowledge or capacity to provide required training and development for the public health workforce. For example, local authorities will be unprepared or able to properly support staff in achieving revalidation and the continuing professional development requirements of the Faculty of Public Health. Unite would query whether authorities, given the financial vice they are in, will be able to develop this capacity.

3.4 One idea that should be explored is whether all public health staff should be employed by Public Health England, with staff then seconded to local authorities. If Public Health England is to be a special health authority, this arrangement would minimise the problems associated with public health consultants and specialists moving to local authority employment.

4. TERMS AND CONDITIONS

4.1 Unite has previously outlined the benefits of national collective bargaining, and specifically the benefits of Agenda for Change to the NHS. As well as bringing about equal pay for work of equal value and providing a framework for career development and progression for staff, it has brought a myriad of other benefits. National negotiation prevents the duplication of resource intensive HR functions and negotiation at local and regional organisations across the country. A single pay spine across the country brings a great deal of stability to the healthcare labour market and means organisations do not get into a "bidding war" for health professionals

²³⁰ The Unite response can be found here:

http://www.epolitix.com/fileadmin/epolitix/stakeholders/Unite_response_Healthy_lives_Healthy_people.pdf

that are in short supply. Unite believes that the non-medical and medical public health workforce should continue to be employed on NHS terms and conditions, with the retention of the public health knowledge and skills framework. This would easily fit with staff being employed directly by Public Health England.

5. WORKFORCE DEVELOPMENT

5.1 There is no suggestion yet that Public Health England will be well-equipped for workforce development roles and government has not engaged with this problem. For example, there appears to be a view that workforce development can be managed at local level but a national shortage of public health specialists and consultants will make that impossible.

5.2 Unite believes that public health teams, which will include registered consultants, specialist and practitioner staff able to work across all three domains of public health, should be retained whether at borough level or higher. These three domains are health improvement, health protection and health services. Given the uncertainty of structure in local government and health and well being boards in public health, there needs to continue to be team working with dedicated leadership at the appropriate level.

5.3 Some local authorities are proposing to disperse their public health staff across the organisation. Unite believes this would lead to the marginalisation of the public health agenda and leave public health staff without sufficient professional support. Unite believes this would also effect the wider general workforce, such as non-consultant level and registered public health staff who would be unlikely to be managed and supervised by a consultant. This would limit the level of public health coaching, management and mentoring received. Furthermore, the continued government emphasis on a “diversity of employers” will lead to public health specialists and consultants increasingly working in professional isolation and with variable support.

5.4 There are concerns that disparity will develop as a result of the multidisciplinary nature of public health. Location of these roles within local authority may disassociate public health as a speciality away from other clinical and medical specialities, making future recruitment of public health specialists and consultants difficult.

5.5 Unite wants to see clarification from the government about how to ensure that public health trainees will have access to the full range of public health experiences, once public health is dispersed across several organisations.

5.6 Unite also wishes to see clarification on the position of defined versus generalist specialists, including where defined specialists would be placed, and the future of these specialists in light of the changes proposed by the government.

6. FUTURE PUBLIC HEALTH CAPACITY

6.1 Increased demand for the public health workforce is already being seen in terms of local authority commissioning and should be part of future GP commissioning processes. If the public health workforce is eroded, and/or split amongst several agencies the variety or skills required and the capacity to deliver these may not be sufficient to meet increased need. A key focus for the public health agenda is prevention of ill health and disease and to date there has been insufficient evidence that the QIPP agenda has delivered on these prevention issues.

6.2 The future funding of public health is not clear. Given the wider spending cuts agenda being pursued by this government there are fears that sufficient funding for public health will not be forthcoming and there is doubt about any funding being ring-fenced. There are serious concerns that the competitive business model and fragmentation of NHS services will cause major problems when implemented. Unite members are predicting serious problems with budgetary responsibility, the impacts on other services and confusion about which organisation is providing infrastructure for public health work.

6.3 Finally, information analysis is another important area of shortfall in the Government’s plans. Unite is concerned that the Government is not taking the necessary steps to preserve the skills in the Public Health Observatories, whose existence is being prolonged by a short term extension with no clear strategy for the longer term.

June 2011

Written evidence from Living Streets (PH 101)

SUMMARY

- Walking is the one form of physical activity that is open to all. In focusing on getting sedentary people active as a key priority of the public health agenda, walking must be promoted as a first step or gateway to more active lifestyles. The promotion of walking through behavioural change initiatives, investment in quality public realm and planning for liveable, compact neighbourhoods is a highly successful, proven and cost effective way to prevent illness and reduce mortality rates and should be promoted throughout public health policy.

- The creation of a dedicated public health body in Public Health England and the devolution of public health responsibilities to local government are welcome, and should be used as an opportunity to ensure that public health is well resourced, that public health professionals have the influence they need to drive change and that the new governance arrangements at local and national level bring together professionals from across disciplines, including planning and education, to ensure a coordinated approach.
- Budgets for public health must be sufficient to address the issues effectively and meaningfully. Whilst flexibility of budgets has great potential in seeing budgets go further to meet multiple objectives, budgets should not be used to fill funding gaps in existing local authority activities such as leisure or environmental health services.
- The implications of poor streets and public realm on health inequality, and the availability of walking to people of all economic backgrounds, make public realm investment an ideal vehicle to help close the health inequalities identified in the Marmot Review.

SUBMISSION

1.1 Living Streets is the national charity that stands up for pedestrians. With our supporters we work to create safe, attractive and enjoyable streets, where people want to walk.

1.2 We have been the national voice for pedestrians throughout our 80-year history. In the early years, our campaigning led to the introduction of the driving test, pedestrian crossings and 30mph speed limits. Since then our ambition has grown. Today we influence decision makers nationally and locally, run successful projects to encourage people to walk, and provide specialist consultancy services to help reduce congestion and carbon emissions, improve public health, and make sure every community can enjoy vibrant streets and public spaces.

1.3 Public health remains a hugely significant issue, particularly with an aging and more overweight population that is widely predicted to impose an unsustainable burden on the public coffers and the NHS by 2050.²³¹ In setting out Living Streets' ideas on the Government's proposals, particularly focussing on the need to deliver results for a minimum financial outlay relative to benefit, this response emphasises the credentials of walking as a cost-effective and sustainable public health solution, open to all and a natural gateway to further preventative health measures. At their best, planning-based and behavioural change strategies to improve public health anticipate and address lifestyle trends that, if left unchecked, could necessitate preventative health measures at a later stage, incurring a higher human and resource cost.

1.4 This submission focuses on four of the key points raised by the Committee: the creation of Public Health England, the future role of local government, the purpose of the Public Health Outcomes Framework and the Government's response to the Marmot Review.

The creation of Public Health England within the Department of Health

2.1 Living Streets broadly welcomes the creation of Public Health England as a means of sharing evidence and best practice on public health problems and interventions.

2.2 We strongly believe that alongside the general move towards a more localist approach, the Department of Health will need to maintain a significant role in coordinating public health and supporting local delivery. Public Health England must be sufficiently well-resourced and influential to achieve this; the body must have operational independence and act as a body which provides advice and recommendations in its own right.

2.3 Public health is an outcome of almost all government activity, as well as a specific function in itself. There needs to be clear, high level responsibility for public health across departments. As we have stressed in our responses to the relevant NHS White Papers, the effective coordination of public health will require cooperation between several departments and agencies, involving, for example, the Department of Communities and Local Government and the Department for Transport to ensure that planning and transport policy, including the National Planning Policy Framework, promote public health through such measures as ensuring good air quality and making active travel the natural choice. It is vital that Public Health England and the Department of Health ensure that this inter-departmental working occurs effectively.

2.4 Public Health England should have a role in assessing wider Government policies and programmes for their impact on public health and wellbeing. As part of this effort it may be helpful for Public Health England to publish definitive standards on public health outcomes which can be promoted for application across departments, ensuring some continuity if the political landscape changes.

2.5 In order to perform this coordination role effectively, Public Health England should contain expertise and knowledge of planning, urban design, transport and education in order to ensure a coordinated approach to creating and maintaining healthy environments.

²³¹ Department for Business Innovation and Skills. 2007. *Foresight—Tackling Obesity: Future Choices*. Available at: <http://www.bis.gov.uk/assets/bispartners/foresight/docs/obesity/17.pdf>

The future role of local government in public health

3.1 We broadly welcome the integration of public health responsibilities and functions within local authorities as a way to increase democratic legitimacy and promote interventions that are better tailored to the needs and characteristics of specific communities. With regard to active travel, decision-makers at this level should be better placed to know which initiatives will improve the walking environment and reduce obstacles, both physical and perceived, which act as a deterrent to walking, within an particular area. We would stress, however, that the increased involvement of local government should also be a vehicle to acknowledge and further the strong links between planning, housing and transport policy and health and wellbeing.

3.2 We feel strongly that the responsibility on local authorities to support joint working on health should be statutory, and welcome the proposed establishment of Health and Wellbeing Boards and the proposed status of Directors of Public Health. In order to be effective across the breadth of the public health agenda, Directors of Public Health must have the professional independence to set out clear advice and guidance, and a status at the Executive Director/Board level of local authorities.

3.3 Whilst we are broadly in favour of a light-touch approach to these arrangements, we feel that the guidance around establishing such boards should explicitly recommend that boards include senior planning, housing and transport policy officers, as well as directors of learning and children's services, senior stakeholders with responsibilities for local sports and recreation and senior stakeholders from primary and secondary education. This is in order to maximise the opportunities for local areas to implement cost-effective preventative measures such as the promotion of physical activity and quality health education, enhancing the general quality of life in addition to providing a basis for better health outcomes.

3.4 The involvement of planners and urban designers in local public health governance is particularly crucial to ensure the health-oriented planning of compact, mixed-use walkable neighbourhoods with good quality public realm. Generally, places displaying characteristics of walking-friendly urban form are associated with a 25–100% increase in people's likelihood to walk.²³² Our breadth of experience in providing consultancy services to local authorities, and in combining walking promotion with grassroots support for physical environment improvements through projects such as Living Streets' Fitter for Walking programme, has consistently shown that getting the quality of the built environment right is crucial to making streets and places where people feel comfortable and safe and where they want to both walk and spend time. "The design and management of the built environment can create barriers to physical activity—or they can create opportunities for activity that make an active lifestyle an attractive and compelling choice".²³³ Transport for London research²³⁴ has shown that the top three potential motivators for walking more included new and improved public spaces with new seating, new and improved crossing facilities at junctions alongside new and improved walks for pleasure.

3.5 The promotion of walking and of quality public realm also have notable social, environmental and economic benefits. Recent research both from the UK and internationally, for example, has demonstrated that investment in the walking environment can increase profits to local businesses, increase rents in certain areas, increase foot traffic and that local residents and business would be willing to pay more or contribute to part of the costs of improvement schemes.²³⁵ Links to such wider outcomes from interventions that promote health have crossover benefits such as reducing carbon emissions and improving air quality. These crossovers need to be reflected in the way that the public health agenda is managed at local level, with the responsibilities and remits of Directors of Public Health relating to a broader range of activities and programmes which impact on public health and wellbeing.

3.6 The decentralisation of responsibility should not be an occasion to reduce funding for public health, but rather to improve the way in which this funding is targeted and used.

The purpose of the Public Health Outcomes Framework

4.1 Living Streets broadly welcomes the structure and priorities of the Public Health Outcomes Framework.

4.2 It is important, however, that monitoring of outcomes is conducted at reasonable intervals. Behavioural change measures—particularly those which challenge entrenched habits such as car use—take time to take effect, paying dividends in the medium to long term, and monitoring practice needs to reflect this.²³⁶

4.3 We support the inclusion in the Outcomes Framework of an additional criterion around the co-benefits of public health interventions—such as the social, environmental and economic benefits of investment in the walking environment—in order to ensure that cost-benefit decisions are made in the round and use resources to the best possible effect.

4.4 We also advocate the inclusion of a measure of walking activity, ideally one which allows differentiation between levels of walking and levels of cycling. If possible this should also include measures which assess

²³² Sinnett, D *et al* 2011. Making the Case for Investment in the Walking Environment. London: Living Streets.

²³³ Living Streets, National Heart Forum, Commission for Architecture and the Built Environment. 2007. Building health: Creating and enhancing places for healthy, active lives. Available at: http://www.bhfactive.org.uk/downloads/BuildingHealth_full.pdf

²³⁴ Synovate/Transport for London. 2008. Attitudes to Walking 2008 Research Report.

²³⁵ Sinnett, D *et al* 2011. Making the Case for Investment in the Walking Environment. London: Living Streets.

²³⁶ See also Sustrans. 2011. Response to "Healthy Lives, Healthy People: Transparency in Outcomes".

perceptions of walking and the walking environment, as walking levels may be suppressed where the walking environment is unwelcoming or perceived to be unsafe or unattractive. Similarly, we advocate a measure of road danger in order to ensure that approaches to the reduction of road casualties genuinely address road safety, rather than deterring walking and cycling and causing a modal shift away from active modes which would conflict with broader preventative health goals.

How the Government is responding to the Marmot Review on health inequalities

5.1 Living Streets believes that a greater proportion of NHS spending should be targeted at preventative measures, and advocates walking promotion, road safety, air quality and improvement of the built environment as key areas in which effective interventions can have profound effects on health inequalities.

5.2 According to the Marmot Review, only 4% of NHS expenditure was spent on preventative measures.²³⁷ This is despite a rapidly growing need for such measures: for example, in 2005, almost 871,000 prescription items were dispensed in England for the treatment of obesity compared with just over 127,000 prescriptions in 1999 (an increase of 585%).²³⁸ Greater investment in preventative health—and within this in the proven and successful measures needed to promote walking—is the rational response.

5.3 The Department of Health's social marketing strategy (Changing Behaviour, Improving Outcomes) explains the value of preventative health campaigns and the dangers of reducing funding; following last year's announcement of cuts, Change4Life's new member rates fell by 80% (90% if considering calls only, Talk to FRANK calls fell by 22% (with a 17% drop in visits to the website), and the NHS Smokefree campaign's user numbers were down 50%.²³⁹ These examples, which are widely viewed as having achieved some success, have demonstrated the value of preventative campaigns.

5.4 Preventative measures targeted at increasing physical activity have been shown to reduce costs to the NHS. Physically active lifestyles are associated with a 40% reduction in the genetic predisposition to obesity.²⁴⁰ Walking has been proven to reduce the severity of dementia (reduces risk by 50%), retain bone density and stability, as well as to reduce the risks of some cancers, cardiovascular diseases (reduced by up to 30%²⁴¹), obesity, depression²⁴² and high blood pressure; and has even been shown to reduce overall mortality rates by up to 20%.²⁴³

5.5 These levels of reductions on mortality alone, even without consideration of improvements to health and disease prevention in non-fatal or life threatening ways, represent a significant reduction in health costs nationally, year on year, in the longer term. The public purse also benefits more broadly: for example, there is strong evidence to suggest that physically active employees take far fewer sick days than inactive employees, with widely quoted research putting the differential as high as 27%.²⁴⁴ Walking also has an important role in secondary preventative health, the management of long-term conditions such as diabetes and in reintroducing physical activity during recovery from serious illnesses such as cancer. In his 2009 report, the Chief Medical Officer stated that "The potential benefits of physical activity to health are huge. If a medication existed which had a similar effect, it would be regarded as a 'wonder drug' or 'miracle cure'."²⁴⁵

5.6 The Marmot Review stresses the importance of targeting walking as a preventative health intervention at children when young. This reinforces our proven belief: not only is infant/child obesity a problem (30% of children aged 2 to 15 were categorised as overweight or obese in 2007²⁴⁶) but behaviours learned in childhood often remain into adulthood. Our experience in managing the national Walk to School programme, which reaches over 1.3 million children across the UK, has demonstrated the potential of building walking into daily routines from a young age: in an independent evaluation of Living Streets' Walk Once a Week programme, 19% of children surveyed reported that they started walking to school because of Walk Once a Week, the proportion of children walking to school in schools running WoW was over 9% higher than the national average

²³⁷ Marmot Review. 2010. Fair Society, Healthier Lives. Available at: <http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf>

²³⁸ NHS. 2006. Statistics on obesity, physical activity and diet, England 2006. Available at: <http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/obesity/statistics-on-obesity-physical-activity-and-diet-england-2006>

²³⁹ Department of Health. 2011. Changing Behaviour, Improving Outcomes; A New Social Marketing Strategy for Public Health. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_126449.pdf

²⁴⁰ Li S, Zhao JH, Luan J, Ekelund U, Luben RN, et al. 2010. Physical Activity Attenuates the Genetic Predisposition to Obesity in 20,000 Men and Women from EPIC-Norfolk Prospective Population Study. *PLoS Med* 7(8). Available at: <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000332>

²⁴¹ Hamer, M, Chida, Y 2008. Walking and primary prevention: a meta-analysis of prospective cohort studies. *British Journal of Sports Medicine* 42: 238–243.

²⁴² Department of Health. 2004. *At least five a week: Evidence on the impact of physical activity and its relationship to health*. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4080994

²⁴³ Hamer, M, Chida, Y 2008. Walking and primary prevention: a meta-analysis of prospective cohort studies. *British Journal of Sports Medicine* 42: 238–243.

²⁴⁴ Physical Activity Task Force, 2003.

²⁴⁵ Department of Health, 2009. Annual Report of the Chief Medical Officer. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_113912

²⁴⁶ Office of National Statistics. 2009. *Health: 3 out of 10 children are overweight or obese*. Available at: <http://www.statistics.gov.uk/cci/nugget.asp?id=2196>

as determined by the National Travel Survey, and there were indications of an associated positive effect on the number of walking trips made by adults.²⁴⁷

5.7 For both adults and children, walking is perhaps the mode of exercise best suited to tackling health inequalities. It is almost unique as a physical recreational activity in the fact that there is no financial outlay and, unlike gym-going in particular, can be participated in across financial divides. The cost-effectiveness of active travel as exercise further extends to the infrastructure needed.

5.8 Improvements to the built environment are among the best ways to address health inequalities. Poor, unsafe walking environments are a typical attribute of areas of deprivation. A recent, detailed statistical study of child road casualties found that children living in Preston are more than twice as likely to be injured on the road than the national average, and five times more likely than those in Kensington & Chelsea.²⁴⁸ The House of Commons Transport Committee's report, *Ending the Scandal of Complacency*, drew out the disproportionate impact of road casualties on both children and young people and deprived communities, noting that "child pedestrians from the lowest socio-economic groups are 21 times more likely to be killed in a traffic accident than those from the top socio-economic group".²⁴⁹

5.9 Air quality is also correlated with deprivation. Environment Agency studies have conclusively found that "The most deprived areas suffer from the poorest air quality. They have the highest concentrations of nitrogen dioxide, airborne dust (fine particulates), sulphur dioxide, carbon monoxide, and benzene. People in the most deprived areas are exposed to 41% higher concentrations of nitrogen dioxide than people living in areas of average deprivation".²⁵⁰ Achieving modal shift away from motor vehicles is a crucial aspect of addressing this inequitable situation, while local authorities should critically assess existing and emerging planning frameworks to ensure that deprived areas do not bear the brunt of major routes and traffic corridors.

5.10 Intimidating and badly maintained walking environments are a powerful reason for people to walk as little as possible, and this is an issue with profound psychological effects in addition to the negative impacts on physical activity and road safety. A focus group participant quoted in the Marmot Review said of their local neighbourhood, "You can see the deprivation. All you have to do is look outside. It is in your face every day—litter everywhere, rats and rubbish, it is a dump... It feels like people around you have no meaning to life. I keep my curtains closed at times. It doesn't give you a purpose to do anything."²⁵¹ In aiming to get more people walking more often, the importance of good public realm, safer streets, cleaner air and intelligent mixed-use planning need to be placed at the heart of the local public health agenda.

June 2011

Written evidence from the Royal Society for the Prevention of Accidents (RoSPA) (PH 102)

SUMMARY

- Accidents are a far greater public health issue than is currently recognised and a strategic approach to accident prevention, placed firmly at the heart of the Government's public health strategy, is required if lives are to be saved, injuries reduced and dramatic cost savings made. The rationale on which this perspective is based is explained fully at www.rospace.com/about/currentcampaigns/publichealth/.
- The local-level assessment of needs and commissioning of public health services, based on robust data and evidence of best practice, is essential if appropriate services are to be delivered, but clear national leadership and guidance are fundamental if important aspects of public health, such as home accident prevention, are to receive the attention they deserve.
- At present, it is difficult to see how third sector organisations, particularly those which operate at a national level, could effectively access the proposed public health planning and commissioning arenas. Without a clear mechanism for participation, the third sector—acknowledged as a key service provider—could be severely damaged.

1. CONTEXT

1.1 RoSPA welcomes the development of Public Health England as a national body to drive forward change, but is concerned that there is no clear remit for accident prevention specified in *Healthy Lives, Healthy People: Our strategy for public health in England*.

²⁴⁷ Wavehill Consulting. 2009. *Evaluation of the WoW scheme*.

²⁴⁸ Road Safety Analysis. 2010. *Child Casualties 2010; A study into resident risk of children on roads in Great Britain 2004–08*. Available at <http://www.roadsafetyanalysis.org/wp-content/uploads/2010/08/PR-Child-Casualty-Report-RSA-edit.doc>, accessed on 20 August 2010

²⁴⁹ House of Commons Transport Select Committee. 2009. *Ending the Scandal of Complacency: Road Safety beyond 2010*. Available at: <http://www.publications.parliament.uk/pa/cm200708/cmselect/cmtran/460/460.pdf>

²⁵⁰ Environment Agency. 2008. *A scoping report: Understanding the relationship between health, deprivation and environmental quality in Greater London*. Available at: <http://publications.environment-agency.gov.uk/pdf/GETH0308BNSV-e-e.pdf>

²⁵¹ Marmot Review. 2010. *Fair Society, Healthier Lives*. Available at: <http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf>

1.2 Although injury indicators are proposed in the accompanying Public Health Outcomes Framework document, the White Paper itself barely mentions accidental injury, its distribution, severities, costs or preventability.

1.3 RoSPA hopes this serious omission will be rectified and that Public Health England will become a truly influential champion of accident prevention that:

- leads on the development of an accidental injury strategy (with home accident prevention at its core) as an integral part of its overall strategy for public health;
- co-ordinates epidemiological work related to accidental injury;
- takes a national lead in establishing an accidental injury database and provides clear guidance to ensure that appropriate priority and consistency is applied to data collection and dissemination at a local level;
- provides, through its strategy document, a robust framework for the development of effective evidence-based accident prevention work at a local level, including the establishment of local accident prevention partnerships;
- encourages the robust evaluation of accident prevention work and promotes best practice;
- ensures that appropriate skills are developed locally by directing local providers to sources of suitable training eg home safety training; and
- recognises the role of the third sector and provides clear national commissioning routes to ensure third sector organisations can participate fully in service provision.

1.4 When we talk about accident prevention, we do not mean “nanny statism” or excessive bureaucracy. On the contrary, we know and can demonstrate that a better informed, more empowered public—more conscious of the causes of accidents and how to prevent them—will be healthier, happier, and far less expensive for the taxpayer.

RESPONSES TO SPECIFIC ISSUES RAISED BY THE HEALTH COMMITTEE

2. *The creation of Public Health England within the Department of Health and the public health role of the Secretary of State*

2.1 Accidents and their prevention can be found among the roles and responsibilities of a variety of “non-health” government departments, the key players being: Department for Transport; Department for Work and Pensions; Department for Communities and Local Government; Department for Business, Innovation and Skills; and, Department for Education.

2.2 However, primary responsibility for accident prevention lies—and, indeed, must lie—with the Department of Health and, at its helm, the Secretary of State.

2.3 As *Healthy Lives, Healthy People* makes clear, the NHS has a “critical role” in promoting health and preventing avoidable illness, and, indeed, injury. This role is critical, not just to improve health outcomes but also because a tremendous amount of money can be saved through prevention. In 2001, it was estimated that the cost of accidents to the NHS in England alone was £2.2 billion a year. Allowing for inflation, this figure could now be in the region of £5–7 billion. We are told the NHS needs to save £15–20 billion; it would therefore seem illogical for the Department of Health not to lead a strategic approach to accident prevention which could save a significant proportion of this sum.

2.4 National leadership has been proven to bring impressive results. Since the mid 1990s, evidence-based road safety strategies led by the DfT, and involving a wide variety of national and local groups, have contributed to a reduction in annual deaths and serious injuries on Great Britain’s roads by nearly 21,000 (44%). Similarly, work by the Health and Safety Executive, supported again by many other groups, has helped cut the number of workers killed in occupational accidents in the UK by nearly half since 1996.

2.5 In 1992, there was a welcome increase in action on home and leisure safety at a local level following the publication of *The Health of the Nation*. Healthy Alliances were established, bringing together local authorities, health professionals and the third sector to address various aspects of public health including the prevention of accidents involving older people and children. In the immediately following years, there was a noticeable drop in home accident deaths. The number of children and older people visiting A&E after home or leisure-related falls also decreased.

2.6 However, national leadership on home and leisure accident prevention has been sporadic. The effects of this can be seen clearly because, while deaths from road and workplace accidents have fallen consistently, home accident deaths are now at their greatest number in England and Wales since 1985, and represent a growing proportion of total accidental deaths. This has contributed to the overall trend in accidental deaths being upwards during the last decade. The accident death rate in England has all but flat-lined since the late 1990s—strikingly at odds with the significant reductions in death rates from cancer, circulatory diseases and suicide. Accidents are the principal cause of death up to the age of 39 and the main cause of death among children, post-infancy.

2.7 Accidents do not just result in untimely and often violent deaths—they also cause millions of injuries that require trips to a GP or hospital. For example, across the UK, accidents result in more than two million visits to A&E departments by children every year, of whom half are injured in the home. A&E attendance following accidents is rising. Hospital admissions for treatment of accidental injuries are also increasing. To give just one example—in 12 years, the number of over-60s requiring inpatient care for falls-related injuries has doubled, standing at more than 333,000 in 2009/10 in NHS hospitals in England alone.

2.8 To provide the strong national leadership that public health, and accident prevention as part of it, warrants, RoSPA favours the creation of Public Health England as a semi-autonomous body within the overarching structure of the Department of Health, its board members representing the full range of public health issues and its chairman reporting directly to the Secretary of State. Without obvious political leadership and vocal support, others involved in the delivery of accident prevention (or wider public health) will not keep up the necessary momentum.

2.9 If Public Health England became a fully independent body, it might be too detached from the budget-holding Department that stands to save billions of pounds from its work and become merely one of many competing lobby organisations. As just another directorate of the Department of Health, it would be constantly vulnerable to the effects of ministerial change and perhaps less able to speak freely about important matters.

3. *The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategy)*

3.1 Local authorities, with their responsibilities for education, transportation, housing, environmental health, social care, children's services and trading standards, are well placed to understand the factors leading to accidental injury within their populations. They have played an important role in accident prevention for many years, and there are numerous examples of successful joint working between local government and the NHS, often with the involvement of the third sector too.

3.2 Earlier, we mentioned the Healthy Alliances that flourished in the early 1990s. A more recent example of successful partnership working can be found in Dudley where a falls prevention initiative, the £158,000 a year costs of which were funded by the Primary Care Trust and the council, saved £3 million over five years due to the corresponding reduction in hip fractures.

3.3 Additionally, Safe At Home, the national home safety equipment scheme, funded by the DfE and delivered by RoSPA from February 2009 to March 2011, involved local authority, NHS and third sector partners in areas with the highest accident rates in England, all working to help disadvantaged families prevent accidents among under-fives.

3.4 RoSPA believes local authorities, guided by the Directors of Public Health employed by them, should have the freedom to develop accident prevention strategies that are tailored to the needs of local people. The Joint Strategic Needs Assessment (JSNA), from which a Health and Wellbeing Strategy will be formed, provides the opportunity for this. To ensure joined-up commissioning at a local level, RoSPA advocates a multidisciplinary approach to this process, considering wider health determinants such as housing, transportation and education.

3.5 Although localism is crucial in developing relevant and effective strategies, a clear national steer is required to counter the risk that valuable life-saving—and cost-saving—work will either not happen, or will begin but then fizzle out. As recognised by the *Healthy Lives, Healthy People* consultation, finances have often been squeezed by other NHS priorities, and it must be recognised that the same pressures will operate within local authorities, necessitating clear guidance and protection for public health funds. RoSPA believes Public Health England should be the body to provide this guidance and that, while not defining the detail, it should specify the need to include accident prevention work, and specifically home safety, in Health and Wellbeing Strategies, with the focus on enhancing existing activity.

3.6 Locally, the health and wellbeing agenda will be driven by local authority and health professionals, which is reinforced by the proposed membership of Health and Wellbeing Boards. However, the mechanism enabling this agenda to be influenced, let alone owned, by local communities is not clear. Nor is it clear how the proposed process differs from the current Local Strategic Partnership approach, which often already includes Health Partnership Boards comprising the partners proposed for Health and Wellbeing Boards. RoSPA believes it is important to strengthen existing partnerships rather than dismantle and rebuild from scratch.

3.7 Although third sector and private business organisations appear to be regarded as key delivery agents for services, their involvement in Health and Wellbeing Boards appears to be only discretionary. RoSPA advocates that relevant third sector organisations, including those concerned with accident prevention, should be properly involved in JSNAs and the work of Health and Wellbeing Boards.

4. *Arrangements for public health involvement in the commissioning of NHS services*

4.1 Given the number of people being killed or injured in accidents—and the huge financial burden that injury treatment imposes on the NHS—it is imperative that accident prevention is considered when NHS

services are being commissioned. We are told regularly that the choice for the NHS is: spend less or do less. But there is a third way—investing in accident prevention would not only save lives and reduce injuries, but would enable the NHS to continue to deliver its vital services and save money. Accident prevention projects are easy to implement, inexpensive to deliver and have impressive return on investment potential. They can bring about immediate savings within the very first year.

5. Arrangements for commissioning public health services

5.1 The commissioning of accident prevention services must be based on robust data that indicates what the priorities should be. There are clear roles for both Public Health England and local government in this. RoSPA welcomes the lead commissioning role for Public Health England in relation to health intelligence and data, while acknowledging that there are some instances in which local authorities will need to commission their own data. At present, data relating to home and leisure accidents is not routinely collected, and therefore is not analysed or disseminated on a local or national scale. This situation needs to be rectified if appropriate services are to be commissioned. Left to those operating at a local level, such data collection will, at best, be fragmented and, at worst, remain non-existent. Public Health England should provide clear guidance on the appropriate level of priority and consistency in data collection and dissemination.

5.2 The third sector is hugely important in providing services that improve public health, and clear commissioning routes are required to ensure these valuable services can continue. At the moment, it is difficult to see how third sector organisations could effectively access the commissioning arena. A national mechanism is needed whereby third sector organisations, and private firms, that deliver services can feed into Health and Wellbeing Boards.

5.3 It will be particularly difficult for national charities to operate within the proposed arrangements for public health, and some way is needed to lessen the challenges that such organisations will face in maintaining contacts with a multiplicity of local Health and Wellbeing Boards. For example, RoSPA, which has more than 90 years' experience in accident prevention, plays a pivotal role in advising national and local commissioners on the leading causes of accidental injury and the best evidence-based practice to tackle them. The proposed structure—with its emphasis on the localism agenda—does not appear to have a mechanism for organisations like this to bring their skills and expertise to the table or to secure funding to continue their role.

5.4 Without clear third sector participation routes, expertise will be lost, there will be duplication of effort at a local level and a failure to share and adopt best practice. Public Health England could play an important role in alleviating the problem by signposting Health and Wellbeing Boards to key national service providers. The Government also needs very clear plans to protect services provided by the third sector in the short term and to properly acknowledge the need for transition arrangements.

6. The structure and purpose of the Public Health Outcomes Framework

6.1 RoSPA welcomes the inclusion of indicators related to injury prevention in the Outcomes Framework. The inclusion is vital to ensure that action is taken on accident prevention.

6.2 RoSPA believes Public Health England should lead on the implementation of robust evaluation of public health interventions and ensure that appropriate skills for this are developed at a local level. This will help local areas develop evidenced-based programmes that can truly deliver the outcomes outlined in the framework.

6.3 However, while the emphasis on evidence-based approaches is acknowledged, it will also be important to build in opportunities for innovative approaches. Failure to do this will stifle creativity. It should be remembered that all evidence-based practice started with an idea, a pilot and a small-scale initiative that grew and developed. Therefore, incentives are needed to promote innovation and its evaluation rather than just limiting activity to what is already known to work.

7. Arrangements for funding public health services (including the Health Premium)

7.1 RoSPA supports the “population health measures” approach for allocating public health funding, taking into account health inequalities, because it appears the most pragmatic means of deciding allocations and of ensuring those in the greatest areas of public health need receive the higher levels of funding. The “cost-effectiveness” approach may be more appropriate for use by local areas in determining how they spend their allocations.

7.2 While RoSPA acknowledges that there will be no centrally-imposed targets or performance management, we believe it is likely that local authorities will be driven by the availability of additional funding through the Health Premium. However, we are concerned that key areas will be undermined if they do not have an indicator linked to the Health Premium.

7.3 On accident prevention, it should be noted that only when the previous Government introduced a “national indicator” did Local Strategic Partnerships give more consideration to the inclusion of injury prevention in their local area agreements. Similarly, the key driver for much falls prevention work in recent years was the National Service Framework for Older People. Therefore, RoSPA believes it is important to ensure that accident prevention indicators are linked to funding offered through the Health Premium,

recognising that interventions in this area can offer long-term benefits in terms of fewer injuries and corresponding cost savings.

7.4 Part of the Health Premium should focus on rewarding areas that are willing to pilot innovative approaches in order to further develop the base of evidence and good practice available to local practitioners.

8. *The future of the public health workforce (including the regulation of public health professionals)*

8.1 The need for accident prevention co-ordinators in every local authority area was highlighted recently by NICE guidance. In its *Strategies to prevent unintentional injuries among under-15s*—published in November 2010—it said that “local injury prevention co-ordinators” could promote a strategic framework for action and encourage local agencies to work together. To help make this happen, it is important that opportunities for training and funding are made available, and Public Health England could play a valuable co-ordination role.

9. *How the Government is responding to the Marmot Review on health inequalities*

9.1 The Marmot Review provided further confirmation of the inequalities in health that have been understood for many years and RoSPA agrees that the indicators outlined in the Outcomes Framework should reflect the need to tackle these as a priority.

9.2 We are aware of the significant social gradient in relation to accidental injury and regard the proposed injury prevention indicators as essential first steps to tackling this.

9.3 Given the scale of the home accident problem involving children and the significant social class gradient in the death and injury rate of children from accidental injury (the death rate of those in NS-SEC Class 8 being 13 times higher than in NS-SEC Class 1), RoSPA proposes that a clear national steer on preventing home accidents involving young children from disadvantaged families would be a highly appropriate response to the Marmot Review.

June 2011

Written evidence from Bristol-Myers Squibb (PH 103)

SUMMARY

- BMS’s response is informed by a programme of work launched in March last year that relates solely to our virology portfolio. This programme has comprised extensive stakeholder outreach to clinicians, commissioners, patient groups, and other healthcare organisations, and has given us a clear idea both of the general public health challenges facing the NHS and those pertaining most directly to patients with HIV and viral hepatitis. It has also provided a unique insight into the commissioning of HIV and hepatitis services, how different service providers currently work together to deliver care to patients, and what further improvements need to be made to help achieve first-class outcomes for people with these conditions.
- BMS agrees with the Government that a radical shift in how we tackle public health is required. We regularly see examples of innovation in public health, and frequently meet committed Healthcare Professionals (HCPs) in the course of our activities. This should be consistent throughout the NHS, and the Health Service should play a greater, more proactive, and more focused role in the promotion of public health. While BMS supports the movement to a leaner structure, this should focus on prevention, and then identify those at greatest risk, detect instances of poor health quickly, and deliver genuine improvements in patient care.
- BMS is keen to work with all stakeholders in public health, including the Department of Health (DH), NHS, local authorities, clinicians and commissioners. It is hoped that the Government’s current programme of reform will result in a Health Service in which joint-working and seamless service integration are the norm, rather than the exception. To this end, BMS looks forward to the imminent publication of the DH’s plan for sexual health. It is hoped that this will put forward a vision of a comprehensive, integrated, and readily accessible, sexual health service across England that looks across the whole patient pathway. It should also align with other strategies the Government is publishing that have a locus on sexual health, including the National Liver Strategy.
- The patient should be squarely at the centre of the Government’s reforms to the NHS: improvements in the quality of their care, and in their quality of life, should be the universal objective of all changes to the Health Service. BMS is therefore supportive of the principle of using outcome measures to encourage improvements in the delivery of care. These outcomes should be ambitious and unambiguous, and should be based on the outcomes that patients value, as well as those that reflect the particular nature of the conditions they have. This insight, that the DH and clinicians might value different outcomes to patients, surfaced at events we have recently held on both liver disease and HIV.

1. *Commissioning and the future role of local government in public health*

1.1 In September last year, BMS engaged stakeholders with an interest in HIV, including clinicians in primary and secondary care, commissioners and patient groups. The purpose was to ask how HIV services should be commissioned and delivered in the post-2014 NHS landscape, and how the transition to this end-point should be undertaken. The group's overall view was that while it was definitely desirable in future for GPs and community-based providers to play a greater role in supporting people to manage their condition, it was unrealistic and inappropriate for HIV services to be commissioned by consortia in the short term. This viewpoint has since been endorsed by the Department of Health, and BMS welcomes the confirmation that the NHS Commissioning Board (NCB) will be responsible for HIV outpatient services, for the short-term at least. It is BMS's view that it makes sense that specialised high-cost, low volume services should not be commissioned and carried out by individual consortia, and that expertise and financial risk for complex conditions should be pooled.

1.2 In February this year, BMS hosted a roundtable session with stakeholders (including the DH) with an interest in liver services. The delegates at the event included clinicians, commissioners and patient groups, and the objective was to elicit views on the impact of the proposed NHS reforms on liver treatment and commissioning and to identify the optimal model of care for patients with liver disease. The consensus view at the event was that there is severely limited understanding of how the commissioning of liver services will be organised in the new NHS. Delegates were also concerned by a lack of clarity around specialised commissioning for liver services in the new structure.

1.3 It is BMS's view that further detail on the precise arrangements for commissioning sexual health services, particularly HIV and viral hepatitis, is needed. In particular, clarity is required about where responsibility for prevention and testing for HIV and viral hepatitis sits. The Government's Public Health White Paper states that local authorities will be responsible for commissioning testing and treatment of STIs, although the NHS Commissioning Board will also be involved in commissioning services where efficiencies can be made by procuring at scale (eg drugs procurement). At present, therefore, it seems that testing would fall within the remit of local health and wellbeing boards in community settings and sexual health clinics. There is scepticism, particularly among the patient group community, that local authorities possess the skills, capacity or resource to commission an effective infrastructure for prevention and detection. There are also questions about who will commission testing in a primary setting. BMS would welcome reassurance from Government that localising responsibility for these services will not lead to a damaging fragmentation in the DH's understanding of how infection rates are changing, and what measures work best in preventing the onward transmission of both diseases. BMS would also welcome certainty that separating the commissioning of HIV and viral hepatitis between the NHS Commissioning Board and local authorities will not hinder the delivery of joined-up services for patients with these conditions.

1.4 The capacity of local authorities to commission sexual health services is open to debate. BMS would, however, also welcome reassurance that devolving sexual health services to local authorities will not result in the politicisation of conditions like HIV and viral hepatitis, which are often stigmatised and misunderstood in the broader community. Local authorities have only limited experience in public health and none in commissioning. They will need to be supported to represent the needs of marginalised and excluded groups, many of whom are at particular risk of contracting conditions like HIV and viral hepatitis.

1.5 In light of the issues noted above, BMS would endorse the development of a sub-national level of commissioning for areas such as London, Birmingham, Manchester and Brighton, where concentrations of HIV and viral hepatitis are highest. These sub-national (or "supra-local") arrangements would provide a compromise between a centralised approach which might seem remote from patients, and an overly parochial system, which lacks the expertise, resource and freedom from financial risk to commission suitable services. In such areas, we recommend that individual consortia pool the commissioning of their HIV and viral hepatitis services, working in partnership with a network of their Public Health Directors and Health and Wellbeing Boards to ensure any specific local issues are taken into consideration. There are already examples of successful joint commissioning of HIV services in the UK, such as the pan-London arrangements which are generally viewed as having driven up the standard of commissioning in the capital. BMS would like to see this model refined and replace the current assumed division of commissioning between the NHS Commissioning Board and local authorities.

1.6 In the next iteration of its plans for public health, the DH will need to ensure any new commissioning arrangements for viral hepatitis are clear, coherent and widely understood. Unlike HIV, there are currently no successful examples of commissioning for liver services, and no understanding of how commissioning in the new NHS will work. BMS would like to see the Sexual Health plan, National Liver Strategy and public health reforms provide clarity on how liver services will be commissioned after 2014.

1.7 BMS would welcome GPs playing a more active role in the Joint Strategic Needs Assessment (JSNA) process, and are supportive of the Government's plans to make GP consortia responsible for preparing the JSNA in collaboration with local authorities. At present, this process largely ignores conditions that do not have a vocal and active patient population.

2. *Public Health England*

2.1 BMS supports the establishment of a national Public Health Service (Public Health England), and the recognition that public health requires a more proactive, preventative style of medicine and care than other conditions. It is hoped that Public Health England will adopt a robust approach to minimising the impacts of poor physical fitness and nutrition, as well as actively tackling conditions such as HIV and viral hepatitis, that often have cultural or behavioural roots. Even within a cash-constrained NHS, it will be important that Public Health England has sufficient resources to educate people about healthier living and healthy behaviours.

2.2 This notwithstanding, BMS believes that GPs and GP practices will continue to play a vitally important role in identifying current and future public health challenges, and providing advice about the most effective forms of treatment for conditions included within the definition of public health. They are the gatekeepers to the National Health Service, and should be encouraged to work actively with local authorities and with their local Directors of Public Health to ensure their patients' needs are being addressed in a targeted and effective manner.

2.3 In addition, it will be incumbent for GPs to continue working with stakeholders such as patient groups, social workers, drug and rehabilitation councillors, and GUM clinics, to ensure that patients, no matter where or how they access the NHS, are staying on their treatment pathway. BMS would expect that the establishment of commissioning consortia will situate GPs in a much broader context than their surgery and immediate local environment, and will encourage them to develop broader networks of contacts, both horizontally (with other public health stakeholders in their community) and vertically (with secondary care clinicians).

2.4 There is no greater need for this than in the field of viral hepatitis. Patients with hepatitis B in this country generally receive a relatively poor standard of care. Awareness of the disease, and access to patient screening, is poor. Diagnosis rates are often low due to insufficient knowledge around markers of the disease and the implications of not managing the disease appropriately. Once patients are diagnosed, they may not be efficiently referred to specialists due to poorly defined (or non-existent) patient pathways. Once treated, patients may not be supported in adherence to their therapy in the long-term, as GPs are not incentivised or adequately informed to provide the appropriate support. In a recent workshop we held on liver disease (referred to above), the consensus view was that the best way to address these problems would be to give GPs greater support and training to identify at-risk patients. This could take the form of a simple checklist of symptoms, the inclusion of liver function tests in the Annual Health Check, and the publication of guidance on referral pathways. These simple measures, with appropriate reporting and data capture mechanisms, will help GPs monitor the prevalence of viral hepatitis in their local communities and provide important insights in treatment best practice to Public Health England.

3. *The Public Health Outcomes Framework*

3.1 As noted above, BMS is supportive of the principle of using outcomes measures to encourage improvements in the delivery of care. The aim of reducing avoidable mortality is to be welcomed, as is the NHS Outcomes Framework's inclusion of preventing premature deaths from liver disease as a key national aim. The development of a "draft indicator" in the Public Health Outcomes Framework is also welcome. It is hoped that the next iteration of the DH's plans will give due consideration to how this ambition will be monitored, and how services will be planned, commissioned and delivered in a structured and coordinated way. The deployment of a multi-disciplinary, network-led approach might be appropriate in this context.

3.2 The emphasis on reducing avoidable mortality as an outcome should lead to a renewed focus on prevention and testing. This is particularly important for HIV, which is currently excluded from the Outcomes Framework and therefore risks competition for ring-fenced public funding with issues like obesity and smoking, which are better understood and more familiar in a local setting. BMS therefore endorses the position of the National AIDS Trust, that the "proportion of persons presenting with HIV at a late stage of infection" should be developed as an indicator of improved clinical management within the Public Health Outcomes Framework. There are compelling arguments in favour of its inclusion. Late diagnosis accounts for at least a quarter of HIV related deaths in the UK (British HIV Association (BHIVA) mortality audit, 2006); in 2009, 52% of people with HIV were diagnosed late. The continuing failure to diagnose patients early prevents patients from receiving the most effective treatment, and increases the rate of onward transmission of HIV. Indeed a number of recent models have suggested that the majority of HIV transmissions are from the undiagnosed (see NAM, 2009). Reducing onward transmission rates also brings with it an unquestionable economic logic. According to the HPA's 2010 HIV Annual Report, if all the 3,780 UK-acquired infections diagnosed in 2010 had been prevented, over £32 million annually or £1.2 billion over a lifetime in costs would have been saved.

3.3 An emphasis on prevention and testing in viral hepatitis is also necessary. At present, there is no screening programme for patients who are at risk from contracting this condition, and early diagnosis rates are poor. The DH should consider developing outcome measures such as the reduction in mortality from liver disease; improved rates of success of treatment; increased patients helped to manage and reduce risks; and more people with liver disease reporting improved quality of life. These were the recommendations of the delegates at the roundtable event hosted by BMS in February this year. In addition, it was suggested that the DH should establish process measures for commissioners in the field of viral hepatitis. Potential measures for

consideration included more people being placed on treatment for viral hepatitis; improved early accurate diagnosis rates; more assessments taking place in primary care, and increased support for lifestyle changes.

3.4 It is hoped that success in achieving these outcome measures will be judged within an appropriate time-frame. While BMS can see the political desirability (both nationally and locally) of measuring outcomes on an annual basis, improvements in clinical management are often only apparent within a longer, two-to-three year period. Short-termism should not be allowed to compromise genuine improvements in the standard of care, and risk demotivating HCPs and patients alike.

3.5 BMS also suggests that outcomes should evolve over time as the DH and NHS improve the way they use this data to commission better services. They should remain open-minded about the process required to make this happen, all the while ensuring that the only outcome measures that are used reflect current public health priorities.

4. Funding

4.1 Over the next four years, the NHS will undergo historically unprecedented changes to its structure and methods of operation, and will be under pressure to deliver the necessary efficiency savings demanded by the QIPP agenda. The Government must ensure that rising healthcare inflation does not systematically erode the ring-fenced funding promised by the Government, and BMS would welcome clarification about how the DH will continue to protect public health spending, both nationally and locally, within this challenging economic context. This is particularly important in the field of sexual health, where evidence has been found in the past (*Disturbing Symptoms*, Terrence Higgins Trust, BHIVA, BASHH) of money being diverted away from sexual health to meet NHS deficits in other areas.

5. The Health Protection Agency, Public Health Observatories and surveillance

5.1 The provision of high quality care is, to an enormous extent, dependent on the quality of data—about disease prevalence, the effectiveness and cost-effectiveness of various interventions, and about patients themselves. On a daily basis, it is easy to see the negative impact that poor quality data can have on people with particular conditions. For example, information covering the number of patients diagnosed with viral hepatitis, how many have been initiated on treatment, how many have stopped their treatment, and how many have been referred does not exist. The DH must address these knowledge gaps if NHS reform is to deliver improved patient care, and BMS welcomes Public Health England's commitment to quality and transparency in its approach to evidence.

5.2 Over the next year, the Department of Health has committed itself to developing a specialist workforce to gather information and intelligence on public health. In many areas, this will involve merging currently separate bodies, such as the Public Health Observatories and Health Protection Agency. BMS would welcome further clarification about the potential impact this transition period could have on the surveillance of complex conditions such as HIV and viral hepatitis. Public Health England's desire to use the reform process to strengthen monitoring, surveillance and data mining is to be welcomed, but BMS would like reassurance that the vital role played by the HPA in monitoring HIV and viral hepatitis prevalence and diagnosis rates will not be compromised in the next few years. Indeed, this capacity should be enhanced in the future, as part of the assessment of performance against any new outcomes measures. In particular, the improvement of national data to demonstrate variation in the provision of liver services should be developed, as should surveillance which points to the most effective and cost-effective interventions to manage viral hepatitis.

June 2011

Written evidence from Turning Point (PH 104)

ABOUT TURNING POINT

1.1 Turning Point is a leading health and social care organisation with over 40 years experience of providing support to people with complex needs including those affected by drug and alcohol misuse, mental health problems and those with a learning disability. We work in over 200 locations, providing specialist and integrated services that meet the needs of individuals, families and communities across England and Wales.

1.2 We have also developed Connected Care, Turning Point's model of community-led commissioning: currently working in 10 areas of England to integrate health, housing and social care.

1.3 We are a social enterprise reinvesting its surplus to provide the best services in the right locations for people with a range of complex needs who need them the most.

SUMMARY OF KEY POINTS

- The recognition of the need to integrate health and social care is welcomed.
- We strongly welcome the recognition made that there is no (public) health without mental health.

- However, the challenge will be how this is achieved to provide effective services. The implementation of Health and Wellbeing Boards will require a culture shift which necessitates careful management and planning. These boards cannot be allowed to fail in their pursuit of outcomes; the cost of this will be too high in terms of the continuing health inequalities in the UK.
- The local community is best placed to understand how innovation can be targeted and pursued in public services and so should be involved in the commissioning of services.
- The period of transition from now until Public Health England is able to deliver its functions is vital. The skills set of professionals should not be lost; this is particularly the case in the substance misuse sector and the changes that are underway to subsume the NTA into Public Health England.

Public Health England

1.4 In setting up Public Health England within the Department of Health, considerations should be given to the relationship with local government and whether there should be a “Duty to provide” for essential services which are proven to provide significant benefit returns to the economy. Public Health England must ultimately hold to account spending on core services, when this may not be happening, ensuring that health inequalities are not worsened. The Secretary of State needs to balance the demands across the remit, particularly with the funding for aspects of mental health and substance misuse all coming from the same budget.

Public Health Outcomes Framework and Commissioning

1.5 Many of the people we support are at the sharp end of the inverse care law. Turning Point exists to reverse the existing trend that those who need the most help receive the least. There is a real opportunity for the health premium and the outcomes framework to integrate the system around this end but this can only be done if both are based on relevant, neighbourhood level intelligence and knowledge.

1.6 Both the Outcomes Framework and the health premium need to be based on an understanding of community need informed by local people. Commissioners need to recognise that people rarely have one public health issue and are likely to have a breadth and depth of need. Commissioning in the past has taken a silo based approach to people’s individual public health needs. We would recommend that an understanding of the whole person rather than a single public health problem should be embedded in every stage of service delivery from assessment to treatment and aftercare.

1.7 Turning Point’s model of community-led commissioning, Connected Care, is based on the principle that if you spend time and resource researching community need and bring this together with commissioner priorities, the redesigned services will be more integrated, inclusive and cost effective. It can also provide a unique insight into the triggers which effect poor public health and wellbeing.

1.8 By identifying weaknesses in service-provision that would not otherwise be addressed, Connected Care is able to demonstrate to local commissioners the usability of current service provision and facilitate discussions as to what more is needed to meet local need.

1.9 This same principle should be applied to the local application of the outcomes framework, along with the consideration of a data set of key measures, and that of the health premium if they are to reduce inequality and advance equality.

1.10 To ensure people from all corners of society benefit from the outcomes Public Health England is setting out to achieve, indicators must provide a profile of each community defined at the most local level (for example a housing estate), highlighting “social connectedness” and encouraging coproduction around community-led issues between communities and their local services. Social Connectedness is also an essential measure, particularly for people with complex needs, if the public health service is to reduce inequalities.

1.11 Data alone can not provide a complete picture of inequality, therefore peer led discussions within communities, as well as with a range of service providers and community support agencies, should be included. This is particularly relevant around data measuring mental health issues where BME communities continue to be significantly under-represented. If services are to improve for BME communities, they need to know where gaps in provision exist—this can only be known through rigorous and reliable information being held at the local and national level.

1.12 The contribution to reducing inequalities by service providers and other agencies should also be considered. For people with the most complex needs, it is often the case that community services, church groups and voluntary organisations have the greatest impact on supporting them to access the information they need; signposting them to the most relevant services and ensuring their most basic needs are met. Many of these groups will be essential but little known to the statutory services, and should be considered by Public Health England as an essential partner to reducing inequalities in all corners of society.

1.13 There has obviously been significant consideration as to how the three frameworks link together however, as we have stated in our responses to the preceding outcomes consultations, it is a shame that the NHS, Adult Social Care and Public Health frameworks are not aligned in one document rather than the three separate ones that have been produced. This would have immediately made the integration of the new public health service, as well as the changes to health commissioning, embedded within existing practice.

1.14 It is too often the case that people with complex needs do not receive the service they require due to teams on the ground working towards different outcomes and priorities. Although there is alignment between the domains and key indicators, there is a risk that teams will interpret them differently, or prioritise one over the other, leading to competing priorities which often act to confuse the person requiring support.

1.15 Turning Point particularly welcomes the emphasis on mental health throughout the indicators and the importance of getting services right for people with substance misuse issues. However there is little mention of people with a learning disability who have historically experienced the most disadvantage when it comes to living “longer, healthier and more fulfilling lives.”

1.16 There also needs to be considerations relating to family or parent interventions. Interventions that address parental issues alongside the child can have a huge impact on inter-generational health and wellbeing and an additional indicator relating to such approaches should be considered.

1.17 In addition Turning Point believes that the substance misuse indicators are crucial in ensuring that there are indicators concerned with how many people leave treatment free of their drug of dependence while also measuring the level of hospital admissions due to alcohol misuse.

1.18 As Turning Point’s Connected Care work illustrates, an individual’s community has one of the biggest impacts on their ability to cope; access services and feel socially included. The current problem is that data collection tends not to go down to a particularly local level but remains based on either the SHA, PCT or local authority areas. This new framework, however, provides the opportunity to set in place indicators that report not only on a national and regional basis, but on a local level which is becoming increasingly relevant, particularly as people take more responsibility for the services they access and giving greater transparency to health inequalities.

1.19 Many of the outcome indicators for public health will not have an immediate impact on health inequalities, but will rather take a longer time for any impact to become evident. To ensure that commissioners and providers are not discouraged from concentrating in these areas, therefore cherry picking those interventions with the quickest results, there will need to be intermediate measures put in place for those indicators which link directly to the health premium.

1.20 The baseline figures need to be taken into account for the health premium not to potentially increase inequality, where more deprived areas which struggle with public health may not benefit as their local areas are affected by variables out of their control for example immigration.

1.21 As well as integrating with existing local authority functions, Directors of Public Health will need to engage with the community and independent sector when developing health improvement plans and breaking down barriers to involvement.

1.22 Turning Point proposes that the following definition of commissioning is used in the provision of public health services which emphasise the need to co-produce services with the local community:

Commissioning: the means by which you understand the needs of an individual and/or a community such that you can build a platform for procurement

1.23 We believe that the methodology of Connected Care, Turning Point’s model of community-led commissioning, offers one way in which communities can be involved in the co-production of public health services.

1.24 Recent cost benefit analysis of Connected Care demonstrates the model delivers significant net benefit to the public purse—with every £1 invested a return of £4.44 is achieved. When the benefits of improving quality of life are included, a return of £14.07 is gained for every £1 invested.²⁵²

Abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse

1.25 The NTA has provided a positive outcome for substance misuse services in increasing the number of people accessing treatment and reducing local waiting times. Nevertheless, the context of substance misuse services has changed and it is right that there should be a greater focus on the holistic recovery needs of an individual. Turning Point has always focused on the wider-needs of the individual and understands how this can promote further progression towards recovery. No one organisation is able to meet these demands alone and this requires providers to work with other organisations. Consequently it is logical that substance misuse is seen through a broader public health vision which is conducive to Recovery-Oriented Integrated Systems.

1.26 Greater integration also ensures that those with Dual Diagnosis and complex needs can be served within the context of the whole public health budget.

1.27 It is important that the role played by the NTA in promoting the wider benefits and impacts of substance misuse are not lost and this expertise is retained in Public Health England. Turning Point is particularly concerned about the wide range of areas which will be contained within Public Health England, areas as diverse as sexual health and national preparedness will be contained within the one body. It is vital this does

²⁵² Turning Point commissioned the London School of Economics’ Personal Social Services Research Unit to undertake cost benefit analysis of two of our delivery models, Rightsteps (Turning Point’s model for IAPT provision) and Connected Care.

not result in a weakening of focus on substance misuse services and a loss of knowledge that has been developed in the NTA since its inception in 2001.

1.28 Whilst it is positive that a “ringfence” will be applied to the public health budget, this budget will also absorb the pooled-treatment budget for substance misuse services. There is concern that the wide range of areas this money will be required to fund may mean the importance of substance misuse funding is eclipsed. Substance misuse services already serve a socially excluded population whose needs often fail to be recognised. It is important that the movement of the NTA into Public Health England does not result in this population being further marginalised through public health funding being divided between an ever increasing number of priorities. It is vital that local Directors of Public Health acknowledge the importance of substance misuse services in their local area and provide a balanced treatment system for the local population. To fail to do this will create further inequities in the local area, for example it will result in greater demand being placed on the local criminal justice system, further costs in health care, as well as increase local unemployment and its related costs. Oxford Economics estimates that Turning Point’s integrated drug treatment model prevents criminal activity that saves £23.9 million each year in Somerset alone.

1.29 It is positive that the transition plans for the NTA indicate that support will be given to local areas to seek alternative commissioning models as well as ensuring the transfer of best practice. Nevertheless, it is important to consider that many local areas are facing a new frontier when it comes to the commissioning of substance misuse services through the pursuit of payment by results and Recovery-Oriented Integrated Systems. For instance, local areas which are not involved in the piloting of payment by results are being encouraged to develop plans for a local area single assessment and referral system (LASARS) while not being given the same level of support in making such a wholesale change. It is important that local areas are able to provide access to balanced treatment systems which are able to progress people towards recovery by addressing wider health and wellbeing concerns.

1.30 Furthermore, there should be a “Duty to Provide” a balanced treatment in substance misuse similar to the level which is currently being provided and this duty should be overseen by the Government through Public Health England.

Role of local government in public health

1.31 Turning Point welcomes the intention of health and wellbeing boards to integrate health and social care. There is a recognition that health is far more than an individual’s physical state but is very much dependent on the wider environment the individual lives in and the effects this has on their wider wellbeing. Local authorities will have pre-existing links with social care, education, leisure, transport and housing services. These are the services which are vital to integrated health and wellbeing service provision and so the movement of Directors of Public Health to local authorities provides an opportunity for the links between health, social care and local services to be fully exploited.

1.32 While these reforms are very positive in recognising the links between local authorities and the health system it is important that the difficulties facing local authorities in terms of their budget constraints are recognised. Cuts are already being made to frontline services and it is important that the value of early intervention services and integration of services continues to be acknowledged. This requires local authorities to take a long-term view which understands that the returns from investments can take some time to accrue. For these reforms to be successful, innovation in services must be embraced as it is only this which will ensure that integration between health and social care services occur.

1.33 There has also been little explanation or guidance as to how health and wellbeing boards will operate in practice. It is necessary that local areas are given the ability to reflect their own local needs but it is also important that this adds to the process of working towards effective services rather than detracting from the intentions of public health to reduce health inequalities.

1.34 Health and Wellbeing Boards demand a shift in culture in the working practice of many professionals. We should not expect such a shift to occur smoothly or naturally, rather some conflict and tension should be expected. There has been little explanation as to what happens if Health and Wellbeing Boards are unable to map a course through pre-existing individual priorities. There is also the related issue of mandates. It is suggested that local councillors are involved in the Health and Wellbeing Boards. While elected officials certainly have a place on the boards through their role in maintaining public accountability, it may be the case that the democratic mandate this membership will hold could be used as a veto against other professionals on the board.

1.35 There could be the possibility that these boards could breakdown through gradual erosion of relationships between the membership and this would have a huge effect on the functions of public health in the local area. This is something which should be further explored and explained. There is a need for the Terms of Reference of the boards to take this into account. Such issues should not be allowed to detract from the important role the Health and Wellbeing Boards will have in holding local Directors of Public Health to account.

1.36 The point has already been made that Health and Wellbeing Boards will cover a wide range of different areas of public health and that they will not only have to have broad expertise but will also have much ground

to cover. The remit of Health and Wellbeing Boards is expanding and it is vital that they are given sufficient time to undertake these tasks effectively. It is essential that Health and Wellbeing Boards are driven by outcomes and are not burdened by processes which detract from their original function. There is always a danger that such organisations become talking shops which achieve little in the long-term, if this happens there will be further long-term costs that, in the current climate, will be too much to bear. This will have further effects on the quality of services in the long-term.

1.37 A further practical point is how Health and Wellbeing Boards will interact with Police and Crime Commissioners. This proposed role will hold responsibility for the levels of crime in area. As low-level crime is often the product of unmet need, there is a direct link between the role of public health in addressing health inequalities and the attempts to reduce crime rates in a given area. However, the area covered by Police and Crime Commissioners will be far larger than that covered by Health and Wellbeing Boards and so there needs to be further consideration of how Health and Wellbeing Boards will reflect the criminal justice needs of a local area. This could have a particular impact on local substance misuse services which significantly contribute to reducing crime in the local area. It is vital that Health and Wellbeing Boards utilise the understanding of the Police and Crime Commissioners.

1.38 The importance of the JSNA in creating the development plans for the local area, means that greater neighbourhood information must be included in the assessments, to allow a higher level of understanding of the local area, to ensure that need is met and that further inequalities are not created. Reference to JSNAs should not be precursory, but a full requirement.

June 2011

Written evidence from the Haemophilia Society (PH 105)

SUMMARY

- Human blood and blood products are an indispensable medical treatment but they can also facilitate the spread of disease. This submission highlights the ongoing importance of blood product safety to public health.
- Blood and blood products are an efficient vector for new pathogens, making swift expert advice indispensable.
- If the Health Protection Agency is abolished, adequate provision must be made for its functions in relation to blood product safety to be carried out by a national body capable of working with international partners.

INTRODUCTION

1. In late seventies and early eighties, almost five thousand people with haemophilia were infected with hepatitis C and/or HIV through blood products. In several cases, recipients of blood products, which were often imported from the USA, unwittingly infected sexual partners, constituting a wider public health concern. Many lessons were learned as a result of this tragedy, and we are concerned that the abolition of the Health Protection Agency would be a step backwards.

The Proposed Abolition of the Health Protection Agency

2. Both the Public Health Agency and the Advisory Committee on the Safety of Blood, Tissues and Organs perform important roles, bringing together expertise to identify and assess potential threats to the blood supply. In recent years, they have debated important matters such as the transmissibility of the vCJD prion through blood products.

3. The Health and Social Care Bill proposes considerable decentralisation, which raises concerns about whether sufficient resources will be maintained at a national level to monitor new and emerging threats to public health.

4. There is an on-going need for vigilance regarding the safety of blood products. Parvovirus is resistant to current heat deactivation techniques. Its small size means that it cannot be removed using nano filtration, and it is not an envelope virus so it cannot be deactivated using a detergent wash. A more pathogenic virus with these attributes could emerge and present a significant public health risk.

5. The controversy surrounding the recently identified blood-borne virus XMRV illustrates the public concern about the pathogenic potential of threats to blood safety. When new blood-borne pathogens are discovered, they can become controversial very quickly. Patients need a respected UK authority to provide trusted oversight and information.

6. It would be most unwise to abolish the Health Protection Agency without making adequate provision for its surveillance role to be covered by a national body capable of working with international partners.

CONCLUSION

7. Blood products can allow viruses and diseases to jump from one community to another. The pooling of blood donations facilitates the rapid spread of disease since the health of thousands of individuals can be jeopardised by a single infected donation. The virus can then spread to the communities of blood product recipients.

8. Despite impressive advances in recent years, blood and blood products will always be vectors for emerging health threats. The Health Protection Agency carries out important responsibilities in relation to blood products that must be retained centrally. If the Government intends to proceed with the abolition of the HPA, it must consider how these functions will be fulfilled.

We would like to thank the members of the Committee for taking this submission into account in their deliberations.

June 2011

Written evidence from the Greater Manchester Directors of Public Health Group (PH 106)

The 10 Directors of Public Health work as part of the Greater Manchester (GM) PCTs Cluster and the Greater Manchester Public Health Network. However the Directors of Public Health also have a professional responsibility to work independently to hold to account statutory agencies for their contribution to public health gain. This submission is written on behalf of the 10 Directors of Public Health in Greater Manchester working as independent advocates for public health. This submission does not necessarily reflect the views of the GM PCTs Cluster or the Greater Manchester Public Health Network.

1. BACKGROUND TO THE GM DPHs GROUP

1.1 The 10 DPHs in GM work together, complementing local action, as independent advocates for Public Health in the conurbation and part of the GM PCTs Cluster.

1.2 We co-ordinate the GM Public Health Network—a programme exploiting collaborative advantage in addressing GM's health inequalities. We oversee leading edge programmes of work, operate and support robust GM wide partnerships, and deliver improving health outcomes for GM's people.

1.3 We also provide professional leadership and guidance to the GM Health Commission—one of several Commissions established by the Association of Greater Manchester Authorities to drive the new GM Combined Authority and Local Enterprise Partnership. These bodies recognise GM as a highly-coherent functional economic area, a conclusion supported independently by the Manchester Independent Economic Review (MIER).

2. SUMMARY

2.1 On each area referred to we comment as follows:

- the creation of Public Health England (PHE) within the Department of Health (DH);
We believe PHE should be an NHS body;
- the abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse;
We fear loss of local links and relationships with Directors of Public Health;
- the public health role of the Secretary of State;
We think the role should be to represent the health of the people across Government on key issues like the alcohol epidemic, active travel's role in preventing obesity, the strength of civil society and the role of poverty and income inequality. Legislation on such issues should be included in Health Acts. Litigation to protect public health is an issue;
- the future role of local government in public health (including arrangements for the appointment of DPHs; and the role of Health and Wellbeing Boards, JSNAs and Joint Health and Wellbeing Strategies);
DPHs as health professionals treat a population. They have a multiagency challenge role, should be properly professionally qualified, managerially accountable to the Chief Executive with right of access to elected members and freedom to put their views into the public domain. The Health & Well Being Board as the democratic strategic voice in the NHS should have powers to require compliance with the health and well being strategy by commissioners, providers and those influencing the determinants of health. Public health staff should be employed by an NHS body (PHE if it has that status) and placed in local authority areas;

- arrangements for public health involvement in the commissioning of NHS services;
Health care public health should be population-based across local authorities and commissioning consortia, working at local level but achieving critical mass and epidemiological stability by cooperating at a larger population level with which NHS Commissioning Board outposts should align;
- arrangements for commissioning public health services;
The child health programme should not be divided at age five. The public health contribution of primary care should be accounted for;
- the future of the Public Health Observatories;
These important bodies have already lost critical capacity whilst Government thinks about them;
- the structure and purpose of the Public Health Outcomes Framework;
We emphasise inequality and the relation between different frameworks;
- arrangements for funding public health services (including the Health Premium);
We describe potential dangers in the current approach;
- the future of the public health workforce (including the regulation of public health professionals);
Workforce development and planning is needed. Capacity building is needed in frontline NHS and local authority staff as well as specialists. There should be statutory registration of non-medical specialists; and
- how the Government is responding to the Marmot Review on health inequalities
Wider determinants are being neglected. We advocate a reporting framework for all Marmot recommendations to support cross governmental action on social determinants of health.

3. OUR RESPONSE TO THE WHITE PAPER

3.1 We welcomed the core principles, recognised the local authority contribution to the wider determinants of health and health inequalities, and seek to work across the whole local authority and other partners for best population health and reduced inequalities. We welcomed the focus on the DPH as an authoritative, independent and influential leader, shaping local services and delivering a public health vision.

3.2 The white paper reflects and partially advances the Marmot Review. Health inequalities are a challenge within GM and between GM and the rest of England. We welcomed the life course approach and commitment to “improving the health of the poorest fastest”. We supported a new, integrated, national public health service, PHE, to drive health improvements.

3.3 We will exploit opportunities for stronger Local Authority leadership on population health and health inequalities. However we fear potential fragmented public health expertise, absence of HR arrangements for transfer, and confused responsibility between PHE, the National Commissioning Board, and Local Authorities. Discussions with the LGA and others suggest value in local public health staff being formally part of PHE allocated to local authorities’ local teams, strengthening public health leadership and professionalism, providing resilience and reducing potential for overlapping responsibility.

4. REPONSES TO THE COMMITTEE’S AREAS OF INTEREST

4.1 *The creation of PHE within DH*

4.1.1 PHE’s roles, responsibilities and nature need clarifying

4.1.2 PHE as part of DH will be a civil service body unless it is recognised that normal models of civil service organisation are inappropriate for some of its functions and alternative provisions explicitly made for areas such as

- occasions requiring separate policy functions and programme delivery;
- areas where PHE directly provides services needing a system of management more akin to an NHS body;
- areas where PHE or its agent directly commissions services needing to be more interventionist than for policy and regulatory roles;
- areas where PHE or DH have duties to the public and the political process rather than solely to Government, including areas where the independence of the CMO is to be promoted;
- negotiation of responsibility deals, whether done by PHE or DH needs an underpinning power of regulation to be taken seriously;
- research—academic contracts should be used and academic freedom, scientific integrity and the right to publish recognised;
- workforce development; and
- external consultancy.

4.2 *The abolition of the HPA and NTASM*

4.2.1 PHE could provide a strategic framework and context for isolated parts of the national system. However these arrangements could lose their relationship to local working. The GM Public Health system has an excellent working relationship with the local Health Protection Unit, with mutual respect, and recognition of the roles of the lead DPH and the professional expertise of HPA staff. We plan to co-locate the health protection agency with the GM Public Health Network unifying public health leadership in the conurbation. PHE need not obstruct this but unbalancing of the local partnership would constitute a step backwards.

4.3 *The public health role of the Secretary of State*

4.3.1 The duty to promote equality should relate to equality of outcomes not just of access

4.3.2 Legislation to improve health should be included in Health Acts, starting with the current Bill. There are many possible broader policy areas which would not previously have been included such as the following;

- Transport and health.
- Spatial planning.
- Pricing of energy for heating.

4.3.3 On the issue of legal action (such as judicial review or applications for injunctions) in the interests of public health we have nothing to add to the evidence of the Transport & Health Study Group.

4.4 *The future role of local government in public health (including arrangements for the appointment of DPHs the role of Health and Wellbeing Boards, JSNAs and Health and Wellbeing Strategies)*

4.4.1 DPHs will manage the services transferred from PCTs but also have a multiagency challenge function. The Bill currently recognises only the first of these. DPHs should not only be local authority officers but also health professionals treating a population, local representative of PHE and independent advocates for health. In the last of these roles they operate across the whole of the public, commercial, voluntary and community sectors.

4.4.2 Public health specialists are change agents for improving the health of the people. Corporate authority and independent advocacy are mechanisms to be used in balance.

4.4.3 The following roles require more than corporate authority.

- Preparing an independent professional report on the health of the population every year.
- It is the duty of the DPH to act as the advocate of public health within all areas of the local authority and to keep health at the forefront of many areas of local authority decision making eg the provision of walking and cycling infrastructure.
- Undertaking health impact assessments of local authority policies, programmes, and services.
- Professional public health advice (rather than corporate advice) to other public and private bodies active within the area.
- A centrepiece of public health practice is the promotion of a big society which will address the cultural determinants of health in local communities. People do not alter their norms of behaviour in response to bureaucratic messages and the DPH must be close to their communities showing an open and honest professional commitment to their well being.
- Public health plays a part in local professional leadership. The profession would be concerned if this were lost or if it became merely a bureaucratic role. The Chair of the Health & Well Being Board needs the protection of being supported by somebody who will be valued as a professional colleague by health care professionals including doctors. The local authority needs the influence that comes from that person's participation in local professional leadership.
- The DPH should be a statutory consultee in local planning, transport and environmental issues and should participate in such processes in accordance with professional judgment.
- When DPHs conduct, or comment on, health impact assessment it should only be their professional public health opinion which influences their judgment.

4.4.4 Prioritisation of tackling health inequalities would be strengthened by nationally requiring the DPH to be accountable directly to the Local Authority Chief Executive (in addition to the Secretary of State) with a right of access to elected members.

4.5 *Public health involvement in commissioning NHS services*

4.5.1 The subspecialty of health care public health is concerned with optimising the contribution the health care system makes to the health of the people. It is concerned with:

- the contribution the provision of healthcare makes to the health of the people;
- the optimisation of resources;
- the application of population perspectives to the use of evidence; and

- the application of evidence to the organisation of health services and the assessment and prioritisation of population needs for healthcare.

4.5.2 There are about 200 public health specialists practising this subspecialty. Ideally there should be a health care public health specialist in each health and well being board area. It is also important that GP consortia have a direct public health input. The only way that both of these criteria can be achieved is if joint appointments are made either through joint employment, through secondments or through honorary contracts.

4.5.3 Health care public health needs a critical mass of analytical and intellectual capacity. It also requires epidemiological stability of need—a population large enough (at least a million) that predicted needs will not vary randomly to a destabilising degree. To achieve this, specialists, working locally should cooperate over a larger population in a team which has critical mass (at least four). To get to this point, workforce planning and workforce development is needed.

4.5.4 The NHS Commissioning Board should have a footprint at the same spatial level as the Greater Manchester Combined Authority, to align decision making overseen by a Greater Manchester Health and Well Being Board.

4.6 *Commissioning public health services*

4.6.1 The division between local programmes and the role of the national commissioning board for under5s undermines the crucial whole family concept. Different commissioning arrangements for young children will complicate co-ordinated activity, contrary to the Marmot's whole life course approach.

4.6.2 Commissioning of primary care services has the potential to be remote from core public health interventions. In some areas improvements in primary care are preconditions of tackling inequality.

4.7 *The Public Health Observatories*

4.7.1 We are concerned about the current position and future role of the Public Health Observatories. Excellent and independent public health intelligence is a cornerstone of public health practice. The current uncertainty around the future of observatories is of great concern. Government is not taking the steps necessary to preserve the skills in the Observatories, whose existence is being prolonged only by a short term extension with no clear strategy. Capacity and direction has already been lost, just when intelligence led public health and health system practice requires it most—supporting identification of interventions of best practice and value. Loss of expertise reduces the likelihood of QIPP delivery and makes the service more reliant on expensive and often less valuable intelligence.

4.8 *The Public Health Outcomes Framework*

4.8.1 We proposed amendments to the range of indicators.

4.8.2 Inequality is key in developing the indicator set—data collection and reporting must address health inequality (for example using postcode or ethnicity).

4.8.3 A separate outcomes framework for public health could cause other associated frameworks, including the adult social care framework and the NHS outcomes framework not fully to reflect the priority afforded to public health. All 3 outcome frameworks need to consider population health and reducing inequalities.

4.8.4 We seek assurance that actions associated with the indicator set are fully embedded in related cross government programmes eg the commitment to addressing fuel poverty must be aggressively pursued with energy retailers.

4.9 *Arrangements for funding public health services*

4.9.1 Concerns with the proposed funding arrangements include:

- additional responsibilities loaded into local public health services;
- reduction of local public health budget to support the creation of Public Health England, by “top-slicing” to support arrangements at the national level, potentially creating a net reduction in public health spend locally;
- unless ACRA's allocation formula corrects the historic underfunding of NHS activity in Greater Manchester, health inequalities will continue;
- inequalities must be weighted appropriately in allocation formula. The weighting for inequalities in the PCT allocation formulae for 2011/12 has been reduced from 15%, to 10%. This shifts target and actual allocations from poor health PCTs to good health PCTs. Other changes and the very slow pace of change partially obscure the effect but there is still a general shift of resources from deprived to prosperous areas; and
- basing overall funding of PHE on 2009–10 sums institutionalises recent cuts in public health funding instead of reversing them.

4.10 *The future of the public health workforce (including the regulation of public health professionals)*

4.10.1 General Public Health Workforce development.

- Workplace development needs in public health arise from transition to new employers and existing shortages.
- The whole Public health workforce, not just Public Health Specialists, should work as change agents.
- Public health capacity building is needed with frontline staff in the local authority. NHS provider organisations including primary care using competency based frameworks in planning and growing the workforce.
- Government views workforce development as a local problem but shortage of specialists will undermine an arms length approach with seriously disruptive short term effects. In particular retirements due to dissatisfaction with the new proposals coupled with loss of new entrants due to disruption of training could worsen the shortage of specialists. Loss of trainees at the end of training due to reorganisation-induced vacancy freezes is particularly wasteful.
- Diversity of employers may lead to professional isolation with variable support.
- Some areas may not attract needed specialists.
- Training should remain within the medical professional training system, with continued arrangements for non-medical entrants alongside medical ones but with a broader range of training placements.
- Workforce development is needed to support public health specialists who focus on health care; PHE, the NHS Commissioning Board and Monitor need to work together.
- Information analysis is another important area of shortfall.
- PHE should take on workforce development with reserve powers to ration scarce resources and apply training levies.

4.10.2 We referred previously to the importance of non-medical specialists in public health. As they are often appointed to roles identical to those occupied by public health specialists from a medical background, including DPHs, public protection requires that they should have a similar system of statutory registration commanding public confidence and conferring a status equal to that of medical specialist registration.

4.11 *How the Government is responding to the Marmot Review*

4.11.1 We recognise the White Paper's response to the Marmot Review with a strong focus on health inequalities and the Life Course approach. However Marmot challenged all to recognise health as a measure of well being, and well-being as a more important societal goal than simply more economic growth. We would wish to see the presentation of all aspects of government policy in the context of health inequalities. There are for example specific recommendations in the Marmot Review on:

- paid parental leave;
- the take up of early years educations from families in areas of greatest deprivation;
- increased availability of non vocational life long learning opportunities;
- the provision of support and advice on training and employment opportunities;
- encouraging, incentivising and enforcing measures to improve the quality of jobs;
- developing greater security and flexibility in employment;
- developing and implementing standards for minimum income for healthy living;
- improving active travel across the social gradient; and
- a national target that progressively increases the proportion of households that have an income, after tax and benefits, that is sufficient for healthy living.

4.11.2 We would wish to see a reporting framework for all recommendations from the Marmot review to allow and support cross governmental action on tackling the social determinants of ill health.

Written evidence from The Campaign Company (PH 107)

SUMMARY

- Unlike controversies surrounding other NHS reforms, the proposals for Public Health seem to have secured broad professional and political consensus. In order to make them more effective we would argue:
 - Broad autonomy on use of local resources subject to full transparency.
 - Strengthened Health and Well-Being Boards to deliver this.
- We support the broad structures proposed, but would argue the following areas need to be addressed in public health if the current proposals are to be seen as just a reorganisation of people and a series of processes divorced from the challenges of people in communities who may face multiple challenges related to social determinants of health. We thus argue for the following:
 - Having a strategy to tackle motivation and not just ability.
 - Communicating to people’s emotions and not just convey facts.
 - Effective segmentation that is not just about “how” but also “why”.
 - Targeting behaviour change strategies not just on patients or the wider population, but also on key professionals such as GPs.
- Many people will respond in process terms because their values are ones that have high regard to addressing “ability” and conveying objective “information”. However when it comes to the client groups that are supposed to benefit from reducing health inequalities the fundamental issues in behavioural terms are around addressing “motivation” and doing this through authentic emotionally resonant communications relevant to their values.
- The paper below explains that case in more detail after covering some initial practicalities

TRANSITION ISSUES

1. The current lack of any formal outcomes after the abolition of targets is leading to a dangerous two year hiatus at a time when PCTs and their staff are somewhat inwardly focused. Whilst the recent publication of *“Changing Behaviour, Improving Outcomes: A new social marketing strategy for public health”* is welcome the Department of Health (DH) needs to issue some interim guidance is issued to make it clear exactly what the public health strategy is for the 2011–13 period.

PUBLIC HEALTH OUTCOMES FRAMEWORK

2. In order that the Outcomes Framework enables local partnerships to work together on health and wellbeing priorities, there will be a requirement to make it local and ensure incentives are big enough to drive local innovation. Perhaps the process should be to develop a “locally agreed JSNA” that first and foremost represents local priorities and that is signed off after negotiation with Public Health England, so that the programme adopted is bottom up and not top down.

3. The Outcome Framework indicators promote a life-course approach to public health, which the proposed “Domains” seem to allow for. However this assumes that a life-course approach is the principal approach to apply. The life course of a person in a safety, security and sustenance driven environment reinforced by social networks is going to be very different to one with very different values and more pro-social networks. We address this issue in more detail below.

4. Almost all the proposed indicators are “Big Government” and about the role of professionals. Very few could be described as “Big Society”. Indeed the only two that did not require automatic leadership by paid health professionals are:

- Cycling participation.
- Social Connectedness.

5. Some might argue that other indicators do at least require co-production by individuals with professionals to achieve those outcomes, however the challenge is that if these are to be achieved with limited resources how does one prioritise this & identify communities with values that are least likely to respond to behavioural change, rather than spread proposed interventions too thin.

6. What the proposed Outcomes currently seem to miss is that many of the separately recorded indicators all involve challenges involving exactly the same communities and target groups. Perhaps a more effective approach is engaging with lifestyles holistically and not produce yet another set of separate strategies for individual problems which are likely to substantially overlap at a time when money is tight?

7. Behaviour change theory tells us that a lot has been invested in ability. In other words “bring the horse to water”, or more likely in the toughest “Nudged” cases “bring the water to the horse”. Yet many of those behavioural approaches also make the point that one has address motivation too. In that case “get the horse to want to drink”!

8. A modern approach to this needs to include targeted values segmentation, network mapping, and using a range of behavioural and influence techniques to build and reinforce new social norms. These cannot simply be about presenting objective public health facts that people sit in workshops and consider in a rational way. We also need to frame things in such a way as to address the needs, emotions and values of a targeted community in order to motivate it!

9. Thus the Public Health Outcome Framework should not be seen as just a menu of indicators for practitioners to make short-list of, but also an opportunity to debate the most effective ways we can deliver behaviour change for a pro-social benefit.

10. There is also a danger that the neatness of alignment of the Outcomes Framework approach NHS, Adult Social Care and Public Health means that it is designed for ease of reporting to Parliament. The use of Domains are a very good approach but they should be looked at first of all in terms of their usability in the field they are being applied to. Then linkages should be identified. This is bottom up approach is likely to be more realistic than the current top down approach, whilst still retaining transparency in what is finally agreed.

11. In term of developing relevant indicators two things are important to consider.

12. Firstly, indicators that are sensitive to local intervention rather than big picture national indicators. The Local Authorities and Health Observatories will collect this big picture data anyway and, assuming open source availability leads to new suppliers of interpreted data, this information will already be available. In other words, make them:

- More locally influenceable at local authority level.
- Make them more influenceable by the public rather than just through the activity of professionals.

13. Thus in terms of incentivising indicators the key ones are those that a local authority can realistically be seen to influence in a given timescale, rather than the more national indicators.

14. Secondly, the levels of self-efficacy and motivation within communities is vital. This will tell one much about how much effort is required in each community and will give you more realistic information so as to inform distribution of the Health premium. This is the approach commercial marketers use, yet DH so far seems committed to fighting these pervasive influences in the community only with information that one already has by having a copy of the Marmot Review. The measurement of subjective experience is being addressed in a broader sense with the consultation by the Cabinet Office over Indicators of National Happiness. DH should link to that with a measurement of levels of self-efficacy and motivation in order for DH priorities to link better to wider government objectives around Happiness and the Big Society. It would also provide the data required by the Cabinet Office Behavioural Insight Team to measure interventions in line with behavioural projects such as “*Mindspace*”, which would increase the value of Public Health to other Government objectives. There are various approaches to segmentation that allow for the objective measurement of subjective outlooks that would enable a baseline to be quickly developed. If this is seen as radical for full roll-out at this stage, then DH should announce “pilot indicators” such as self-efficacy in order to then early on under the new arrangements be able to evaluate new indicators within the first two years of it, to create some potential for alternative indicator sets in preparation for when the initial Outcomes Framework is evaluated & reviewed.

HEALTH PREMIUM

15. The only way the health premium will work to seriously incentivise organisations and communities to reduce inequalities is through big incentives. The lesson of behavioural economics is surely that the incentive should not just be a sop for the sake of it, but designed to make a difference. DH should conduct a review of the research into incentives as well as conduct pilots in the remaining lifetime of PCTs run services to test what really works. In addition can resources here be used as a revenue stream to enable organisations to seek additional resources through Social Impact Bonds to seek to deliver locally agreed outcomes and if not where might that apply in a Public Health context or is that being discounted?

16. We would argue that segmentation that takes account not just the how and where of public health challenges but also the “why” in terms of “motivational values” is important as some segments of the population will be far less responsive to positive behavioural change than others and this has now been measured for a long period. Funding and the Health Premium should recognise and incentivise progress in those areas which are “tougher nuts to crack” and inequality, low community resilience and poor social capital is more deeply ingrained. This is likely to be the only way to motivate organisations to motivate people in those areas over a number of years.

17. DH has suggested linking access to growth in health improvement budgets to progress on elements of the Public Health Outcomes Framework to provide an incentive mechanism. However this sounds too much like a tragedy of the commons problem. Whilst professionals are well-meaning, there is a danger that it will be then be “no-one’s fault” if there is not progress. We should incentivise any local progress and use that bottom up approach to create innovation and transferability to other places. Some localities will be much harder to make progress due to certain values and social norms reinforced in those communities by the nature of their current social networks. Measurement of this challenge is important in order to inform the basket of indicators that determine the Premium and the segmentation has long existed to do it.

 TAKING FORWARDS THE MARMOT REVIEW: MEASURING AND ADDRESSING “MOTIVATION” IN PUBLIC HEALTH

18. The Cabinet Office’s own “*Mindspace*” report draws from current behavioural theory. What this tells us is that one cannot achieve a successful behavioural outcome without addressing two questions for the individual you are targeting.. They are:

- **Ability:** “Do I have the ability to continue, start, adapt or stop this behaviour”? eg skills, tools, finance, time, physical and mental effort, knowledge and physical access.
- **Motivation:** “What’s in it for me, or for people like me, to start, adapt or stop this behaviour?”

19. Public Health strategies tend to aim to focus on the first question—Ability. This approach relates to tackling and supporting the ability of people to utilise the service or behave in the desired way by making the information as accessible as possible. In other words much of the effort has gone into building mechanisms that enable people to access information without understanding who will use the information and how its use varies between individuals. Understanding how different individuals are likely to respond will make communications more effective, achieve better outcomes and be a better use of resources. Addressing motivation is likely to be far less expensive than all the resources poured into tackling ability.

20. The Department of Business and Innovation and Skills recently commissioned as part of its “*Sciencewise Expert Resources Centre*” a report by the well-known environmental campaigner Chris Rose entitled “*Consultation and Communication in relation to motivational needs*”. Since with public health behaviour change we are increasingly recognising the importance of motivation, it is surprising that DH is not drawing from that knowledge base too. Segmentation based on geo-demographics such as MOSAIC and ACORN tell you “how” people behave and we now have lots of data at each Health Observatory telling us “where” and to what intensity. However when it comes to motivation we need to understand “why” people behave. That requires as Chris Rose argues an understanding of the values in a given community. From our research and the work we are now commencing with the RSA—who are doing pioneering work on social networks—we believe this is often reinforced by the social networks and types of social capital that people have.

21. Values are one’s judgements about what is important in life and the lens that you look through when you view and try to make sense of the world.

22. Our values are derived from our unconscious motivation to satisfy a range of needs as we navigate our way through day to day life. A need is something that is necessary for us to meet if we want to live a physically and emotionally healthy life.

23. Needs can be objective and physical, such as food and water, or they can be subjective and psychological, such as the need for security or self-esteem.

24. The key thing to understand is that it is from our “dominant need” that our values—what is most important to us—are derived. And when faced with a decision it is these values that provide the unconscious “frame” that kicks in and sets the context before we actually take action.

25. Once we understand values, we understand what makes people tick. And we can start to understand how they might perceive services, how to deliver them in an in an empathetic way that matches their values and, crucially, how to motivate them to do things.

26. UK based values segmentation data is based on 37 years of data collected via the British Values Survey of 8,500 people in a nationally representative survey. The information gathered contributes to the global academic network that has built the World Values Survey, led by Professor Shalom Schwarz. The resulting segmentation gives us three principal values groups:

- **Sustenance Driven “Settlers”:** motivated by the core needs of safety, security and belonging. Home, family and immediate neighbourhood are important, and the wider world often feels threatening. Change is often seen as negative.
- **Outer Directed “Prospectors”:** motivated by the need for self-esteem and the esteem of others. Job progression, money and social status are important to them and although usually optimistic, they can worry for example about their status or they perceive declining quality of an environment.
- **Inner directed “Pioneers”:** motivated by ideas, aesthetics and personal development. Interested in new information and often the initiators of change. They tend to have large social networks, but individuality is more important than following the crowd.

27. Applying these three core values groups help us understand how people make sense of the world, what motivates them to act, and therefore means we are able to more effectively craft information and messages—whether verbal or written—which resonate with these motivations.

DEVELOPING A NEW ROLE FOR GPs AND GP PRACTICES IN PROMOTING PUBLIC HEALTH

28. The King’s Fund Paper “*A pro-active approach. Health Promotion and Ill-health prevention*” covers many of the areas of this issue and we recommend it is read as part of this inquiry. Hopefully the King’s Fund themselves will make a submission along these lines.

29. QIPP incentives are likely to be too low in many areas which contain a minority of deprived communities and thus behaviour change strategies may need to be addressed towards GPs behaviour rather than just their patients! The 1990 contract increased GP involvement in preventative medicine from 5% to 25% with GPs enquiring more of patients. However GPs were not drawn beyond the surgery door and still focused on clinical duties.

30. Policy initiatives have sought to increase the advice role of pharmacies and developed phone lines such as NHS Direct, but GPs still remained the most used with 300 million GP consultations. GPs remain the most-accessed part of the English healthcare system.

31. GPs are comparatively used less for health promotion than their equivalents in other European countries. The Inquiry may want to consider what assists the GPs in other countries to make a bigger impact and is it transferable to the UK.

32. Many GPs say they lack the skills to deliver effective health promotion. Surveys show GPs were prepared to counsel about alcohol consumption but only 21% thought they were effective.

33. Smoking Cessation programmes requires the GP enquiring about patients smoking status & recording it. The QOF system provides prompts and reminders, however it does not incentivise asking those with no current health problems. In other words it is not population based, but targeted at those with health problems. Less than half of GPs consistently advise patients to stop smoking and advice to quit is only given in 20–30% of UK primary care consultations with smokers. 42% of GPs thought discussing it was too time consuming. 22% said they lacked confidence. Is this about emotions rather than facts? It is most likely to be done when a patient presents with a smoking related problem, but less so in other cases.

34. GPs need more support and training to be more proactive. Consideration needs to be given as to how can they be encouraged to take it up. Could local authorities as part of their new public health role have a role through social norms to improve their training?

35. GPs say they are more comfortable managing illness than promoting health despite the opportunities to be proactive. Does there need to be proper research into the varying attitudes and values of GPs in order to achieve behaviour change with them?

36. There is a tradition of individual “activist” doctors addressing public health and ill-health prevention in deprived communities. What are the differences between them and other GPs? Has there been any research into this?

June 2011

Written evidence from the Chartered Society of Physiotherapy (PH 108)

1. SUMMARY OF MAIN POINTS

- The CSP is committed to improving public health and welcomes the opportunity to submit evidence and information to the Health Select Committee Inquiry.
- This submission is focussed on the areas in which we feel physiotherapy can most effectively contribute to the debate. We are willing to provide additional information or clarification and would welcome the opportunity to present oral evidence to the Committee. We are content for any part of this evidence to be made public or included in the Committee’s report.
- Physiotherapists are already actively engaged in improving public health through early intervention; primary and secondary prevention; the treatment and rehabilitation of chronic and long term conditions; keeping people fit to work; and promoting the benefits of regular physical activity for good health and wellbeing.
- The CSP supports the creation of Public Health England within the Department of Health and hopes this service will take the lead responsibility and determine clear direction for the public health agenda at both the national and local level.
- There should be an Allied Health Professions (AHP) Director in Public Health England.
- Physiotherapists and other AHPs are well placed to act as integrators of care and often help form the “bridge” between hospital clinicians and GPs or community based health and social care services. Given this and the important contribution that physiotherapists make to improving public health, the CSP is calling for the Health and Social Care Bill to be amended to mandate AHP involvement in commissioning at both the national and local level.

2. THE CHARTERED SOCIETY OF PHYSIOTHERAPY (CSP)

2.1 The CSP is the professional, educational and trade union body for the UK’s 50,000 chartered physiotherapists, physiotherapy students and support workers.

2.2 Physiotherapists offer clinically effective and cost-efficient services for patients, across healthcare sectors and along the whole patient pathway, in the management of long term conditions, rehabilitation, return to work,

mental health and public health. Physiotherapy enables people to move and function as well as they can, maximising quality of life, physical and mental health and well-being.

2.3 Physiotherapists keep people mobile, active and independent, they promote the health benefits of regular physical activity, encouraging people to adopt and maintain a healthy lifestyle. The CSP is running a long-term public education campaign called “Move for Health” to encourage people to build physical activity into their daily lives (link: www.csp.org.uk/moveforhealth).

2.4 Physiotherapy delivers high-quality, innovative services in accessible, responsive, timely ways. It is founded on an increasingly strong evidence base, an evolving scope of practice, clinical leadership and person-centred professionalism.

2.5 Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity. Physiotherapists work with a wide range of population groups; across sectors; and in hospital, community and workplace settings. Physiotherapists facilitate early intervention, support self management and promote independence, and help prevent episodes of ill health and disability developing into chronic conditions. Physiotherapy supports people across a wide range of areas including musculoskeletal disorders; many long-term conditions, such as stroke, MS, COPD, and Parkinson’s Disease; cardiac and respiratory rehabilitation; children’s disabilities; cancer; women’s health; continence; obesity management; mental health; and falls prevention.

2.6 Physiotherapists are also experts at recognising in their patients any risk factors or social determinants of preventable diseases. They address these through providing evidence based advice and behavioural change interventions and signposting or referring onto appropriate services.

3. THE CONTRIBUTION OF PHYSIOTHERAPY TO PUBLIC HEALTH

3.1 Being in work leads to better physical and mental health. The Black review²⁵³ identified the importance of early intervention and access to physiotherapy, and estimated that up to £100 billion a year could be saved by reducing working-age ill health.

3.2 The evidence for the long term health benefits of regular physical activity is compelling. Sir Liam Donaldson in 2009 (then Chief Medical Officer), stated “if a medication existed that had a similar effect on preventing disease, it would be hailed a miracle cure”. The CSP would like specific outcomes to be agreed to improve levels of physical activity in local populations. The CSP is concerned that approximately 27 million adults in the UK are not getting the recommended amount of physical activity, and feel this should be a priority for public health interventions and information campaigns.

3.3 Active people are up to 50% less likely to be at risk of major chronic disease such as coronary heart disease, stroke, diabetes and cancer. A recent study by Professor Kathleen Wolin of Washington University School of Medicine²⁵⁴ showed that exercise has a positive effect on bowel polyps risk.

3.4 Being overweight and inactive is also linked to an increased risk of post menopausal breast cancer. A recent new study by Dr Amanda Phipps at the US Women’s Health Initiative confirms the risk of the aggressive “triple negative” breast cancer in obese women who fail to keep active²⁵⁵.

3.5 Despite overwhelming evidence about the health benefits of regular exercise, only a minority of the population take the recommended 30 minutes of daily exercise, five days a week. A public opinion survey²⁵⁶ commissioned by the CSP showed that one in five people (20%) exercise only once a month or less. This survey revealed confusion about how much exercise adults think they should be doing. Just 13% know how much daily exercise they need.

3.6 Being overweight can put children at risk of serious health conditions and can put an unnecessary stress on their growing bones. Physiotherapists know that children are likely to remain overweight as adults unless they exercise regularly and eat well. The CSP has learned that only one in five parents know how much time children need to spend exercising each day.

3.7 The CSP would therefore like to see Public Health England do more to raise public awareness about the recommended amounts of exercise for adults and children, and about the importance of physical activity as part of a healthy lifestyle.

²⁵³ Dame Carol Black, National Director for Health and Work (2008) Working for a healthier tomorrow; DH: London http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083560

²⁵⁴ Reported in the Daily Express, 2 March 2011 in an article by Jo Willey “30 Minutes exercise each day ‘cuts bowel tumour threat’”. <http://www.express.co.uk/posts/view/232047/30-minutes-exercise-each-day-cuts-bowel-tumour-threat-30-minutes-exercise-each-day-cuts-bowel-tumour-threat->

²⁵⁵ Reported in the Daily Express, 2 March 2011 in an article by a Daily Express Reporter “Breast disease risk of obese women”. <http://www.express.co.uk/posts/view/232048/Breast-disease-risk-of-obese-womenBreast-disease-risk-of-obese-womenBreast-disease-risk-of-obese-women>

²⁵⁶ Public opinion survey conducted by Opinium Research for CSP, through an online poll of 2,084 UK adults between 9th and 14th April 2009.

3.8 As physiotherapy and other AHPs have such an important role to play in public health, we believe Public Health England will require AHP input at the highest level and the CSP is calling for an Allied Health Professions Director to be involved, at the same level as the Nurse Director post already announced.

3.9 The CSP is pleased to be contributing to the work of the new “Physical Activity Network” as part of the Public Health Responsibility Deal. We want to see local and national government protect and develop opportunities for people to take low cost or free regular exercise.

4. The public health role of the Secretary of State

4.1 The CSP understands that the ageing UK population is placing an ever increasing burden on health and social care services across the UK. Therefore the Secretary of State has a vital leadership role to ensure that long term strategies which improve the overall health of the population and prevent avoidable ill-health are put in place at national and local level, and are adequately funded.

5. The future role of local government in public health, the role of Health and Wellbeing Boards and Joint Strategic Needs Assessments

5.1 Physiotherapists will have an increasingly important role to play as the responsibility for public health moves to local authorities. Physiotherapists and other AHPs are well placed to act as integrators of care and can often help form the “bridge” for patients between hospital clinicians and GPs or community-based health and social care services.

5.2 In order to make informed decisions, local authorities, Health and Wellbeing Boards, Directors of Public Health, commissioning consortia and other commissioners will need a wide range of skills and must have broad representation from a range of healthcare professional including physiotherapists and other AHPs.

5.3 The CSP believes that the proposed new Health and Wellbeing Boards will be central to ensuring that robust strategies are developed to deliver effective public health outcomes. These strategies should tackle health inequalities, and ensure that all relevant local services are directed to collaborate to deliver long term improvements to public health in local communities.

5.4 Given the important role of AHPs in integrating care, and the key contribution that physiotherapy can make to improving public health, the CSP is calling for assurances that the Health and Social Care Bill will be amended to mandate AHP involvement. This wider clinical involvement in strategic planning, joint strategic needs assessment development and decision making will help deliver better, cost effective outcomes for patients and for public health.

5.5 The CSP supports the alignment of service development with financial and workforce planning, as one of the fundamental weaknesses of workforce planning in the past has been these two issues being considered independently. The lack of involvement of clinical service managers, such as physiotherapy managers, in workforce planning has been another fundamental weakness. We wish AHPs to have a voice on the proposed skills networks which are to be responsible for making decisions about the numbers of healthcare professionals being trained. The Skills Networks remit must take account of the workforce needs of both local government and the NHS and private sectors to ensure the future workforce is available to meet those needs.

6. Arrangements for commissioning public health services

6.1 The CSP recommends that the *Health and Social Care Bill* should establish wider “Clinical Commissioning Consortia”, not just “GP Commissioning Consortia”. The CSP also recommends that Consortia board members be appointed against a series of competences needed for commissioning—which include the ability to understand and commission evidence based public health interventions.

6.2 The CSP believes that Commissioning Consortia boards need to be made up of a wide range of professionals who can demonstrate the breadth of experience, knowledge and expertise across health and social care commissioning pathways, including physiotherapists and other AHPs.

6.3 The CSP is concerned about the conflict of interest that may arise from private companies being awarded contracts to undertake local needs mapping and commissioning activities when they are also competing to provide the commissioned services to the NHS. There must be clear and transparent rules introduced to ensure that no company or individual with an interest in running NHS services can be involved in any way in the process of commissioning or subsequent performance management of contracts.

6.4 The CSP recognises the importance of local authorities being able to make decisions based on the need of local populations. We also recognise the need for national monitoring and surveillance to ensure that any signals or unacceptable variations in care (or postcode lotteries) between geographic areas are avoided.

6.5 For Health and Wellbeing Boards to be effective, the CSP believes that they must have formal input from all relevant healthcare professionals, including AHPs, such as physiotherapists. It is important that this input is published and available for public scrutiny.

6.6 Commissioning should be undertaken on the basis of whole pathways of care and not for individual single elements of care. The role of physiotherapy in spanning sectors of care can clearly demonstrate the importance of this and the need for physiotherapists and other AHPs to be involved in re-designing pathways.

7. *The structure and purpose of the Public Health Outcomes Framework*

7.1 The CSP has responded to the recent consultation *Healthy Lives, Healthy People: Transparency in Outcomes—proposals for a Public Health Outcomes Framework*.

7.2 The key points made in that submission were that the CSP would like to see:

- Outcome indicators for the percentage of people in work with access to:
 - advice on occupational health; and
 - early intervention services.
- Indicators for the percentage of children and teenagers meeting the recommended guidelines for physical activity.
- Indicators on the levels of obesity among children and teenagers.
- An indicator on the percentage of adults meeting the Food Standards Agency’s “Balance of Good Health” recommendations.
- Specific indicators on working conditions and work place assessments, so that levels of health in the working population are carefully monitored. Encouraging work place assessments will help with early identification of potential problems—such as musculoskeletal disorders. Early intervention with effective physiotherapy can prevent these conditions from worsening and becoming more serious or long term.
- An outcome indicator—to be shared across public health and NHS services—to measure the proportion of people living with chronic musculoskeletal disorders (preventable ill-health).
- Outcome indicators shared across Public Health and the NHS for work sickness rates; acute admissions as a result of falls or fall injuries for over 65s; and health related quality of life for older people.

8. *The future of the public health workforce (including the regulation of public health professionals)*

8.1 GPs have until now had the most well recognised role in the management of chronic disease and the care of people with or at risk of developing these diseases. It is now well recognised that other health professionals including physiotherapists have a significant part to play in the prevention and management of chronic and preventable disease and injury.

8.2 Access to a greater range of health providers has been linked to the capacity to build more effective self management techniques and accountability in people with chronic disease.²⁵⁷ As the largest of the Allied Health Professions, physiotherapy has a significant contribution to make.

8.3 The skills and training of physiotherapists mean they are capable of working with a wide variety of conditions and disabilities and they are able to improve the health status of individuals across a lifespan. In addition they are able to positively impact on population health in the local areas where they practice.²⁵⁸

8.4 Physiotherapists are valuable members of multidisciplinary teams, making an important contribution to primary health care through their health promotion, prevention, screening, as well as triage, assessment and treatment activities.²⁵⁹ Evidence has shown that people with heart failure enrolled in programs that feature multidisciplinary team care have shorter inpatient stays and lower rates of re-hospitalisation.²⁶⁰

8.5 Being primary contact professionals with excellent communication skills, physiotherapists are accessible to members of their local community. They are well placed to promote physical activity guidelines and healthy lifestyle choices. However, the potential for physiotherapy to impact on chronic disease prevention and management has not currently been reached.

8.6 There are a number of ways in which physiotherapists can actively contribute to decreasing the burden of disease in England. Physiotherapists work in health promotion at public events, within hospital and communities and as first contact professional within primary care settings such as private practices. They work with clients across the age spectrum from infants and children through to the elderly population. This places physiotherapists in an ideal position to provide information and advice to people with existing conditions of those at risk of developing these conditions.

²⁵⁷ Dennis SM, Swar N, Griffiths R Roland M, Hasan I, Davies GP et al. Chronic disease management in primary care: from evidence to policy. *Medical Journal of Australia*, 2008. 188 S53–7

²⁵⁸ Soever L 2006. Primary health care and physical therapists—moving the professions agenda forward, discussion paper, Canadian Physiotherapy Association, Toronto, Ontario

²⁵⁹ College of Physical Therapists of Alberta, Alberta Physiotherapy Association and Canadian Physiotherapy Association 2007. *Primary health care. A resource guide for physical therapists.*

²⁶⁰ Sochalski J, Jaarsma T, Krumholz HM, laraamee A, McMurry JJ et al. What works in chronic care management: the case of heart failure. *Health Affairs*. 2009. 21 p179–189

8.7 Physiotherapists manage people with chronic lung diseases including asthma and COPD through exercise prescription and cardio-pulmonary rehabilitation.²⁶¹ Individuals with complications from cancer surgery such as lymphodema are treated by physiotherapists using complex physical therapy, and physiotherapists prescribe exercise therapy to improve glucose control in people with or at risk of developing diabetes.²⁶²

8.8 Physical activity is recommended for the prevention or treatment of many conditions.²⁶³ Physiotherapists can prescribe and implement therapeutic exercise at an individual or group level and lead exercise and education classes for people who have been diagnosed with or who are at risk of developing chronic diseases.

8.9 Aside from the treatment of musculoskeletal conditions, physiotherapists have a well-established role to play in chronic conditions such as cardiovascular disease, chronic obstructive pulmonary disease, diabetes, osteoporosis, obesity and hypertension.²⁶⁴ The education focus they adopt in areas such as chronic disease management, self-management techniques, lifestyle and physical activity guidance aligns well with the primary health care philosophy of consumer and community empowerment.

9. *How the Government is responding to the Marmot Review on health inequalities*

9.1 The CSP notes that there are now three aligned frameworks; the *NHS Outcomes Framework*, the *Outcomes Framework in Adult Social Care* and the new *Public Health Outcomes Framework*. The Society is concerned that there may be a risk of a fragmented approach to public health, with some health inequalities “falling through the gap” between the NHS, Public Health, social care and other sectors. The proposed Health and Wellbeing Boards will be absolutely key to ensuring that effective strategies are developed—across all sectors and services—to deliver effective public health outcomes. Allied Health Professionals must have a role on these Boards.

June 2011

Written evidence from Tunstall Healthcare (PH 109)

1. EXECUTIVE SUMMARY

1.1 Tunstall Healthcare is the world’s leading provider of telehealthcare services. Across the UK, Tunstall is already working with over 80 primary care organisations and the vast majority of councils responsible for social services to commission telehealthcare services for older people and those with long-term health conditions.

1.2 Tunstall is grateful for the opportunity to contribute to the Health Select Committee’s inquiry on public health and we would like to make the following recommendations in our evidence submission:

- 1.2.1 Public Health England should take steps to ensure it works with other government departments and agencies when delivering the public health agenda.
- 1.2.2 Public Health England should regularly review positive examples of intervention and service delivery, and takes steps to communicate these with public health commissioners.
- 1.2.3 The Department of Health should publish the findings from the Whole System Demonstrator programme as soon as possible and incorporate these into Public Health England’s proposals to improve public health.
- 1.2.4 The Department of Health and Public Health England should take steps to ensure local authorities and health and wellbeing boards have the necessary support to carry out their functions.
- 1.2.5 Health and wellbeing boards should include a section on the steps they are taking to promote joint working across public health, NHS and social care services in their joint health and wellbeing strategies (JHWS).
- 1.2.6 Health and wellbeing boards should ensure they consult with a range of stakeholders when developing JHWS.
- 1.2.7 The Department of Health and Public Health England should put sufficient safeguards in place to ensure local ring-fenced public health budgets are spent on genuine public health areas.
- 1.2.8 Public health commissioners should be incentivised to deliver public health outcomes efficiently, including focusing on the prevention agenda.
- 1.2.9 The Department of Health should include indicators in the Public Health Outcomes Framework on the management of long-term conditions, and getting carers back to work.

²⁶¹ Cambach W, Wagenaar RC, Koelman TW, van Keimpema AR, Kemper HC. The long-term effects of pulmonary rehabilitation in patients with asthma and chronic obstructive pulmonary disease: a research synthesis. *Physical Medicine and Rehabilitation*, 1999. 80(1) p103–111

²⁶² Yassine H, Marchetti C, Krishnan R, Vrobel T, Gonzalez F, Kirwan J. Effects of exercise and caloric restriction on insulin resistance and cardio metabolic risk factors in older obese adults—a randomised clinical trial. *The Journal of Gerontology: Series A biological sciences and medical sciences*, 2009. 64A(1) p90–95

²⁶³ Armstrong T, Bauman A, Davies J. Physical activity patterns of Australian adults. Results of the 1999 National Physical Activity Survey. Canberra: AIHW, 2000.

²⁶⁴ Australian Physiotherapy Association. 2008. The role of physiotherapy in the provision of primary healthcare—a background paper.

2. NATIONAL SUPPORT

2.1 Tunstall welcomes the Coalition Government's decision to establish a dedicated body within the Department of Health—Public Health England—to deliver high quality, evidence-based and responsive public health services nationally.

2.2 Preventing a rise in costly long-term conditions should be a priority of the new public health agenda. Around 15 million people in England have a long term condition.²⁶⁵ People with long-term conditions are the most frequent users of healthcare services. Those with long-term conditions account for 29% of the population, but use 50% of all GP appointments and 70% of all in patient bed days.²⁶⁶

2.3 The range of issues affecting public health are multi-factorial and Public Health England will need to work with other government agencies, for example the Department for Work and Pensions, the NHS and the Treasury in order to deliver improvements in outcomes. This will be particularly important for Public Health England when seeking to deliver improvements to public health for the most disadvantaged and to address health inequalities.

2.4 The Committee should consider recommending that Public Health England take steps to ensure they work with other government departments and agencies when delivering the public health agenda.

2.5 Improved data collection and publication will be critical for improving public health and Public Health England will need to take steps to ensure this information is collected in an efficient way which can be shared and easily analysed. For local authorities, this will be particularly important given public health responsibilities have previously laid with primary care trusts.

2.6 The mainstream introduction of telehealthcare—such as Tunstall's icp triagemanger—technology can support this. The data collected by clinicians through the introduction of telehealthcare can increase commissioners' understanding of their population as they are provided with up to date information on a section of their population's health needs and can therefore allocate resource effectively. As well as driving efficiency and improving patient care, this information can support local health and wellbeing boards when carrying out their joint strategic needs assessment and commissioning services effectively.

2.7 Where there is national evidence for the commissioning of certain types of intervention and service delivery, Public Health England should take steps to communicate this clearly and quickly to public health commissioners.

2.8 This will be particularly important with the forthcoming publication of the Whole Systems Demonstrator telehealthcare project. With the project expected to show benefits in relation to patient outcomes, patient experience, quality of care and efficiency, sharing the evidence widely and communicating ways for commissioners to implement new interventions will be critical to improving the public health for people in their area.

2.9 The Committee should consider recommending that Public Health England regularly reviews positive examples of intervention and service delivery, and takes steps to communicate these to public health commissioners.

2.10 The Committee should consider recommending that the Department of Health publishes the findings from the Whole System Demonstrator programme as soon as possible and these are incorporated into Public Health England's proposals to improve public health.

3. *Future role of local government*

3.1 Tunstall broadly supports the decision to devolve responsibility for commissioning of public health services to local authorities and the decision to establish local health and wellbeing boards which will play a vital role in ensuring integrated services and delivery across the NHS, public health and social care.

3.2 As new bodies, Public Health England should ensure health and wellbeing boards have an adequate level of central support in order for them to function effectively. This will be particularly important in light of these being new bodies at local authority level, and local authorities are being asked to deliver more services for less, often in areas where they have had limited experience.

3.3 The Committee should consider recommending that the Department of Health and Public Health England take steps to ensure local authorities and health and wellbeing boards have the necessary support to carry out their functions.

3.4 We welcome the duty in the Health and Social Care Bill for boards to develop JHWS for their local area. In order to be effective these strategies must be transparent and include a section on what measures are underway to promote joint working across public health, NHS and social care.

3.5 Telehealthcare technology can help deliver better integration of health and social care services. Tunstall already works with local authorities and health trusts to breakdown traditional healthcare boundaries to deliver

²⁶⁵ Department of Health, Ten things you need to know about long term conditions, 2011

²⁶⁶ Department of Health, Ten things you need to know about long term conditions, 2011

a single view of an individual's care. Working with Milton Keynes, for example, Tunstall is supporting both the Council and the local primary care trust to deliver integrated health and social care services. Rather than working separately—therefore doubling the amount of data entry and making for incomplete health assessments—telehealth and telecare systems are able to monitor and combine an individual's care records into a single source. Telehealthcare contributes to health and social care integration and reablement by:

- aiding recovery and building confidence;
- providing 24 hour safety and security when vulnerability is highest;
- enabling scarce staff resources to be utilised more effectively;
- guarding against the need for re-entry into the care system;
- providing continued, low cost support beyond the initial reablement phase; and
- helping to deliver the goal of 70% of people not requiring further services.

3.6 Health and wellbeing boards will need to consult a range of groups including patient groups, clinicians, voluntary organisations, primary care professionals, adult social care professionals and private providers in order to deliver effective joined up services. The health and wellbeing strategy should stipulate what discussions and initiatives the board has undertaken with such groups in order to ensure that it is providing integrated, holistic services for its populace.

3.7 The Committee should consider recommending that health and wellbeing boards include a section on what steps they will be taking to promote joint working across public health, NHS and social care services.

3.8 The Committee should consider recommending that health and wellbeing boards ensure they consult with a range of stakeholders when developing health and wellbeing strategies and details of these communications are made available.

4. *Commissioning and funding of public health services*

4.1 Tunstall supports the decision to allocate a ring-fenced public health budget both locally and nationally. However, locally, we believe adequate safeguards need to be put in place to ensure that the ring-fenced budget and the health premium allocated by Public Health England is spent on appropriate and effective areas of public health, rather than used to subsidise other areas of local authority responsibility.

4.2 The Committee should consider recommending that the Department of Health and Public Health England put sufficient safeguards in place to ensure local ring-fenced public health budgets are being spent on genuine public health areas.

4.3 In light of the broad scope of public health we believe it is important that local health and wellbeing boards are able to effectively scrutinise how the ring-fenced budget is being used and, in particular, to ensure that funding is used most effectively.

4.4 Given the broad nature of public health and the proposed list of activity which will be funded from the new public health budget,²⁶⁷ it will be essential that public health commissioning is delivered efficiently while at the same time seeking to deliver the best possible outcomes.

4.5 Commissioners should be incentivised to deliver improvements in public health outcomes more efficiently and it is important that the new commissioning outcomes framework reflects this.

4.6 Telehealthcare is one example of how commissioners can deliver services more efficiently. Telehealthcare can improve public health outcomes for people with long term conditions such as Chronic Obstructive Pulmonary Disease (COPD), Chronic Heart Failure (CHF) and diabetes and improve service efficiency. Tunstall's mymedic health monitor measures patient's vital signs, such as blood pressure and temperature, which are then sent across to icpatriagemanager clinical software that is monitored by health professionals. Any deviation from set parameters will alert the health professionals so that patient treatment can be modified or an intervention can be made, improving outcomes. Studies internationally have shown that following the introduction of telehealthcare has seen an average reduction of admissions to hospital per year for patients with COPD of 54% and with heart failure of 38%.²⁶⁸

4.7 Nationally, the NHS Commissioning Board and Public Health England need to ensure that there are clear channels of communications and accountability between the two, and opportunities to share examples of good practice in commissioning public health services.

4.8 These channels of communication need to be reflected at a local level too through local health and wellbeing boards. For example, we believe that the legal obligation for local authorities and local NHS services to develop JHWS will play a crucial role in encouraging local commissioners to inform one another of existing public health initiatives and for commissioners to be best informed of relevant public health advice.

²⁶⁷ Department of Health, Healthy lives, healthy people: consultation on the funding and commissioning routes for public health, December 2010

²⁶⁸ Ernst and Young, Telehealth: A review of the evidence, 2010

4.9 The prevention agenda should be a priority of the new public health system. Up front investment in public health initiatives will result in significant savings later as a result of individuals in care needs and emergency admissions. This is particularly the case in relation to long term conditions.

4.10 Getting patients with conditions such as COPD and CHF out of hospital and back into the community is essential to improving the quality of care patients receive and helping them to live independently in a setting of their choice.²⁶⁹ Telehealthcare has an important role to play in this and can improve outcomes for people at risk of falls or stroke through earlier intervention. For example for stroke victims, guaranteeing early intervention is critical in order for patients to have the best possible outcomes and chance of survival.

4.11 The Committee should consider recommending that public health commissioners are incentivised to deliver public health outcomes efficiently, including focusing on the prevention agenda.

5. Improving public health outcomes

5.1 Tunstall broadly supports the overall structure of the proposed Public Health Outcomes Framework and we particularly welcome the decision to align the Framework with the NHS and social care outcomes frameworks, which is particularly important for individuals who have long-term care needs who often need access to social care and NHS services.

5.2 Telehealthcare technology can play a crucial role in supporting commissioners to deliver more integrated services for patients, helping to improve outcomes and deliver more efficient services. By delivering telehealthcare solutions, Tunstall has already demonstrated success in working with local authorities and NHS commissioners to provide personalised, integrated and tailored care to those with long-term care needs; thereby helping patients to better manage their health needs and deliver better public health outcomes.

5.3 Telehealthcare will have a key role to play in improving the outcomes in Domains: 2, 3, 4 and 5, in particular the introduction technology in the home can have in the following areas:

- 5.3.1 **Domain Two:** Supporting people with long term health needs to better manage their conditions independently and in the community
- 5.3.2 **Domain Three:** Helping healthcare professionals to monitor an individual's vital signs and lifestyle changes, and support them in better managing their health needs
- 5.3.3 **Domain Four:** Telehealthcare can play a vital role in re-ablement and the prevention of more intensive care packages or admission to hospital
- 5.3.4 **Domain Five:** Appropriate and timely introduction of telehealth or telecare technology can allow for quicker interventions by healthcare and social care professionals, thereby potentially saving lives

5.4 Overall, Tunstall supports the current indicators proposed within the Public Health Outcomes Framework and the criteria chosen in determining these indicators for public health. However, Tunstall are calling for the development of indicators on the “*percentage of people with long-term care needs feeling supported to manage their condition*” and the “*percentage of patients with long-term care needs who say they are confident that they can manage their own health*”.

5.5 Empowering individuals to better understand their own health needs and to have greater confidence in managing their own condition can act as proxy in helping to deliver better outcomes in public health. Evidence from the Picker Institute has shown that improved patient engagement can improve patient experience and health outcomes.²⁷⁰

5.6 By delivering telehealthcare solutions, Tunstall has already demonstrated success in working with local authorities and health commissioners to deliver personalised and tailored care to those with long-term health needs; thus allowing them to live independently in the community.

5.7 Telecare, for example, has shown success in improving the experience of care, both for users, by enabling them to live independently and for carers, by giving them greater confidence that the person they are caring for has access to immediate help 24 hours a day. Satisfaction surveys conducted by NYCC have found that: 95% of users felt telecare equipment made them feel safer, whilst 87% believed telecare helped them carry on living at home.²⁷¹

5.8 The Committee should consider recommending that the Department of Health include the indicators set out above in the Public Health Outcomes Framework on the management of long-term conditions.

5.9 The benefits extend beyond improvements in well being to the individual concerned. There are also broader benefits to carers as a result of increased support and reduced anxiety. Consideration should be given to including carer wellbeing, captured through the proposed carers survey as a joint public health and social care outcome indicator. Carers role in preventing ill health for the person they are caring for is critical and it

²⁶⁹ Department of Health, £70 million support to help people in their homes after illness or injury, October 2010

²⁷⁰ Picker Institute, Worldwide evidence of the effectiveness of patient and public engagement launched online, March 2010

²⁷¹ Tunstall, Innovation, Choice and Control—Telecare North Yorkshire, 2009. Available at: <http://www.tunstall.co.uk/assets/literature/647-NYCC%20Case%20Study.pdf>

has been estimated that carers save health and social services £119 billion a year as a result of the unpaid care they provide.²⁷²

5.10 That is why another indicator which should be considered is the ability of carers to take up employment. Many carers unfortunately have to give up full and part time work in order to fulfil their care duties. This not only affects the wellbeing of the carer, but is a huge loss of a potentially productive workforce. Thus whilst the employment of people with long term conditions is a welcome indicator, we believe an additional indicator focused on the employment should be considered for inclusion in domain 2.

5.11 The Committee should consider recommending that the Department of Health include the indicators within the Public Health Outcomes Framework on the ability of carers to take up employment.

6. Patient empowerment

6.1 As set out above, one of the key ways of improving the country's public health will be through empowering individuals to have a greater understanding and ownership of their own health. By providing individuals with an enhanced understanding of their own health needs, real progress can be made on delivering the prevention agenda and in so doing reduce the projected burden on health and social services over the coming years.

6.2 Telehealthcare can improve an individual's knowledge of their particular condition. Tunstall's myclinic enables a group of patients within a common location, for example a residential home, to participate in a collective telehealth programme. It provides patients with individualised monitoring plans, while enabling shared use of a terminal and appropriate medical device peripherals to measure vital signs such as blood pressure, pulse rate and blood oxygen levels. This proactive approach helps to reduce the need for visits to and by clinical staff, alleviating the demand on the healthcare system and supporting people in a community setting.

6.3 In supporting people with long term conditions, the technology has already demonstrated success in improving public health, making patients feel empowered and confident in making decisions about their care, which is critical when maintaining their independence, improving their health and wellbeing.

6.4 By providing real time information to individuals and clinicians about their health, users of telehealthcare services have reported high levels of satisfaction (>90% compliance and >85% satisfaction), an improved ability and confidence to manage activities of daily living, and reduced anxiety.

6.5 The Committee should consider recommending that local authorities are incentivised to commission public health services which empower individuals and help prevent more serious complications and conditions from developing.

June 2011

Written evidence from the UK Commissioning Public Health Network (PH 110)

SUMMARY

- Health Services Public Health (PH) is that branch of the discipline that deals with the health needs of the population and the strategic development, planning and delivery of healthcare to services. This includes the monitoring of the quality of the services that are provided.
- Health Services PH is not properly considered in this legislation. This needs to be corrected. Public health should have a lead role in commissioning and this should be put on a statutory footing.
- Many public health specialists are clinicians with considerable experience in health service public health. These individuals are the only clinicians who have the training and the skills to provide a both a medical and population perspective.
- Public Health England should not be part of the Department of Health, but should be part of the NHS.
- We believe that fragmenting the specialist PH workforce between many organisations will reduce the effectiveness of that workforce and would be a retrograde step.
- PH observatories, and cancer registries, are an integral and important part of the public health infrastructure and should be commissioned as such.
- We believe that the proposals as currently constituted risk driving down quality and increasing health inequalities.

BACKGROUND INFORMATION ABOUT THE UK COMMISSIONING PUBLIC HEALTH NETWORK (UKCPHN)

1. The UKCPHN is a professional network of senior public health doctors and other specialists working for the NHS either in primary care trust commissioning or specialised commissioning teams.

²⁷² Carers UK, Unpaid carers save £119 billion a year, May 2011

2. The group was first established in 2002 and now has 230+ members. These members are drawn from all 10 England specialised commissioning teams and the majority of PCTs in England. As such the membership represents a significant proportion of public health specialists actively working in commissioning.

THE CREATION OF PUBLIC HEALTH ENGLAND (PHE) WITHIN THE DH

3. The specialist PH workforce consists of consultants in public health that have been trained in PH and have demonstrated that they have achieved a sufficiently high level of expertise. They work in all three domains of PH, health protection, health improvement, and health services, often undertaking roles in more than one area.²⁷³

4. The UKCPHN remains of the view that Public Health England should not be a part of the Department of Health. There is a need for an organisation that can employ PH specialists, and this should remain part of the NHS. This is to ensure that we have the ability to speak freely, analysing the health of the population and not being fettered by being part of government.

5. In addition, many public health specialists are of the view that Public Health England should employ all PH specialists, thus preventing the fragmentation that we perceive to be one of the greatest risks of these proposals.

6. Those specialists that have concerns about Public Health England being the sole employer of public health specialists within the NHS have reservations because, unless Public Health England is an integral part of the NHS structure, health service public health in particular will merely be reduced to a technical function rather than providing a leadership function as a core member of the commissioning multi-disciplinary team. This will be to the detriment of the NHS given that public health specialists have training in most aspects of commissioning and are the only specialty / professional group trained in some aspects of commissioning.

7. It is therefore essential that any new structure both prevents the fragmentation of the specialty and does not reduce health service public health to a merely technical and distant function from health service commissioning.²⁷⁴

ARRANGEMENTS FOR PH INVOLVEMENT IN THE COMMISSIONING OF NHS SERVICES

8. The role of PH in commissioning is both strategic and operational. There is nothing in this Bill that takes cognisance of this, or that even hints at the realisation that managing change to improve quality and value for money is a complex and highly skilled task. Whilst many, including GPs, have a remit for evidence-based medicine, analysis of and advocacy for evidence based policies and practices are a core function of Public Health consultants as specialists in population health.

9. Health services public health has a unique configuration of skills that are relevant to commissioning. These include:

- Assessing, reviewing, interpreting and presenting scientific evidence in a comprehensible manner.
- Engaging and leading clinicians as trusted partners in improving service quality and patient outcomes.
- Understanding the complete care pathway and ensuring that decisions are implemented and monitored.
- Maintaining independence and objectivity so that funding decisions are based on evidence and need.
- The ability to work across multiple clinical areas.
- Clinical knowledge (for many).
- Leadership.

²⁷³ Public health specialists are concerned not only with improving health and well being through addressing inequalities, the social and physical environment and health behaviour but also with improving mortality, health outcomes and quality of life through the delivery of healthcare services. This is a core driver underpinning priority setting. In addition inequity of access is still prevalent across the NHS whereby those populations with the poorest health often have lower access to services, and lower levels of funding. Public health has a crucial function in highlighting these problems and working with health services to address them.

²⁷⁴ Public health training covers the core elements of commissioning: including for example: strategic planning, priority setting, evidence review, the development of service specifications and standards and quality measures, assessment and evaluation of health service provision. A large proportion of public health practitioners specialising in health service public health also have a clinical background and many had public health training that also included clinical leadership and the management of change. As such they were trained to have oversight of health programmes. This role has slowly been undermined over the last few years and has been reduced to a technical support function. As a result the NHS is already not making sufficient use of workforce with considerable skills and expertise. Within the proposed structures there are clinicians (GPs and secondary care clinicians) who have clinical training but no public health or population medicine training and commissioning support which will include people with some training in commissioning but no clinical knowledge. These two elements are brought together in those public health practitioners who have a clinical background—whether this is medical, nursing, pharmacy or paramedical. Public health doctors, for example, will have been clinical trained, many to specialist level, and then completed a further five to six years training in public health.

10. This combination of skills, superimposed on previous clinical experience and a sound understanding of how the NHS and its partners work, give us the ability to deliver cost effective, population based and patient oriented outcomes. Our role as “expert population advocates” enables us to harness the expertise of others and to coalesce it to the benefit of the public. Our unique role as advocates for the entire population needs to be recognised and utilised. The need for a population perspective in commissioning health care is not clear in the Bill. Setting priorities for health care investment depends on an understanding of the needs of the population, understanding of the relative and absolute benefits to be obtained from proposed investments, the ability to assimilate and explain evidence, and the ability to take and push through difficult decisions. This cannot be done for each individual patient. It must be done collectively for a defined population, where the individual members of the population are not identified and cannot, therefore, influence the decision-making process with essentially irrelevant issues (eg the social status of a particular individual).

11. Many clinical services are complex and each defined clinical area will have its own set of issues, depending on the disease and the associated medicines and technological interventions, and these issues will need addressing separately so as to meet the patient and population needs. Public health has a major contribution to make to this in the annual commissioning cycle. This is not delivered in isolated parts but through a well-coordinated commissioning team, combining the expertise of public health with that of finance, information and experienced commissioning managers. Remove any one of those parts and it will become considerably more difficult to manage the risks inherent in health services commissioning and to deliver the end result of a well specified and good value contract with the associated good relationship with local providers.

12. Care pathways should be designed as a seamless whole, from prevention, through primary, secondary and tertiary care where necessary and, ultimately, end of life care. The proposals fragment the responsibility for these different aspects and this will make the designing of care pathways far more difficult. It will also make it harder to move resources from one sector to another eg if the primary prevention for a particular condition sits with public health in the Local Authority, and secondary care is commissioned by GP Consortia, will it be possible to move resources out of hospital and into the Local Authority? We should be striving for a joined up commissioning process, not a fragmented one.

13. Commissioning across the health needs of a population is complex and in order to acquire such high level skills GPs will have to invest significant time and effort. It may be neither necessary nor appropriate for GPs to have to acquire the high level skills required to commission operationally at this level. They will, however, need to have access to professionals with these skills, and have partners that can help them to make the best value commissioning decisions.

14. The key elements of successful commissioning include:

- Having good understanding and oversight of the entire healthcare programme.
- Making difficult choices on the allocation of resources based on the scientific evidence of the value of interventions.
- Setting priorities based on magnitude of need, and patient and population oriented outcomes.
- Working and improving the care pathway for patients to focus on outcomes, reduce unnecessary interventions and include treatment threshold decisions.
- Explaining to the public and patient groups about the needs of one patient being balanced against the needs of all the others (opportunity costs).
- Agreeing specifications and standards for services that clearly identify the clinical, quality and productivity outcomes that are important for patients and the NHS, and monitoring services to ensure delivery of these outcomes.
- Developing and managing relationships with providers including clinicians.
- Ensuring implementation of robust commissioning decisions.
- Auditing the entire process in a commissioning cycle.

15. As the paradigm of control moves to a more local level, public health is best placed to work in partnership with GPs to make the best value decisions. Our ability to analyse health services information from a population perspective, combined with deep clinical knowledge, will enable effective commissioning decisions. We work closely with secondary care clinicians through acute commissioning units, and in secondary and tertiary care, to ensure best quality clinical outcomes.

16. We are different to non-clinical managers in our ability to bridge the gap between clinical practice and a bird’s eye view of healthcare needs.

17. We are ready and willing to work closely with GPs to enable them to focus on their whole practice population and the health care needs of that population.

18. We fully endorse the recommendations in paragraphs 36, 37 and 41 of the previous health select committee report relating to the need for more clinical skills in commissioning. Indeed these proposals constitute the only mechanism so far suggested that would provide consortia with health service public health expertise supported by medicines management. Board level presence is of particular importance because this branch of public health practice is central to the priority setting process that enables health care resources to

be allocated in an equitable way. Consortia will be responsible for the allocation of the majority of the NHS budget and we would echo the opinion of the committee that reductions in health inequality can only be achieved with appropriate public health input into acute sector commissioning. Further, the skills of health service public health professionals will provide consortia with robust assessments of new treatments and medicines. In this way consortia can mitigate the significant risk of financial volatility that can result from the introduction of high cost interventions and medicines without an evaluation of their value to the NHS and appropriate placement within an overall clinical management programme.

19. Finally, we are concerned that there is no realisation of the difficulty of implementing and monitoring commissioning decisions. The fact that a Consortium has decided something does not make it happen. There is then a major piece of work to be undertaken to ensure understanding and acceptance of the policy at all levels. PH consultants are well placed to undertake this task and to ensure successful implementation of treatment policies.

ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

20. Optimising population health must be a key consideration for any health service. Authoritative specialist public health advice and guidance should be delivered from a single NHS organisation, with any necessary joint appointments (which already exist between LAs and PCTs) being maintained or created, but with contracts of employment for public health specialists being held in the NHS. This will maximise the influence of the small specialist PH workforce and have the biggest impact on the health of the population while retaining flexibility of deployment. Individual specialists could then be seconded into other organisations.

21. All health services, from Primary Care through to tertiary referral hospitals, have a fundamental role in improving the public health, preventing disease and reducing health inequalities. PH involvement with Commissioning Consortia can only help to keep the public health focus in primary care.

THE FUTURE OF PH OBSERVATORIES

22. Public Health Observatories are a hugely useful resource for commissioning population health care. They must be preserved and would be best placed with the total public health family in one organisation. They must also include cancer registries, without which we shall be unable to monitor the effects of changes on cancer outcomes.

THE STRUCTURE AND PURPOSE OF THE PH OUTCOMES FRAMEWORK

23. We regret that the outcomes for public health are being considered separately from the NHS and Social Care outcomes. We believe that, once again, it endangers the development of integrated care pathways and systems across organisations. We would suggest that a common Outcomes Framework should be developed.

THE FUTURE OF THE PH WORKFORCE

24. There is a real danger that PH will fragment into three completely distinct sub-specialties, with the director of public health and a small team being responsible for health promotion/health improvement within the LA, some PH consultants working with GP consortia with a brief for commissioning and yet others at the NHS Commissioning Board and yet others in Public Health England working within the Department of Health. It also increases the disconnection between public health and providers making it more difficult to engender change in the provider sector.

25. The fragmentation runs the risk that there will be no continuity of thinking. It also risks de-skilling an already under-resourced and over-stretched workforce, and it could lead to real problems in designing adequate training programmes for the next generation of PH consultants.

26. Obtaining value for money in the commissioning of services will not be assisted by the fragmentation of the commissioning function. It is unlikely that consortia will have greater ability to control the hospitals than PCTs have had. Indeed, it seems not unlikely that the major power in the system will reside with the Foundation Trusts.

27. The training of the next generation of PH professionals is a cause for major concern. It is still very unclear where they will be based, how the training will be organised and what the implications are. It is imperative that:

- Training is seen as an integral part of the public health function.
- Clinical Governance of the training function is assured.
- All locations where PH trainees might potentially be placed understand the ways in which the training works and what they will be expected to provide.
- We are still in a position to train in the skills needed for commissioning.

Written evidence from National AIDS Trust (PH 111)

A. INTRODUCTION

1. NAT (the National AIDS Trust) welcomes the inquiry of the Health Select Committee into Public Health.

2. NAT is the UK's leading charity dedicated to transforming society's response to HIV. We provide fresh thinking, expert advice and practical resources. We campaign for change. All our work is focused on achieving four strategic goals:

- effective HIV prevention in order to halt the spread of HIV;
- early diagnosis of HIV through ethical, accessible and appropriate testing;
- equitable access to treatment, care and support for people living with HIV; and
- eradication of HIV-related stigma and discrimination.

3. This submission addresses issues in the order set out in the Committee's call for evidence. We comment only on those areas where we have, we trust, relevant points to make on the basis of our work. In particular NAT is concerned to ensure:

- the continuation of the independent high-quality surveillance and analysis currently undertaken by the Health Protection Agency;
- clarity on the distribution of responsibility for public health, with particular attention to the role of the NHS;
- arrangements which provide consistent comprehensive sexual health and HIV services across the country;
- an Outcomes Framework which genuinely incentivises the broad range of actions necessary for public health; and
- an adequately resourced ring-fenced public health budget with agreement as to how this fund should complement other resources which have a public health impact.

B. SUMMARY

4. The creation of a specific body responsible for public health has real potential for bringing about improvements to public health. However it is important that comprehensive surveillance and a full analysis of data required by both local and national service providers and decision makers continues to be carried out to the high standard currently delivered by the Health Protection Agency (HPA).

5. It is also important that Public Health England retains a degree of independence from Ministerial intervention. Public Health England must be able to make decisions about the best course of action for public health based on evidence and expertise. The data collected and collated by Public Health England must remain as publicly available and accessible as it currently is under the HPA.

6. We have some concerns about whether the political nature of local government will impact on the commissioning of unpopular or controversial issues, such as HIV and sexual health.

7. Greater clarity is needed as to how at the local level the NHS (for example GP practices) can be required to address identified public health need. This is also important for funding responsibility.

8. NAT strongly recommends that Public Health England develop a new national programme for HIV prevention which will allow for research, information exchange and the development of materials to support vital local HIV prevention work.

9. It is vital that the essential elements of an open-access sexual health service be specified by Public Health England so that the same level of service is available across the country.

10. All commissioners and providers of public health services must, in respect of their public health responsibilities, take a "whole population" approach and not discriminate within the local population on the basis of residency status.

11. NAT recommends that the Government retain and develop further a broad and indicative range of public health outcome indicators. We particularly call for the retention in the final Framework of the late HIV diagnosis indicator which will be key to improving the health of HIV positive people and reducing onward transmission.

12. Both in their needs assessments and then in the planning of services, local authorities should be required to demonstrate attention to all key elements of public health (including HIV and sexual health) and to the diversity of the local population (to avoid simply an aggregated or majoritarian approach, which misses concentrations of severe need).

13. There is value in having a ring-fenced budget for public health separate from the NHS and provided to Local Authorities to protect long-term investment in public health from the immediate demands of acute care, however there is also a danger it will act as an artificial "cap" on public health investment where previously there was flexibility within a single local PCT budget to meet treatment and health improvement needs.

14. It would be useful to have clarity as to what should be funded from the local authority health improvement budget, what funded from Public Health England monies allocated elsewhere and what funded from other budgets as part of a wider obligation to promote public health

C. THE CREATION OF PUBLIC HEALTH ENGLAND AND THE ABOLITION OF THE HEALTH PROTECTION AGENCY

15. The creation of a specific body responsible for public health has real potential for bringing about improvements to public health. By bringing together all strands of public health Public Health England will have the ability to see the bigger picture, to consider issues within the wider context, ie how sexual health and HIV relates to education, to drugs and alcohol, to understanding of risk, etc. This wide-angle lens could bring better integration and more joint working which can only be beneficial.

16. However it is important that comprehensive surveillance and a full analysis of data required by both local and national service providers and decision makers continues to be carried out to the high standard currently delivered by the Health Protection Agency (HPA). It would be very helpful if the Committee sought assurances over continuing funding for effective surveillance, that such surveillance will be directed according to public health need rather than political considerations, and that analysis is also undertaken by Public Health England at the national level to identify needs and possibly effective interventions—this is essential for an impactful public health response.

17. It is also important that Public Health England retains a degree of independence from Ministerial intervention. If it is to be part of the Department of Health it will be important to include appropriate safeguards. The current independence of the HPA enables it to carry out its functions without undue influence from Government. It is important that Public Health England is able to make decisions about the best course of action for public health based on evidence and expertise. It is also important that the data collected and collated by Public Health England remains as publicly available and accessible as it currently is under the HPA.

D. THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

18. We are not opposed in principle to an increased role for local government in public health. Indeed it has the potential to allow for greater integration into wider wellbeing issues such as housing, education and social care. However **we have some concerns about whether the political nature of local government will impact on the commissioning of unpopular or controversial issues, such as HIV and sexual health.**

19. It is currently not clear how responsibility for public health will be distributed between the different structures, people and processes proposed in the reforms, such as Directors of Public Health, Health and Wellbeing Boards, HealthWatch, Public Health England, the NHS Commissioning Board and GP Consortia (to name only the key ones). In particular it is important to ensure that the NHS works both to address acute ill-health, and also to prevent future ill-health and promote good health. **Greater clarity is needed as to how at the local level the NHS (for example GP practices) can be required to address identified public health need. This is also important for funding responsibility, to which we return at the end of this submission.**

20. The Joint Strategic Needs Assessment and the Health and Wellbeing Strategy must take account of more than just those areas included in the Public Health Outcomes Framework. As further discussed below, they must also consider the needs of vulnerable groups in the area and health issues specific to the local population (for example HIV prevention needs in areas of high prevalence, or areas with large high risk populations). They should also consider how to ensure that fragmented commissioning structures don't affect the provision of integrated and effective services.

E. ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

21. Public Health England should retain and develop a role to commission certain public health programmes at a national level. It would be useful for the Committee to explore with the Government appropriate health areas for such national work. NAT's view is that such national programmes are particularly important where it appears unlikely that there will be the will or expertise at the local level to meet relevant need. In particular, HIV is a condition which requires a sensitive and complex response, which may not affect many people in some areas but which at the national level is a serious public health threat, and which is vulnerable to prejudice. **NAT strongly recommends that Public Health England develop a new national programme for HIV prevention which will allow for research, information exchange and the development of materials to support vital local HIV prevention work.**

22. Undoubtedly there should be some public health services which should be mandatory. The Government used open-access sexual health services as an example of the type of services that should be mandatory in the white paper and we agree with this. However it is unclear what is meant by and included in these services. **It is vital that the essential elements of an open-access sexual health service be specified by Public Health England so that the same level of service is available across the country.** Comprehensive services must include (but not be limited to):

- (a) rapid, open-access sexual health services (which must include GUM, contraception and abortion),
- (b) specialist and reference services for STI microbiology,

- (c) submission by local services of the range of data required for national and local surveillance to ensure public health strategic planning if informed by current evidence of need,
- (d) and, according to need, community based HIV and STI prevention interventions and testing services.

There must be guidance as to the content of comprehensive sexual health services to ensure consistency and clarity across the country. NAT are concerned at reports that the Government wish to keep to an absolute minimum Public Health England “mandates” or requirements imposed on local authorities as to how they commission public health. But inconsistency is unacceptable when dealing with services which are meeting acute ill-health, such as STI infection, or are addressing the spread of infectious disease in a population.

23. While the majority of the focus of public health appears to be falling to local government it must not be forgotten that GPs still have a role to play in commissioning services relevant to public health. However we are concerned about the definition of the responsibility of GP consortia and how that relates to public health—para.4.50 of the Public Health White Paper reads, “As NHS commissioners, GP consortia will have responsibility for the whole population in their area, including registered patients, unregistered citizens and visitors requiring urgent care”. This is an inadequate remit to encourage the engagement of GPs on “the health of the local population as a whole” particularly in relation to an infectious disease such as HIV which affects people irrespective of their citizenship or residency status. We know of no definition of public health which limits its scope to a particular category of citizens in a particular locality. **It is vital that all commissioners and providers of public health services, in respect of their public health responsibilities, take a “whole population” approach and not discriminate within the local population on the basis of residency status.**

F. THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

24. The emphasis on outcomes in public health is welcome. NAT has concerns over the desire of the Government to reduce significantly the number of public health outcomes from those in their draft consultation document. It should be noted these are not targets but simply collected, published and accessible data (much of which is already available) on the basis of which local populations and stakeholders are meant to consider performance. Given that fact, a limited number of outcomes far from providing real autonomy at the local level, in fact unnecessarily constrains the breadth and flexibility with which local councils can consider need and services. Furthermore, to reduce the number of outcomes for the sake of reducing them, rather than having as many outcomes as is necessary to ensure equitable and high quality public health provision—has the potential to hamper attempts to improve health. **NAT recommends that the Government retain and develop further a broad and indicative range of public health outcome indicators.**

25. We do also have concerns at the end of national targets for achievement locally. In NAT’s experience these have been effective in raising standards across the country (for example in reducing waiting times for GU services). Particular attention needs to be paid to how to incentivise local effective investment in public health given that (with the exception of STI treatment) the direct costs of ill-health arising from the neglect of public health will not be borne by local authorities themselves but by the NHS (in the current system PCTs to a degree pay for the consequences of failures in health promotion by increased secondary care bills).

26. In the Government’s draft consultation document there were three sexual health related outcome indicators relating to teenage pregnancy, Chlamydia diagnosis and late HIV diagnosis, all of which are welcome. **NAT particularly calls for the retention in the final Framework of the late HIV diagnosis indicator which will be key to improving the health of HIV positive people and reducing onward transmission.**

27. We note, however, that there is no currently proposed public health outcome indicator relating to the promotion of safer sex behaviour and the reduction in HIV and STI incidence. One reason for this is simply that it is difficult to identify nationally relevant and available data which could be used for this purpose. But this then highlights a limitation to relying solely on such indicators to incentivise appropriate local health promotion. Available indicators may not map comprehensively onto known public health need. In the absence of a relevant indicator what encouragement will there be for local authorities to invest in HIV prevention in most at risk communities such as gay men and African communities, already too often stigmatised or neglected? In addition to the Public Health Outcomes Framework, Public Health England will need to put in place some essential requirements for, and components of, acceptable and effective public health work at the local level in the mandate given to local authorities. **Both in their needs assessments and then in the planning of services, local authorities should be required to demonstrate attention to all key elements of public health (including HIV and sexual health) and to the diversity of the local population (to avoid simply an aggregated or majoritarian approach, which misses concentrations of severe need).**

G. THE ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES

28. **There is value in having a ring-fenced budget for public health separate from the NHS and provided to Local Authorities to protect long-term investment in public health from the immediate demands of acute care, however there is also a danger it will act as an artificial “cap” on public health investment where previously there was flexibility within a single local PCT budget to meet treatment and health improvement needs.**

29. The danger is especially serious if there is an underestimate of the real costs of public health need and an inadequate ring-fenced budget. NAT has heard concerns as to how public health expenditure has been estimated for the purposes of the planned ring-fenced budget. There are questions as to the boundaries between treatment and care on the one hand, and public health interventions on the other. The NHS and local authorities already fund interventions which have an important public health impact but which are not directly identified as “health improvement”. It will be important that such interventions continue to be funded from outside the specific health improvement ring-fenced budget. There is a danger of arguments between various agencies or bodies as to who (or which budget) is responsible for funding particular public health interventions. **It would be useful to have clarity as to what should be funded from the local authority health improvement budget, what funded from Public Health England monies allocated elsewhere and what funded from other budgets as part of a wider obligation to promote public health.** Within the HIV sector, for example, there has been debate as to who under the new arrangements would fund HIV testing in primary care in high prevalence areas.

June 2011

Written evidence from Jude Williams (PH 112)

This short submission is making the case to:

- increase the assessment of public health work in provider trusts as part of the remit for the Care Quality Commission (CQC) (points 2 to 6);
- utilise the full range of local government functions to improve health and reduce health inequalities through the support of the “in-house” public health team (point 7);
- support the introduction of the Health and Wellbeing Boards, and Health and Wellbeing Strategies based on JSNAs, whilst addressing the need for the board to influence GP Commissioning and visa versa. Ensure the crucial role public health staff could play in this integration including use of the Annual Director of Public Health’s Report (point 8 and 9);
- review the idea of a premium and how that would operate (point 10);
- monitor the impact of the changes on health inequalities (point 11); and
- ensure there is cohesive national support in place for health inequality work going into the future, for both GP Commissioning Consortia and local government (point 12).

1. To give some context to this submission, I worked in the Department of Health (DH) up to 2003. Just before leaving I took a key role in writing the standards for public health, included as one of the seven domains in *Standards for Better Health* (2003), the quality standards for the NHS. I then became Head of Public Health at the Healthcare Commission for six years (2003–09), up until the time it was closed down and its functions were taken into the Care Quality Commission. Over the past two years I have been deputy head of the Health Inequalities National Support Team, which ceased to exist at the end of March 2011.

2. At the Healthcare Commission, I established a small public health team and we developed criteria (in consultation with key stakeholders) for use in core and developmental standards-based annual assessment of all healthcare organisations in England. We ran this assessment process for five years. We assessed the impact of this work and found a noticeable improvement of the quality and quantity of public health work being undertaken by all healthcare organisations.

3. PCT trusts improved their public health planning, partnership and engagement, commissioning and service delivery. Provider trusts improved their public health work, particularly in relation to incorporating one-to-one lifestyle advice in the work of their frontline staff, improving their own staff’s health and an increased participation of partnerships with a focus on health improvement and emergency preparedness. About 30 provider trusts even established public health experts within their staffing. This included, for example, taking the opportunity to do prevention among patients and families of patients to reduce recurrence of diseases, unintentional injury, excess drinking etc. As this work developed, trusts then recognised that “it makes good business sense”.

4. Unfortunately there is currently very little focus on public health in CQC and therefore the driver for more provider trusts to take up this, or a similar approach, has reduced considerably. Whilst it is easy to see how other safety and quality of care issues are their top priorities, if we are to ensure the NHS plays an important role in preventing disease and improving health in the future there needs to be some focus on public health within the national inspectorate and the assessment process. NICE, with their new standard setting duties could be key in supporting CQC in this task.

5. The proposed move of public health teams to local authorities is bold and holds great potential for improvements in health and health inequality outcomes, particularly in relation to the broader determinants of health—provided adequate resources continue to be allocated to this function. It would be a great loss if this were at the expense of losing the NHS potential to maximise the health gain that could be reaped from all their healthcare activity and their large staff groups. Ensuring that CQC has a greater role in relation to public health would help to prevent this.

6. In addition to our assessment work the Healthcare Commission undertook a series of national reviews and reports on public health issues such as obesity (report jointly produced with Audit Commission and National Audit Office), sexual health, tobacco control, unintentional injury and *Are We Choosing Health?*—a review of the impact of 10 years of public health and related policies. By shining a light on specific public health issues we were able, as an independent inspectorate, to consider the issues in order to drive improvement.

The next six points will focus on health inequalities (and therefore drawing on experience gained from the last two years of working in the Health Inequalities National Support Team):

7. A focus on health inequalities brings together health improvement work and access to diagnosis and treatment—ensuring access to health care and health improvement to the most vulnerable. It is important to reap the benefits of the public health team moving to local government, both in relation to the wider determinants of health and in utilising the local government’s deep reach into communities allowing them to support those with the poorest health access necessary health treatment and care (including lifestyle advice).

8. The concept of Health and Wellbeing Boards offers a positive opportunity for health promotion and health inequality interventions that have impact in the short, medium and long term. The development of a Health and Wellbeing Strategy, informed by the Joint Strategic Needs Assessment (JSNA), should be seen as an opportunity to refresh local partnerships. The detail of how the board will influence the GP’s commissioning agenda and visa versa must, however, be strengthened. Otherwise the whole system for delivering population health gain and tackling health inequalities could break into silos.

9. It is important that the move of the public health team to local government doesn’t leave health care commissioning by GPs separated from local Health and Wellbeing Strategies and public health support. Public health staff could be key to this integration but would need greater imperatives than voluntary agreements to ensure they could become effective throughout the country. The Director of Public Health’s Annual Public Health Report could maintain its independence and have a legislative duty to fully report on how the population’s health and health inequalities are improving or deteriorating in light of the local Health and Wellbeing Strategy, and how that relates to the commissioning and provision by all partners in the area. This could be an important component of local accountability necessary in the commissioning and provision of services by GPs.

10. I have concerns about the proposed financial premium based on areas achieving improvement in their life expectancy. This currently appears to give little recognition of where areas are starting from—those that have delivered well in the past might be unable to raise their game as much as previously poor performing areas. It also takes little account of some areas with more transient populations or those suffering the worst impact from the changing economic climate.

11. The impact of the changes on health inequalities between and within local authority areas needs to be closely monitored over the next few years so that adjustments can be made to delivery systems if figures are worrying, albeit acknowledging the difficulty in separating the impact of system failure from the overall public sector cuts.

12. The wide range of public health NSTs closed last March (2011), including the one with a specific focus on health inequalities. I understand that The Healthy Communities Team in LGID is also scheduled to close in the autumn. It will be important that there is cohesive national support in place for health inequality work going into the future, for both GP Commissioning Consortia and local government, with some degree of independence from central government departments. In that way, some of the past models and resources can be used in the new system and as the system develops new learning can be shared between areas.

June 2011

Written evidence from Cambridge Weight Plan (PH 113)

SUMMARY

Cambridge Weight Plan (CWP) offer a number of flexible weight management programmes, which provide the overweight and obese with an effective and sustainable way to achieve a healthy weight. Whilst CWP welcome many of the Government’s plans, we have a number of comments to make:

- Most experts agree that central government, local government and the NHS will all have to work in co-operation to achieve real improvements in public health. The Government recognise this and many of their plans work on the basis that all will co-operate without any friction, but this is by no means guaranteed. It is essential that systems are found to ensure that local government can work successfully with the NHS and that their services complement each other.
- CWP have some concerns over the amount of money allocated to tackling obesity. Considering the vast sums that obesity will end up costing the NHS, we would like more clarity on how the Government’s £4 billion a year for public health will be allocated and reassurances that obesity treatment will be properly funded. This is important given the huge savings that could follow from overweight and obese people successfully managing their weight.

- CWP also question whether the Public Health Outcomes Framework, as per its format in the recent consultation, will successfully achieve its objectives of encouraging better public health in local areas through measuring particular indices. Experience with the QOF has shown that merely measuring the number of obese people in a given area has almost no impact; instead, an Outcomes Framework needs to measure amongst other the number of people treated for obesity, to encourage innovation and the sharing of best practice.

INTRODUCTION

1. Obesity is a major and growing public health problem in the UK. According to data released by the Health and Social Care Information Centre in February 2011, over two thirds of men and half of women in England are overweight or obese. The 2007 Foresight Report on obesity predicted that by 2050 obesity could affect 60% of adult men, 50% of adult women and 25% of children. The resulting costs to the NHS could be in the region of £10 billion a year, with wider costs to society reaching nearly £50 billion a year. This is due to the large number of serious health conditions associated with obesity such as heart disease, type 2 diabetes, stroke and increased risk of cancer.

2. CWP offer a variety of weight management options, including Low Calorie Diet (LCD) and Very Low Calorie Diet (VLCD) programmes, for those who are overweight and clinically obese. They are primarily aimed at those with severe weight problems, typically with a Body Mass Index (BMI) greater than 30.

3. We offer flexible programme options between 415 and 1,500 kcal/day, all using a nutritionally balanced formula food as their foundation. The products contain carefully formulated amounts of energy, protein, carbohydrate, fat, fibre and all essential micro-nutrients, and at least 100% of the RDA of essential vitamins and minerals when used as a VLCD.

4. In addition to the weight loss modules, CWP also provide weight stabilisation and long-term weight maintenance programmes. These are achieved through a gradual re-introduction of different types of food and continuous professional support.

HOW CAMBRIDGE WEIGHT PLAN PROGRAMMES WORK

5. CWP products and programmes are only available through specially trained and accredited Cambridge Consultants, who provide initial screening and advice to clients. The Consultants provide extensive individual and/or group out of hours support, which is a major factor in maintaining motivation and achieving long-term maintenance of weight loss.

6. Protocols are in place to ensure that clients only participate in appropriate programmes, to ensure that they do not have any listed contraindications, and to refer the client to their GP if necessary. All clients are also strongly encouraged to see their GP before commencing a programme.

7. The CWP programmes use a four-stage process: preparation, losing weight, stabilising weight, and weight maintenance.

8. During the **weight loss** stage, clients with one stone or more weight to lose can use a **very low-calorie diet** programme, completely avoiding conventional foods for an appropriate period of time. These are replaced with three or four specially formulated, nutritionally balanced soups, shakes, porridges or meal bars a day. This approach allows participants to take a complete break from traditional food, with which they have a difficult relationship.

9. A **slightly higher energy very low-calorie diet** (615 kcal/day) allows one conventional meal a day. In accordance with the NICE Obesity Guidance, very low-calorie diets can be used for up to 12 weeks at a time.

10. There is a further range of **Low Calorie Diet** programmes, in the range of 810–1200 kcal/day, for people needing to lose less weight or choosing to lose weight more gradually. These programmes use a mixture of CWP products and conventional meals. They are organised into different steps with the number of calories increasing at each step.

11. Following the weight loss stage, weight stabilisation and maintenance is guaranteed through a two-step approach. Different types of food are re-introduced gradually, so that clients do not regain the weight they lost. Once weight has stabilised, continuous professional support is provided to help clients to develop the necessary skills to maintain their weight in the long term. This continued support and use of meal replacements are two of the key elements of successful weight maintenance, as has recently been shown in a one year maintenance trial using Cambridge Weight Plan in Sweden published in the British Medical Journal in June 2011 (Johansson K et al BMJ 2011; 342:d3017)

12. Additionally, clients can follow **Cambridge Active**, a stepped programme of physical activity which encourages them to develop appropriate activity and increase fitness levels. This can range from easy to do stretches to full aerobic movements and pool exercises.

13. CWP would like to thank the Health Select Committee for this opportunity to comment on the Government's public health plans.

The creation of Public Health England within the DH

14. CWP welcome the establishment of Public Health England as a body that has the potential to provide national level advice on options available to health professionals to tackle public health problems and encourage the use of innovative solutions to these problems.

15. Particularly in the field of obesity, CWP believe that Public Health England should not be restricted to merely providing dietary advice. Public Health England should have a broad remit in ensuring that up to date advice on tackling obesity, including advice on private providers, is available to all commissioners. Public Health England should also be able to actively recommend all methods of tackling public health problems, especially when there is a good evidence base to show clinical effectiveness, are considered and used. CWP has sometimes found that cultural barriers amongst health professionals can prevent patients from accessing the best options available to them; indeed CWP have numerous examples in which doctors point blank refuse to cooperate despite the scientific evidence that many people safely and effectively lose weight with CWP programmes. Encouraging professionals to overcome such barriers should therefore be part of the role of Public Health England.

16. In addition, Public Health England is in the best position to ensure that any guidance provided is consistent across the country. This will help to counter some of the inconsistent advice that is provided in the area of obesity, allowing for a more uniform and effective approach in tackling obesity levels across the country.

The public health role of the Secretary of State

17. CWP welcome both the priority accorded to public health and the formation of a Cabinet Sub-Committee on Public Health, as only through working across Government can public health problems effectively be tackled.

18. We are keen to ensure that obesity will be prominent on the public health agenda considering the ever increasing costs that the growing obesity rate will place on the NHS and ultimately the Exchequer. Providing effective solutions in a uniform manner across the country has the potential to significantly reduce the future cost on the NHS of obesity related co-morbidities. In this respect, programmes such as those offered by CWP, which not only help individuals to maintain their weight loss but also encourage personal responsibility, could prove to be a cost-effective alternative to other existing treatments for obesity.

The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)

19. CWP strongly welcome the focus on local authorities working to improve outcomes in their area as it is clear that national level guidance on obesity needs to be complemented by appropriate and relevant involvement of local and national stakeholders. Devolving decisions on local priorities makes sense: numerous studies have linked deprivation to obesity, so poorer areas will require greater focus on obesity.

20. The role of local government in public health should also encourage innovative working and the sharing of best practice, particularly in the treatment of obesity since it is the responsibility for local authorities to commission weight management services.

21. One concern is that the Government's entire strategy rests on close co-operation between local government and the NHS—this is absolutely essential for public health problems to be properly tackled, yet far from guaranteed.

22. Another concern is over the £4 billion ring-fenced public health budget; cash-strapped local authorities may be tempted to look at this ring-fenced budget and push for the broadest definition possible of what public health constitutes. In addition, to be effective, obesity budgets needs to be sufficient to allow for the different options to be effective. Not providing sufficient resources will ultimately reduce the future potential for NHS savings relating to the reduction of obesity linked diseases.

Arrangements for public health involvement in the commissioning of NHS services; arrangements for commissioning public health services

23. A key point to acknowledge here is that GPs need help to commission weight management services. Many GPs are not familiar with treatments available for the obese and consequently do not have the expertise to commission appropriate services (indeed, many GPs are embarrassed to broach the subject with overweight or obese patients in the first place). It is here that guidance from Public Health England and NICE becomes crucial.

24. In terms of obesity treatment, there is also some confusion over responsibility for who does what: Public Health England will provide dietary guidance, responsibility for commissioning surgery and drug treatment for obesity will remain with the NHS, whilst responsibility for weight management—the crucial treatment that fills a therapeutic gap between the above options—rests with local authorities. These confused lines of responsibility require clarification.

25. Nevertheless it is clear that the NHS must be involved in commissioning public health services as it clearly has a stake in their success—it will be the NHS that will remain responsible for treating patients if other public health services fail to prevent and reduce obesity (related to the point above in section 21). The weight management programmes that CWP offer can be provided at different levels of an obesity treatment pathway and the one factor that connects all these levels is the involvement of the NHS.

The structure and purpose of the Public Health Outcomes Framework

26. The Public Health Outcomes Framework is helpful but limited and, on the specific issue of obesity, the Framework is almost certain to fail in the key objective of creating a healthier Britain. The reason for this is that the Framework fails to reward areas that actively take steps to bring obesity rate i.e. through measuring the number of people who lose a percentage of weight over a set time.

27. Experience with the QOF has shown obesity experts that simply registering the number of obese people does almost nothing to help bring down the obesity rate. A better Outcomes Framework would also help local authorities learn from each other and share best practice.

28. Measuring the numbers of people who have lost weight would also target money to those in need: as previously noted, the more deprived the area, the more likely there will be greater numbers of obese people living there.

Arrangements for funding public health services (including the Health Premium)

29. Although CWP welcome the £4bn of ring-fenced money for public health that the Government has promised, we still have a number of concerns. As noted above, the definition of public health can, at times, be a broad one and it is uncertain how funds will be allocated. We are also concerned that treating obesity may not be a high enough priority for this Government and so not enough money will be spent on funding effective obesity treatments. Such treatments would also prove to be highly cost-effective considering the burden that an increasingly overweight UK population will place on the NHS.

30. On other aspects of public health funding, there is a clear case for incentivising Local Authorities to take action against obesity through the judicious use of extra money distributed via a health premium. Targeting this extra money to effective, and cost effective, weight-management services will ensure that the poorest in society are able to lose weight, live healthier lives and ultimately improve their life chances.

31. Programmes such as those offered by CWP, which help individuals to take responsibility for their weight, also help people beyond their weight management issues in taking greater responsibility in other aspects of their lives.

How the Government is responding to the Marmot Review on health inequalities

32. The Marmot Review concludes that “obesity is associated with economic and social deprivation...and is becoming increasingly common”. This makes the Government’s health premium idea extremely welcome, as is the Government’s commitment to maintain ring-fenced spending on public health. Notwithstanding our concerns over this spending, expressed above, in past times of austerity public health spending has to often been the first victim of cuts.

33. As we note, the Government could do more to tackle inequalities through slight adjustments to the Public Health Outcomes Framework. CWP also believe that greater use can be made of innovative ways of funding healthcare, which can reduce inequalities. Increased use of Personal Health Budgets, for example, would enable socially deprived individuals to take greater control over their care and exercise greater choice over who provides this care.

CONCLUSION

34. CWP broadly welcome the Government’s focus on public health and its commitment to ensure that public health services are properly funded. We do however see some problems ahead, in particular the lack of mechanisms to ensure that central and local governments work together, as the Government wishes them too. CWP also question whether the Government is ambitious enough in the outcomes that it has proposed in its Outcomes Framework.

35. There is a lack of clarity around some of the Government’s proposals for public health, and, until the publication of the Government’s obesity strategy, which we expect soon, CWP are unable to comment in more detail on the Government’s plans for tackling this key public health problem.

Written evidence from Breakthrough Breast Cancer (PH 114)

1. INTRODUCTION

1.1 Breakthrough Breast Cancer welcomes the opportunity to submit written evidence to the House of Commons Health Committee Public Health inquiry.

1.2 Breakthrough Breast Cancer is a pioneering charity dedicated to the prevention, treatment and ultimate eradication of breast cancer. We fight on three fronts: research, campaigning and education. Our aim is to bring together the best minds and rally the support of all those whose lives have been, or may one day be, affected by this disease. The result will save lives and change futures—by removing the fear of breast cancer for good.

1.3 Nearly 48,000 women are diagnosed with breast cancer each year in the UK, and over half a million women are now living in the UK following a diagnosis of breast cancer, making it the most common cancer diagnosed and the most prevalent. Over the last 20 years, mortality rates for people diagnosed with breast cancer in the UK have improved significantly, thanks to a combination of better breast awareness, screening and improved treatments, however there is still more to be done.

1.4 This submission reflects the views of Breakthrough, based on our experience of working with people with personal experience of, or who are concerned about, breast cancer. We regularly consult with members of our Campaigns & Advocacy Network (Breakthrough CAN) for their views on a range of breast cancer issues. Breakthrough CAN brings together over 1,500 individuals, regional groups and national organisations to take action locally on our national campaigns to secure important improvements to breast cancer research, treatments and services.

2. THE CREATION OF PUBLIC HEALTH ENGLAND WITHIN THE DEPARTMENT OF HEALTH

2.1 Public Health England must provide credible, strong leadership and overall strategic direction for public health to ensure national and local needs and priorities are balanced.

2.2 Public Health England should take full responsibility for sharing best practice and act as a hub for data and provide guidance for health and wellbeing boards. NHS Evidence, the National Social Marketing Centre and the National Awareness and Early Diagnosis Initiative (NAEDI) for cancer all currently fulfil part of this role, therefore Public Health England should not seek to replicate this work, but to provide links between and join up all the relevant information.

2.3 For Public Health England to fulfil its role in using data to assess needs, set priorities and forecast future requirements for local authorities, learning from the third sector and NAEDI needs to be shared on the effectiveness and cost effectiveness of different activities to improve cancer survival. Additionally, approaches to tackle other diseases need to be shared across the sector. For example, effective initiatives to tackle stroke could be applied to promoting early diagnosis of cancer.

3. THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

3.1 Breakthrough welcomes the whole systems approach to public health, and agrees that local authorities being responsible for tackling the wider determinants of ill health in their populations should see improvements in the health of the nation. However, for this approach to be successful it is critical that the NHS, Adult Social Care and local authorities each carry responsibility and accountability for their areas of work.

3.2 It is essential that all policy areas underpin the planned “life-course” approach. There will be many factors that impact disease risk at different life stages but also in the future. For example, breast cancer prevalence is highest in the over 50s but risk factors act at all stages of life, possibly including *in utero* and in childhood. Therefore, although the “ageing well” group are clearly an important audience for intervening to improve breast screening attendance and encouraging breast awareness, other groups will be important for risk reduction interventions. In particular the “working well” group, whose risk of developing breast cancer will be increasing, are an important audience for behaviour change interventions around risk factors and breast awareness.

3.3 Breakthrough believes that enabling older people to contribute and participate in their community can help address a range of health challenges. It is recognised that one of the reasons why older age groups have lower breast cancer survival rates is because breast cancer tends to be diagnosed at a later stage, when there is less chance of successful treatment. Keeping people connected and active in their community could help tackle this—if opportunities are also taken to encourage breast awareness and breast screening uptake in these age groups. Research has shown that if a woman does not mention a possible breast change to a friend or member of the family, she is less likely to seek medical help.²⁷⁵ Increasing social connectedness within local authorities could help address this, thus reducing inequalities.

4. ARRANGEMENTS FOR PUBLIC HEALTH INVOLVEMENT IN THE COMMISSIONING OF NHS SERVICES

4.1 Breakthrough welcomes Public Health England taking on responsibility for funding and quality assuring the NHS Breast Screening Programme (NHSBSP). Since Public Health England will also manage the design,

²⁷⁵ Macleod, U et al (2009) **101**, S92-S101

the piloting and rolling out of any extensions to the Programme, this should help ensure service consistency, especially regarding implementation of changes to the service.

4.2 However, more clarity is needed on how the NHSBSP and NHS Commissioning Board will work with Cancer Networks, local providers and GP consortia to make sure breast screening is fit for each local population. For example, it is important that access to breast screening in rural areas is considered especially given the ageing rural population. It is also important that current commitments/agreements and partnerships between PCTs, GPs and the NHSBSP are transferred to the new arrangements to ensure consistency of efficient working practices where needed.

4.3 Breakthrough agrees that the public health role of GPs can be strengthened. We have previously suggested future indicators for the Quality and Outcomes Framework (QOF),²⁷⁶ recognising the key role that primary care plays in promoting breast awareness and breast screening:

- playing an active role in encouraging previous non-attenders to attend screening;
- encouraging women over 70 to make their own screening appointment; and
- availability and provision of advice and information relating to breast awareness.

5. ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

5.1 It is essential that Public Health England, health and wellbeing boards and the NHS Commissioning Board design and commission the best possible public health services and outcomes are measured and continue to improve. A role must also be included within the commissioning process role for effective patient and public involvement (PPI).

5.2 Breakthrough recognises the need for flexibility in commissioning to ensure that funding flows are determined by decisions as to how services would be best commissioned. However, more clarity is needed on the extent to which these decisions will be subject to local approaches. For example, where services are best commissioned nationally, or where the NHS Commissioning Board chooses to pass the responsibility down to GP consortia, how will local needs be balanced within a national picture? Given there is no obligation for GP consortia to be co-terminus with local authority boundaries, it is crucial that health and wellbeing boards serve their whole local population.

5.3 Local people should have access to information on public health commissioning arrangements. However, for this transparency to be effective the information needs to be understandable and useful to the public and there needs to be a clear mechanism of action for the public to highlight any concerns on how public health money is spent.

5.4 Breakthrough is particularly pleased that local HealthWatch is included in the minimum membership of health and wellbeing boards. To achieve effective commissioning of public health services, PPI in public health must be robust and meaningful and integrated into the wider set up of the public health system to ensure that the needs and views of people in the community are taken into account. We have previously commented²⁷⁷ that in order to give patients and the public a voice in shaping NHS services, the role of PPI in commissioning should be defined in statute to give Commissioning Consortia a duty to involve patients and the public in the same way the duty was defined for PCTs. We would also argue that the role of PPI should be defined for public health and that “early implementer” health and wellbeing boards will provide an important platform to ensure that PPI mechanisms are enshrined as not just best practice, but essential practice.

6. THE FUTURE OF PUBLIC HEALTH OBSERVATORIES

6.1 A robust evidence base, information and intelligence at national and local level is vital in delivering outcomes as well as running an efficient and effective public health service.

6.2 It is important that data collected by organisations such as the National Cancer Intelligence Network (NCIN) is included in data available to health and wellbeing boards and that the data is used to provide commissioners with good quality information so they are able to make informed decisions about their services.

6.3 In order to be useful in calculating breast cancer survival rates and other important statistics (eg stage at diagnosis) to measure England’s progress on improving cancer outcomes, cancer registration must be complete and accurate.

7. THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

7.1 Breakthrough welcomes the Government’s approach to co-producing the Outcomes Framework with the public health sector and local government. Developing the detailed Public Health Outcomes Framework must involve professionals at all levels, along with patients and the public, carers and representative groups. It is essential that the Outcomes Framework is well designed, and buy-in is achieved at all levels to ensure the

²⁷⁶ Submitted to NICE, Sept 2010 for 2012–13 Quality Outcomes Framework consultation.

²⁷⁷ Health and Social Care Bill, Memorandum submitted by Breakthrough Breast Cancer (HS 45): <http://www.publications.parliament.uk/pa/cm201011/cmpublic/health/memo/m45.htm>

Framework will work for local, regional and national arrangements and that outcomes are measured and continue to improve.

7.2 Breakthrough also welcomes the Government's aim to set out the outcomes for public health at national and local levels. However, it is important to recognise that this focus could very easily become disjointed. Local partnerships must use this framework to develop a comprehensive plan to tackle all public health challenges in their area, and not solely focus on those with direct indicators.

7.3 While Breakthrough also welcomes the flexibility for health and wellbeing boards to go beyond their minimum statutory duty we are concerned that one area is not focussed on to the detriment of others. In addition, outcomes must be coordinated across the NHS, public health and social care in order to be truly meaningful. For example, following patients from breast screening through to swift referral to a specialist breast unit to receiving prompt diagnosis and treatment, plus tailored community support, should result in a better quality of life and improved survival outcome.

7.4 More clarity is needed on how the indicators will develop with progress. It is essential that outcome indicators can evolve over time to take account of new developments but that some core indicators continue to track progress over time. Since any positive impact of changes in public health services will not be seen immediately, and any negative impacts may also not be immediately visible, setting appropriate measures to allow for the continuous monitoring of progress and long-term investment in public health is vital.

7.5 Breakthrough is concerned that action against some of the proposed indicators will not be enough to reduce the incidence of breast cancer in the UK and to decrease mortality.

7.6 For example the proposed measure *D5.5 Mortality rate from cancer in persons less than 75 years of age* will have negative impact on older age groups. Around one third of breast cancers are currently diagnosed in women over 70. Breast cancer survival is lower in the over 70s than in women aged 50–69.²⁷⁸ Older women tend to present later with breast cancer, and are diagnosed at a later stage, thus improvement in this area will improve survival and reduce inequalities. While recognising the complexities of measuring outcomes in older patients due to co-morbidities, Breakthrough would like to see the Outcomes Framework work to improve survival for all women diagnosed with breast cancer, and would like the indicator to reflect the picture of cancer incidence in the UK, by measuring the mortality rate for all patients, not just those under 75.

7.7 In addition, while welcoming the focus to reduce the impact of alcohol related harm, it is important to note that 19% of women drink more than the weekly recommended limit of 14 units.²⁷⁹ Additionally women from higher socio-economic groups, on average drink more per week than those from lower socio-economic groups. Regularly drinking even just one unit per day can increase a woman's risk of breast cancer—The World Cancer Research Fund (WCRF) estimates that 22% of breast cancers can be prevented by not consuming alcohol²⁸⁰—therefore focusing efforts solely on tackling heavy drinking, especially in deprived groups may not impact on overall breast cancer risk and we would like to see this indicator amended so progress will also impact on conditions from long term regular drinking.

7.8 Since breast cancer is the most common cancer in the UK, with nearly 48,000 women diagnosed each year, it is vital that health and wellbeing boards consider the impact of initiatives to tackle alcohol consumption, and also obesity and improving physical activity in reference to reducing breast cancer incidence. Breakthrough recommends women maintain a healthy weight, try to cut down the amount of alcohol they drink and exercise regularly to reduce their risk of developing breast cancer in the future.

8. ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES

8.1 Breakthrough understands the Government's commitment to prioritising public health funding. However, given the current economic climate, and cost reductions and efficiency gains required across the NHS coupled with savings needed across local authorities, Breakthrough is concerned that this provides considerable challenges to delivering the public health agenda. While we support the principle of investing in public health to deliver long term cost savings for health services, Breakthrough would welcome further information about the initial investment in public health and the expected return from this investment.

8.2 The Government's commitment to earlier presentation and diagnosis of disease is particularly welcome. However, it is important that investment in this area is sustained to ensure that people continue to be aware of the signs and symptoms of various conditions and know when to visit their doctor. This is particularly important for conditions such as breast cancer as the earlier breast cancer is diagnosed, the more successful treatment is likely to be. Recent investment in raising cancer awareness, through the £10.75 million signs and symptoms national and local campaigns, focussing on breast, lung and bowel cancers, has been vital in providing impetus for local activities. If these campaigns are shown to be successful, we would like to see a further financial commitment to rolling these out across England in a sustainable manner.

²⁷⁸ <http://info.cancerresearchuk.org/cancerstats/types/breast/survival/#age> accessed 25 March 2011

²⁷⁹ Statistics on Alcohol: England 2010, NHS Information Centre

²⁸⁰ Policy and Action for Cancer Prevention. Food Nutrition and Physical Activity: a global perspective (2009), World Cancer Research Fund/American Institute for Cancer Research.

8.3 Breakthrough would welcome clarity over how the central and local budgets will be rebalanced over time. It is essential that the outcomes framework and the health premium are both robust and responsive so progress can be measured fairly and to ensure the system is sustainable.

8.4 More clarity is needed around how the health premium will be developed and applied. While Breakthrough welcomes the commitment to develop the health premium formula in a transparent and evidence based way, there is a danger that focussing exclusively on reducing inequalities will not improve the health of the nation as a whole. For example, breast cancer incidence is higher in affluent populations, but survival is lower in less affluent groups. Different, and complementary, approaches will therefore be needed to reduce the burden of breast cancer in the different groups, without increasing health inequalities. Additionally all PCTs currently have one year breast cancer survival below that of consensus best practice²⁸¹—improvements are needed in all areas, in addition to those with high areas of deprivation.

9. CONCLUSION

9.1 It is essential that accountability for preventable mortality is shared between the NHS and Public Health Outcomes Frameworks. For example, there is evidence that being “breast aware” (knowing the signs and symptoms of breast cancer and the importance of early presentation) and regularly attending NHS breast screening appointments are two of the three most influential factors on breast cancer survival in the UK (the third being improved treatments).

9.2 It is particularly important to recognise that in order to prevent people from dying prematurely from breast cancer, more needs to be done to promote early diagnosis. In patients with breast cancer it has clearly been shown that delayed diagnosis is associated with poor survival.²⁸² Increasing awareness of the signs and symptoms of breast cancer, the benefits of screening and the importance of early diagnosis is therefore vital for improving outcomes. In addition, whilst it is a positive sign that breast cancer mortality rates in the UK have fallen dramatically, it is important to note that incidence remains high. Ultimately, the biggest savings in breast cancer care would be realised if breast cancer could be prevented or at least if incidence were to decrease.

9.3 Excess mortality from breast cancer in the first few months to one year after diagnosis in England as compared to other European countries can give an indication of success at encouraging early diagnosis of the disease. Excess mortality in the first year after diagnosis in England is still higher than some other European countries²⁸³ and it is estimated that 2,000 deaths from breast cancer each year could be avoided through early diagnosis.²⁸⁴ This is equal to one sixth of the total breast cancer deaths each year in the UK. It is vital that the public health system is designed in the best possible way to give women affected by breast cancer the best chance of survival.

10. Thank you for the opportunity to comment on the consultation on the Health Select Committee Inquiry into Public Health. Breakthrough Breast Cancer is keen to support the work of the Health Select Committee in coming parliamentary sessions through written or oral evidence.

June 2011

Written evidence from Lancashire County Council (PH 115)

- Clarity is urgently needed around the role and accountabilities of Public Health England compared to local authorities.
- Close working relationships with other Government Departments that have an impact on population health will be required if Public Health England (PHE) is created within the DoH.
- For the local public health system to work effectively, the three domains of PH need to be integrated at the local level with the ability to set local priorities.
- The proposed dual accountability of DsPH to local authorities and PHE for different elements of their role is a matter of concern to the County Council.
- It is important that DsPH have the capacity to fully integrate within local authorities and are able to influence the use of wider local authority budgets to maximise their impact on health outcomes.
- Proposals for how Health and Wellbeing Boards (HWB) would be implemented in two tier local authority areas does not seem to have been considered.
- The statutory role of HWB would need to allow sufficient flexibility to enable all partners to agree a local model.
- The Health Bill needs to include a statutory requirement for JSNA data to be shared.
- Joint Health and Wellbeing Strategies should be underpinned by statutory powers.
- The three domains of public health integrated within the local authority would prevent fragmentation of the public health function and promote efficiency.

²⁸¹ Cancer Reform Strategy Achieving local implementation—second annual report (2009) Department of Health

²⁸² Richards, M A (2009). *British Journal of Cancer*, **101** S125-S129

²⁸³ Moller, H, et al (2009) *British Journal of Cancer* **101**, S110-S114

²⁸⁴ M Abdel-Rahman et al (2009), *British Journal of Cancer*, **101**, S115-124

- Local authorities are best placed to commission all children’s public health.
- GP Consortia boards should not replace the HWB.
- The County Council has significant concerns about the loss of regional expertise should PHE take on the role of the Regional Public Health Observatories.
- Children with additional needs and mental health issues need further consideration in the PH Outcomes framework.
- The County Council would like to see the population health measure approach used to determine the allocation of PH resources with a district level population based formula.
- Incentivisation needs to be on as small a geographical area as possible.
- Action to address health inequalities needs a cross-departmental approach to address the wider determinants of health.

1. The creation of Public Health England within the Department of Health

Lancashire County Council (LCC) believes that bringing public health into local government provides important opportunities to align action to improve health status with local authority responsibilities in relation to the wider determinants of health. The creation of PHE within the Department of Health could make it difficult to facilitate a similar approach at a national level, lead to silo working and dilute the potential opportunities created by the reforms. If PHE is created within the DoH, concerted efforts will be required to ensure close working relationships with other Government Departments that have an impact on population health and influence the work of local authorities.

Clarity is urgently needed about the role and accountabilities of Public Health England compared to local authorities.

2. The abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse

The County Council welcomes the streamlining of public health agencies at a national level and the consequent opportunities to align national programmes. However the county council believes that for the local public health system to work effectively, the three domains of public health (health protection, health improvement and health and social service quality) need to be integrated at the local level with the ability to set local priorities. This will require strong *local* relationships with Public Health England’s health protection and substance misuse functions.

3. The public health role of the Secretary Of State

The county council supports the change to the role of the Secretary of State for Health in terms of its wider responsibility and shift of focus to tackling health inequalities and (together with local authorities) protecting and improving public health.

4. The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)

Lancashire County Council warmly welcomes the proposal to transfer responsibility for public health to local authorities and is confident that with support from a Director of Public Health (and his/her team) it can exercise this role effectively.

The county council recognises the influences its own functions have on health outcomes, such as: educational attainment, transport and economic development and in response to this we have recently appointed a Cabinet Member for Health and Wellbeing, (whose portfolio includes oversight of the organisation’s developing public health function). We also recognise the significant impact that functions of district council partners have on health, through housing, planning, environmental health and leisure provision.

5. Arrangements for the appointment of Directors of Public Health

The joint appointment of the DPH between the county council and PHE will provide the local authority with specialist public health expertise to ensure it maximises the impact of its services and commissioning on population health and wellbeing. It will also enable public health skills and tools to be used to improve the effectiveness of wider local authority interventions. This will require the three domains of public health to remain integrated at the local level.

The proposed dual accountability of DsPH to local authorities and Public Health England for different elements of their role is a matter of concern to the county council and we seek clarity on how this will work in practice.

Local authorities will need the support and skills of public health professionals in order to carry out our new responsibilities and capitalise on the opportunities to integrate public health with our existing responsibilities. We will need to be assured that this will be prioritised by the DPH under the proposed arrangements. It is

therefore important that DsPH have the capacity to fully integrate within local authorities and are able to influence the use of wider local authority budgets to maximise their impact on health outcomes.

Local authorities will need to be fully involved in the appointment of the DPH. We should be free to decide for ourselves the most appropriate location for the DPH within the organisation to ensure s/he can provide strong leadership and influence across the full range of local authority decisions that impact on population health and wellbeing.

6. Role of Health and Wellbeing Boards

Lancashire County Council supports the establishment of a Health and Wellbeing Board (HWB) and agrees with the proposed role and remit of the Board. We also agree that it should be established on an upper tier local authority footprint, as this is the most appropriate level to enable integration of social care, public health and NHS commissioning plans. We agree that the Board should be established on a statutory basis and, given its system management role, its **levers** and **governance** will have to be as robust as possible.

The White Paper's proposals for how HWBs would be implemented in two tier local authority areas does not seem to have been considered: for example a county-wide HWB, whilst essential for providing a strategic oversight and aligning commissioning priorities, would have a very large membership if it were to involve all relevant partners. It might also be perceived as being distant from some of our local communities. We therefore welcome the opportunity to design our own health partnership system that can carry out the functions of a HWB, and which has the Board at its heart.

The Board should take a cradle to grave approach to health and ensure that links are made to existing arrangements, eg Children's Trusts, in order to be able to fulfil its role of joining up commissioning plans. Both tiers of local government in Lancashire make a significant contribution to, and impact on, health. Whilst we agree with the statutory role of the HWB it would need to allow sufficient flexibility to enable all partners to agree a local model that can operate effectively to meet the needs of the people in Lancashire.

7. Joint strategic needs assessments

We welcome the centrality of the JSNA to the role of the HWB, and the proposed duty on GP commissioning consortia to contribute to its production.

In Lancashire we have a particular approach to health intelligence which aims to develop a culture of intelligence, make intelligence widely available, and empower commissioners and communities to use the intelligence to inform decisions.

A good JSNA should consider the needs of different equality and diversity groups (beyond those enshrined in legislation). The Health Bill therefore needs to include a statutory requirement to share data, including individual data, as necessary across partners to overcome any additional unnecessary barriers to effective integrated working.

8. Joint Health and Wellbeing Strategies

Lancashire County Council fully supports the proposal to develop Joint Health and Wellbeing Strategies (JHWS). The county council is well placed to build on the good practice already in place in Lancashire and has been working with partners to improve health and reduce health inequalities for some time. The JHWS will provide a vehicle to escalate this to the levels needed to create better health outcomes for all. We feel that this responsibility should be underpinned by statutory powers (with minimal statutory requirements) with a duty to cooperate for all partners to ensure the alignment of priorities. This will also help to ensure that key partners such as GP consortia work closely with local authorities when identifying their commissioning priorities.

9. Arrangements for public health involvement in the commissioning of NHS services

The county council would like to see the three domains of public health, including support to NHS commissioning, integrated within the local authority public health function. This will prevent the fragmentation of specialist public health skills needed to support all domains (eg intelligence, research and development and social marketing) and will maximise efficiency. It will also enable health improvement and health protection measures to be integrated into NHS commissioning.

10. Arrangements for commissioning public health services

A number of the proposals for the commissioning of public health service create considerable risk of system fragmentation. For example we are very concerned that the proposals that children's public health interventions for the under 5's are commissioned by the NHS commissioning board, yet those for school age children be commissioned by local authorities, will undermine the potential to streamline services for the 0-19 population. Local authorities are best placed to commission all children's public health and to align it with our wider responsibilities for children and young people. Local authorities are also better placed than the NHS

commissioning board to commission public health for those in prison or custody to enable integration with offender management programmes and our wider community safety responsibilities.

11. *GP Consortia*

Consortia will need access to specialist public health advice to inform effective public health commissioning. This should be provided through an integrated local public health service based within local government.

We support the suggestions from some quarters to increase transparency and democratic legitimacy in relation to consortia decision making. One way of doing this might be to include elected members on consortia boards. However, we feel strongly that even with the membership of elected members, GP consortia boards should not replace the HWB, whose role is to manage the whole health and wellbeing commissioning system, rather than make decisions about which NHS services should be commissioned.

If they are to have elected members of their boards, consortia will need to clearly understand members' constitutional responsibilities (what individual councillors can and can't commit to on behalf of their local authority). Their main role should be to reflect the views of the authority and to act as community champions, based on their detailed knowledge of, and legitimate advocacy role in relation to, their constituents. Members of the consortia boards will need support to achieve this understanding, and elected members will need support in order to effectively apply their democratic role to health service commissioning.

Consortia should be required to demonstrate that they are acting in partnership with local authorities in order to be established and approved by National Commissioning Board. It is vital that the consortia maintain an appropriate level of engagement with local government and other partners, including involvement in the Health and Wellbeing Board. Individually local authority representatives on the commissioning consortia boards will aid this, but should not become a substitute for it.

12. *Health and Wellbeing Boards*

Led by Local Authorities, the HWBs (with membership from Local HealthWatch), will play a vital role in supporting local authorities, consortia and the NHS Commissioning Board to make effective commissioning decisions informed by public insight. Seldom heard groups need support to contribute to the commissioning process. The contribution of children and young people will be essential in articulating their health needs.

13. *The future of the Public Health Observatories*

The County Council has some significant concerns about the loss of regional expertise should Public Health England take on the role of the Regional Public Health Observatories.

There are potential resource implications about PHE's capacity to respond and provide the technical expertise and high quality intelligence about the health of local populations. Having this level of skill and expertise at a regional level is ideal as it is concentrated enough to have the expertise but local enough to understand local issues, to influence regional policy and improve understanding amongst local clinicians and commissioners of population health.

The County Council is also concerned that PHE will not provide the breadth and depth of data to inform local intelligence operations. We have already seen the removal of, and reduction in, data provision due to the government's proposals and actions. We fear that the shift to PHE will result in a similar reduction in the data made available to us.

14. *The structure and purpose of the Public Health Outcomes Framework*

We feel that the public health outcomes framework has limited focus on issues related to children and young people. Although, there are some domains where outcomes for children and young people are included, this is not true across all domains and is particularly concerning for children and young people with additional needs. We also feel that mental health is not explicitly reflected as a priority within the five domains identified for the outcomes framework.

15. *Arrangements for funding public health services*

In determining the allocation of public health resources, focus should be on population need, rather than the way resources have been used previously. We would strongly advocate that the population health measure approach is adopted to determine the allocation of public health resources. However as deprivation is a key determinant of health need we would prefer a district level population based formula which is sensitive to variations in deprivation in large areas such as Lancashire. This approach would not penalise deprived areas who have effectively improved health outcomes to date, and would reflect a focus on wider determinants of health.

Local Authorities working with partners through the Health and Wellbeing Board should have the flexibility to spend any health premium awarded on any activity that they consider will improve their priority health outcomes and reduce health inequalities.

Incentivisation through the health premium needs to be based on as small a geographical area as possible, otherwise the shortcomings of the spearhead system will be replicated i.e. small pockets of deprivation in otherwise affluent areas will be forgotten. A purely geographical approach to incentivisation will not reduce inequalities between population groups which fall within the definition of, “protected characteristics”. Indeed, financially rewarding areas with better health can be perverse, as it is those areas with the highest level of need that will need the greatest capacity to improve the public’s health.

The county council welcomes the possibility of the Health and Wellbeing having responsibility for any place-based budgets for health improvement. We feel that the use of the ring-fenced public health budget should not be limited to a narrow definition of “public health” but should be able to be used to fund action to address the wider determinants of health. It will be critical to the success of new structures that public health principles are embedded in all services that contribute to health outcomes at the commissioning level.

16. *The future of the public health workforce*

Lancashire County Council believes that the integration of training between the NHS and local authority staff whose role involves social care, health policy and strategy or primary prevention is essential in order to support integration of public health into health and care delivery and to improve outcomes for communities, service users and patients.

The transfer of responsibilities for public health to local government, which we fully support, will create significant training requirements for existing public health and local government staff as well as elected members. The professional training requirements of public health staff operating within a local government environment will need to be addressed, as will equity of access to public health training for staff currently within local government. This is likely to be challenging in current financial circumstances.

Lancashire County Council agrees with the Local Government Information Unit that in terms of advice and leadership the skills of all public health, social care and associated local authority professionals need to be recognised, as well as those of the medical profession. In Lancashire for example we have recognised that wherever it is located, public health provides an essential bridge between local authorities and the NHS, which must not be lost as a result of the new arrangements. We are happy to report that many of our emerging GP consortia recognise the value of public health skills to support their commissioning responsibilities, particularly their ability to provide a population perspective and advice on primary prevention of ill-health.

17. *How the Government is responding to the Marmot Review on health inequalities*

The government should recognise that action to address health inequalities needs a cross-departmental approach and it must support interventions within the NHS and those that address the wider determinants of health—such as housing, working conditions and early childhood education. In our view this is not well reflected in *Healthy Lives Healthy People*.

The Government must also commit to long term investment in initiatives to tackle health inequalities as these do not produce instant returns. It is imperative that politicians continue to support the reduction of inequalities as a goal, even if the outcomes might not be achieved within a political term.

June 2011

Written evidence from Cancer Research UK (PH 116)

BACKGROUND INFORMATION

1. Cancer Research UK is the world’s largest independent organisation dedicated to cancer research; in 2009–10 we spent £334 million on research. We receive no government funding for our research. Our vision is that “Together we will beat cancer”. We carry out world-class research to improve our understanding of cancer and to find out how to prevent, diagnose and treat different types of the disease. Around 300,000 people are diagnosed with cancer in the UK every year. And every year more than 150,000 people die from the disease.

EXECUTIVE SUMMARY

2. The determinants of public health are varied as are the necessary interventions to tackle ill health. Those directly responsible for delivering public health must be able to work with those in the NHS, social care and other relevant areas of government to effectively tackle public health problems and to promote cancer prevention and early diagnosis. The transfer of health improvement to local government has a number of merits:

- More of the determinants of public health are in the control of local councils and many of the solutions need local adaptation.
- It engages politicians in public health and this can be a driver for action in services while public health measures sometimes need political skills to be delivered.

- It creates local focus. For example, most of the tools for reducing smoking levels will be delivered by the local authority with a stronger sense of ownership: NHS Stop Smoking Services, trading standards enforcement of smokefree legislation and age-limits and activity in schools.

3. However, Cancer Research UK is concerned that with the changes to the structure of the NHS and public health in England, partnership working could suffer. It is vital that the delivery of public health initiatives do not suffer whilst relationships between GPs and local authorities are being built. The NHS and Public Health England will need to work together to continue to improve awareness and early diagnosis of cancer. Whilst the outcomes framework acknowledges the importance of joint working and collaboration there is little detail in the document about how this will work in practice to support the prevention and diagnosis of cancer and how specifically it will be encouraged.

4. GPs will need to be made aware that they continue to play a role in improving the public health of England. This will include encouraging patients to take up screening and understanding the key role they play in raising awareness and the early diagnosis of cancer.

5. GPs will also have an important role to play as commissioners of preventative health in secondary care.

6. Directors of Public Health must have the necessary skills and experience for this demanding and important job and they must be in a senior enough position to enable them to enact change within their areas and not just act as advisors to local authorities. They should also have control of an adequate ring-fenced budget for health improvement to ensure that it is not squeezed by local authorities.

7. To improve public health, the government must put effective tobacco control measures at the heart of any public health strategy.

8. We are concerned that proposals for a health premium could lead to inequalities in some of the most deprived areas being reinforced. These areas may be penalised for failing to improve public health against the agreed set of public health outcomes.

9. We would also welcome further details about how best practice in public health will be evaluated and the structures which will be developed to share this information so that it won't be duplicated in the future.

10. In the response below, we have focused our efforts where we feel our expertise is strongest.

THE ROLE OF GPs IN PUBLIC HEALTH

11. GPs play a key role in formulating local public health strategy. In particular, GPs should play a specific role in encouraging patients to participate in the bowel cancer screening programme. Early indications from the bowel cancer screening programme suggest that men and those in the most deprived groups are less likely to participate in bowel cancer screening than women and more affluent people.²⁸⁵ Efforts should be made to encourage greater participation and GPs should play a role in this.

12. GPs also play an important role with brief interventions to promote smoking cessation, which have been shown to be highly cost effective.²⁸⁶ Such interventions should be actively encouraged among GPs on issues with the strongest evidence base and extended to other areas of preventative health as the evidence base develops.

13. Cancer is a complex condition and a cancer patient will require the support of different aspects of the health service throughout their treatment and care. We are concerned that the reform to public health will risk fragmenting cancer services, at least in the short term and there is a risk that efforts to improve the early diagnosis of cancer will be fragmented.

14. Currently, GPs have working relationships with public health specialists at PCTs, giving them access to information about local initiatives in health promotion and prevention. The loss of PCTs and the delivery of these services by local authorities could potentially weaken this link, particularly in the short term. It takes time to build relationships across organisations and teams who often have very different professional backgrounds.

15. Public Health England and the NHS need to work very closely to drive improvements in the earlier diagnosis of cancer. Our concern is that this will not happen unless both parts of the service are jointly incentivised to promote early diagnosis. We would like assurances that this will be taken seriously and closely monitored.

16. Public health expertise must be embedded in GP-led commissioning consortia. The strategic input of public health professionals is essential to ensure that services are commissioned to meet the needs of the whole population.

²⁸⁵ Von Wagner C et al (2011) Inequalities in participation in an organised national colorectal cancer screening programme: results from the first 2.6 million invitations in England. *Int J Epidemiol.* 2011 Feb 17. <http://www.ncbi.nlm.nih.gov/pubmed/21330344>

²⁸⁶ NICE (2006) Brief interventions and referral for smoking cessation in primary care and other settings

DIRECTORS OF PUBLIC HEALTH

17. It will be very important that Directors of Public Health (DsPH) retain their independence and ability to advocate on the basis of their expertise as their role may sometimes be unpopular and may bring them into conflict with local politicians. It is important that they have the necessary skills and experience needed for this demanding and important job and are in a senior enough position to enable them to enact change within their areas and not just act as advisors to local authorities. They must have access to senior decision makers within local government, be able to influence commissioning decisions and be able to manage the ring-fenced public health budget.

18. Given the important role and wide range of responsibilities that the DPH has it is vital that they have support from public health specialists with appropriate skills and expertise. There is a risk that public health expertise which has been developed in Primary Care Trusts could be lost when they are abolished in 2013. Steps should be taken now to ensure that public health experts are retained during the transfer to local authorities to avoid a potential vacuum in knowledge.

A RING-FENCED BUDGET

19. If DsPH and local authorities are to deliver public health gains it is vital that they have an adequate budget for health improvement. We welcome the decision to have a ring-fenced public health budget. This will be particularly important as in previous times of budget constraint public health budgets have been historically used to shore up acute services. However, it is important that local authorities do not use the public health budget to fund services and activities that were previously funded from existing council budgets. The DPH should have responsibility for the budget at a local level to ensure it is spent on public health priorities and not raided for short-term political demands.

TOBACCO CONTROL

20. To improve public health, the government must put effective tobacco control measures at the heart of any public health strategy. As the government's tobacco control plan rightly acknowledged, tobacco use remains one of our most significant public health challenges, accounting for more than 80,000 deaths in England in 2009.²⁸⁷ To tackle this challenge, local authorities must ensure adequate resource for tobacco control and smoking cessation activities.

21. Smoking is also the single biggest cause of inequalities in death rates between the lowest and highest income groups—smoking-related death rates are two to three times higher in low-income groups than in wealthier social groups.²⁸⁸ Tobacco control measures are therefore essential to tackle health inequalities. Smoking prevalence and prevention should be key components within the public health outcomes framework.

22. The experience of tobacco control in recent years has also demonstrated the significant benefits of investment at a sub-national level rather than local areas working in isolation.

23. The Regional Tobacco Policy Managers which up until April 2010 were based in each of the regional Government Offices in England, and the Regional Offices of Tobacco control in the North East, North West and South West of England, which were established and continue to be run with PCT funding, have clearly demonstrated the value of coordinating communications and marketing of cessation services for greater impact and cost effectiveness.

24. However, the abolition of PCTs and the migration of public health funding and responsibilities to local authorities pose a risk to the future of these collaborative organisations. Despite acknowledging the value of such interventions being commissioned and delivered at a higher level in its national tobacco control plan for England, the public health reforms in general and the tobacco control plan in particular provide little encouragement for such cooperation.

25. The Government should give clearer encouragement for bodies to commission jointly on a larger geographical scale where this provides better value.

THE PUBLIC HEALTH OUTCOMES FRAMEWORK

26. If the government is to achieve its aim of making England's cancer outcomes among the best in Europe and saving an extra 5,000 lives by 2014–15—as set out in *Improving Outcomes: A Strategy for Cancer*—it is vital that early diagnosis including screening are prioritised by both those working in the NHS and public health. There must be a strong focus in both the public health outcomes framework and the NHS outcomes framework on early diagnosis of cancer. As patients diagnosed later are less likely to live to one year, one year survival trends can prove a good proxy measure for the later diagnosis of cancer. An indicator that measures the number of patients surviving cancer one year after diagnosis must be added to the outcomes framework.

²⁸⁷ Department of Health (2011) *Healthy Lives, Healthy People: A Tobacco Control Plan for England*

²⁸⁸ The Marmot review (2010), *Fair Society, Healthy Lives*, p145

TACKLING INEQUALITIES AND THE HEALTH PREMIUM

27. In recent years, policies to reduce health inequalities have focused predominantly on encouraging people to change their behaviour. Whilst we agree that it is important for people to take responsibility for their health, the government also has a responsibility to address the wider social problems that are linked to this behaviour. We know that people face many complex difficulties and challenges in their lives that make it difficult for them to change their behaviours. In order to narrow health inequalities the government must address the wider determinants of health inequalities such as unemployment, stressful work conditions, and poor quality housing.

28. Because of the complex nature in which people's choices are structured, the acceptance and uptake of healthier behaviours as a result of public health initiatives is likely to be more difficult in more deprived areas. Focusing the health premium on health improvement rather than need may have the perverse effect of penalising the communities where need is greatest. The government should carefully consider how to design the health premium to protect against this. One way would be to link the health premium to tackling the wider determinants of health (domain 2) rather than healthy behaviours (domain 3). The Marmot review recommended that interventions should have a health equity impact assessment rather than a focus on individual behaviours and lifestyle.²⁸⁹

29. It is also important to bear in mind that the Marmot review was based on a principle of proportionate universalism—to reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. Whilst it is tempting to focus limited resources on those most in need, this will only tackle a small part of the problem.²⁹⁰

30. As the Marmot review highlighted, tobacco control should be central to any strategy to tackle health inequalities. Smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups and smoking-related death rates are two to three times higher in low-income groups than in wealthier social groups.²⁹¹ Smoking prevalence and prevention should be key components within the health premium. The “national ambitions” in the recently published tobacco control plan should be incorporated into the outcomes framework, including the ambition on youth smoking rates.

31. Tackling obesity and alcohol misuse are also necessary to reducing health inequalities. Individuals from lower socio-economic groups are more likely to be overweight or obese than those who are more affluent²⁹² and whilst those in lower socio-economic groups drink less than their better off counterparts, harm from alcohol consumption disproportionately affects the poorest in society. Prevalence of healthy weight in adults and children and indicators that account for alcohol-related harm should also be included in the health premium.

SHARING INFORMATION AND BEST PRACTICE

32. We welcome the role Public Health England will have in drawing together information into a more coherent form so that it will be easily available for those who will use it and more likely to be used. The most important principle for this function will be transparency as this will help reduce duplication in public health research and provide information about current research.

33. It will be particularly important for Public Health England to develop systems and networks to encourage the greater dissemination, sharing and cascading of research. We also recommend that there should be key leads in each local authority with responsibility for disseminating good practice.

34. Public Health England should identify and map current gaps in public health research and develop a strategy to commission and carry out this work. This could include:

- Identifying gaps in behavioural economics research.
- Evidence and research for when greater levels of intervention should take place, in line with the Nuffield Council on Bioethics intervention ladder.
- Developing criteria for how the health premium will be shared between local authorities.
- Guidance on local incentive schemes to encourage smoking cessation.
- Models for maximising the impact of social networks promoting healthy behaviours.
- Guidance on the local promotion of social norms that foster healthy behaviours.
- A report on the scope of applying highly effective strategies for changing youth attitudes such as the Truth Campaign.²⁹³
- An evidence base on the role of media representations of unhealthy behaviours.

35. Public involvement in the design and implementation of behaviour change policy interventions is vital as these are measures which require public support to be effective and cost-effective to implement. Voluntary and community organisations can be supported in using high quality research to articulate the needs of users.

²⁸⁹ The Marmot review (2010), Fair Society, Healthy Lives

²⁹⁰ The Marmot review (2010), Fair Society, Healthy Lives

²⁹¹ The Marmot review (2010), Fair Society, Healthy Lives, p145

²⁹² Summerfield C, Babb P (eds), Social Trends No. 34. ONS 2004

²⁹³ <http://www.thetruth.com/>

36. Local partners can engage in local qualitative research to understand the needs and attitudes of the population. For example, a screening programme for oral cancer was carried out in the Bangladeshi community in East London between 2006 and 2008.²⁹⁴ The research set out guidance on the development and promotion of oral cancer screening activity among the Bangladeshi community and the development of accompanying oral cancer awareness literature as well as criteria for screening, the development of referral pathways and determination of inclusion criteria. The project demonstrated the feasibility and acceptability of oral cancer screening using a mobile dental unit among the Bangladeshi community of Tower Hamlets.

June 2011

Written evidence from the National Cancer Intelligence Network (PH 117)

SUMMARY

1. The National Cancer Intelligence Network (NCIN) was established in 2008 as part of the implementation of the Cancer Reform Strategy. Its role is to coordinate national developments in information and intelligence, and it has a key role in the oversight of the regional cancer registries in England.

2. The National Cancer Intelligence Network (NCIN) is a partnership organisation, funded largely through the DH in England, with substantial investment from Macmillan Cancer Support, and further investment from Cancer Research UK.

3. The NCIN is located alongside the National Cancer Action Team (NCAT), and reports to the National Cancer Director, the DH Cancer Programme Board and the Board of the National Cancer Research Institute (NCRI).

4. The NCIN has already succeeded in improving the collection and coordination of information by bringing together data specialists, organisations and datasets and linking clinical, demographic and performance data from a range of sources. This has resulted in the generation of new analyses and insights, as well as the provision of clearer and more accessible information for cancer commissioners.

5. The information collected by cancer registries, Hospital Episode Statistics (HES), the cancer waiting times database and national clinical audits is largely complementary. Linkage of these datasets has enabled important new analyses to be undertaken, which would previously have been impossible.

6. The relationship between the NCIN and the regional cancer registries is key in ensuring continued improvements in consistency of data is exploited at the national level to drive outcomes and deliver for the requirements of cancer patients within the information revolution.

7. The NCIN works closely with other key national areas of cancer planning and delivery, in NCAT. There will need to be continued strong working links between NCAT and the NCIN once the NCIN moves to PHE and the NCAT moves into the NHS Commissioning Board. The role played by the National Cancer Director in having oversight of these two domains will be crucial.

INTRODUCTION TO THE SUBMITTER

Chris Carrigan is the head of the National Coordinating Team of the National Cancer Intelligence Network (NCIN). His role is to lead, steer and develop the structure, composition and outputs of the NCIN, which launched in June 2008.

Sitting within the umbrella of the National Cancer Research Institute, the NCIN is a UK-wide initiative working to drive improvements in standards of cancer care and outcomes by improving and using the information collected about cancer patients for analysis, publication and research.

FACTUAL INFORMATION

8. The National Cancer Intelligence Network (NCIN) was launched in June 2008 as part of the implementation of the Cancer Reform Strategy. The NCIN brings together epidemiologists from the eight regional cancer registries in England and the Office for National Statistics (ONS), leading clinicians and experts in the analysis of large administrative datasets (eg Hospital Episode Statistics—HES).

9. The NCIN oversees and works closely with the regional and national cancer registries in the UK, and in particular in England.

10. The NCIN receives the bulk of its funding from the Department of Health, with NHS London acting as the financial host organisation. In 2010–11 the allocation was £4.2 million. In 2011–12 the proposed allocation is reduced to £3.55 million.

²⁹⁴ Nunn H, Lalli A, Fortune F, Croucher R (2009) Oral cancer screening in the Bangladeshi community of Tower Hamlets: a social model British Journal of Cancer (2009) 101, S68–S72

11. From 2011–12 onwards, Macmillan Cancer Support have committed to fund up to £0.5 million per year. Further funding to cover a post dedicated to enabling research is received from Cancer Research UK, the MRC, the National Cancer Research Network and the NCRI.

12. At the end of 2010–11 the central NCIN Coordinating Team had a headcount of 16.6 WTE, comprising staff employed by a range of organisations within the network.

13. The NCIN funds a range of work across the network, mainly with the regional cancer registries in England. The NCIN funds 13 specialist “cancer lead area” roles, spread across the registries. Each lead area role receives an allocation of £100k.

14. The NCIN also resources the building and maintenance of several national analytical resources and toolsets, including the National Cancer Data Repository, the National Cancer Information Service, the Cancer e-atlas and the Cancer Commissioning Toolkit.

CORE ROLES AND FUNCTIONS OF THE NCIN

15. The NCIN links the information collected by cancer registries with HES, the cancer waiting times database and cancer screening. Linkage of these national datasets has enabled important new analyses to be undertaken, which would previously have been impossible.

16. Key analyses undertaken by NCIN since launching in June 2008 include:

- Cancer incidence and survival by ethnic group.
- Major resection rates by cancer site and age.
- Incidence and mortality by gender for cancers affecting both men and women.
- Mortality trends by age group.
- Overall prevalence of cancer, and prevalence by age and cancer site.
- Trends in admissions, lengths of stay and bed utilisation by cancer patients.
- Numbers of patients presenting as emergencies by cancer site, and the impact of emergency presentation of survival.

17. The NCIN also has a major role in making information on all aspects of cancer available to commissioners and to NHS providers through the Cancer Commissioning Toolkit.

18. The NCIN has worked closely with cancer registries in England to deliver year on year improvements in timeliness of registration. From 2011–12 the NCIN will begin to take a stronger role in the management of the contract for cancer registration as part of the transition of registries and NCIN into the new PHE framework.

19. The NCIN funds 13 clinical reference groups, and funds a distributed national analytical infrastructure to support the analytical requirements of these groups. This distributed infrastructure is based in the regional cancer registries in England.

20. The NCIN aims and objectives cover five core areas to improve the quality and availability of cancer data from its collection to use:

- Promoting efficient and effective data collection throughout the cancer journey.
- Providing a common national repository for cancer datasets.
- Producing expert analyses, to monitor patterns of cancer care.
- Exploiting information to drive improvements in cancer care and clinical outcomes.
- Enabling use of cancer information to support audit and research programmes.

THE ROLE OF THE NCIN IN THE NEW NHS

21. The work being done by the NCIN is at the forefront of two of the key strands of Liberating the NHS: The Information Revolution and the Focus on Outcomes.

22. The NCIN will continue to develop closer integration and links with the NHS Information Centre, to ensure the IC role (to collect and supply national data and statistical information in health and social care) is augmented by the NCIN.

23. The NCIN will further develop and establish its role as the primary source of data on cancer services. As part of the Information Revolution, and in support of the overall transparency agenda, information will be made openly available such that other organisations, including charities, are at liberty to present information as they wish.

24. The NCIN needs to continue to collate and publish high quality information on different aspects of cancer services and ensure that it is used to support decision making by the NHS and patients and those seeking to scrutinise the quality of cancer services.

25. Working with and across the cancer registries, the NCIN will develop and manage a single national integrated work programme for cancer intelligence. This programme will be a significant asset to PHE and will enable transition into PHE to progress more smoothly.

26. The relationship between the NCIN and the regional cancer registries is key (both for data and analysis).

RISKS

27. As with any transition and period of uncertainty, retaining key people is an important factor to ensure continuity and to provide a solid platform from which to build. There are particular difficulties in this area within the NCIN and across the registries which are hosted by SHAs or PCTs. It is becoming increasingly difficult to renew key contracts of employment, or place new contracts beyond March 2012.

28. The enviable position of the NCIN, sitting beneath the National Cancer Director and alongside other key areas of cancer delivery (in particular the National Cancer Action Team and Cancer Peer Review) must be recognised in the new PHE structure. The strengths of this relationship must be maintained and built upon. This could prove challenging in a period of major change and uncertainty.

29. The NCIN has always been seen with a high level of “ownership” by the cancer community, and in particular by the NCRI Partners, by the major cancer charities and by the national patient and consumer groups. With this “ownership” has come strong support across the community, which has enabled the NCIN to develop quickly and flexibly.

30. Unless the cancer registries within PHE are able to continue to work in partnership with the NCIN and be commissioned to undertake work (eg lead areas) then there is a risk to NCIN’s work.

31. The NCIN role spans the breadth of cancer intelligence. It is important that the benefits of the move to PHE embrace and further develop the role of the NCIN to continue to support public health intelligence, service monitoring and outcomes and further drive use of cancer data for research (with NCRI partners).

June 2011

Written evidence from the Optical Confederation (PH 118)

SUMMARY

- We are strongly concerned about the omission of eye health in the Government’s *Healthy Lives, Healthy People* strategy. This is a major oversight and a missed opportunity;
- According to the RNIB, the number of people with partial sight or blindness is set to increase by 115% to nearly four million people by 2050. Furthermore, 100 people start to lose their sight every day and at least 50% of this is preventable.²⁹⁵
- The gravity of the challenge facing the public’s eye health has also been well illustrated by Professor Nick Bosanquet in his recent report, *Liberating the NHS: Eye Care—Making a Reality of Equity and Excellence*.²⁹⁶
- Given such a rise in the levels of avoidable sight loss, which place a huge burden not only on the individual, but also on the NHS and social care services, this major public health challenge must be addressed as part of the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategies.
- We strongly believe that reducing avoidable sight loss should be included as an indicator in Domain 4, “Prevention of ill-health”, of the public health outcomes framework.

INTRODUCTION

1. This document sets out the response of the Optical Confederation to the Health Select Committee inquiry into public health. It builds on information already submitted to the Department of Health’s consultations on public health.

2. The Optical Confederation represents the 12,000 optometrists, the 6,000 dispensing opticians and 7,000 optical businesses in the UK who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of the five optical representative bodies: the Association of British Dispensing Opticians (ABDO); the Association of Contact Lens Manufacturers (ACLM); the Association of Optometrists (AOP); the Federation of Manufacturing Opticians (FMO) and the Federation of Ophthalmic and Dispensing Opticians (FODO).

²⁹⁵ Access Economics (2009) *Future sight loss UK (1): The economic impact of partial sight and blindness in the UK adult population*

²⁹⁶ Bosanquet, N, *Liberating the NHS: Eye Care—Making a reality of Equity and Excellence*, Dec 2010, Annex 1: Public Eye Health Need—a more detailed analysis, pages 27–32
<http://www.library.nhs.uk/eyes/viewResource.aspx?resid=398122&code=d53b5f8d6ffa145955849a86f586fb74>

3. Our policies have long been the promotion of eye health for all and the prevention of avoidable blindness and sight loss. As part of this, we are delighted to be active members of the Eye Health Alliance, a coalition of professional and patients groups, which campaigns to reduce avoidable sight loss in the UK. The Confederation is also a member of Vision 2020 UK and the cross-sectoral UK Vision Strategy (a Vision 2020 UK initiative led by the Royal National Institute for Blind People and involving all four UK Governments). We therefore comment from the perspectives of our eye care patients and as providers of community eye care services.

4. In eye care, early detection and timely intervention are key both to the prevention of visual impairment and blindness and to avoiding significant downstream costs for both NHS and social services. We hope therefore that the Government will ensure that this important public health challenge features high on the *Healthy People, Healthy Lives* agenda. In particular, this would be welcome in the areas of low vision, visual impairment and blindness support where so much more can be done to promote needs of people with visual impairment.

5. As is now formally recognised in the UK Vision Strategy, (April 2008) the most effective public health intervention for eye health is regular sight testing, especially for the most at risk groups. This enables treatable pathologies to be picked up and addressed at an early stage before they become sight threatening. With some eye conditions such as glaucoma (tunnel vision), waiting until the patient has started to notice a problem with their eyesight is usually too late as the permanent damage has been done and any sight loss that has occurred cannot be restored.

6. The risks of visual impairment and blindness are also correlated with ethnic origin, health and social inequalities, where lack of information and late presentation are major problems. This increased risk of visual impairment among minority ethnic groups is examined in detail in a recent report by Access Economics (2009)²⁹⁷ [see pages 30–32 for details]. The Public Health Service also therefore needs to focus on increasing access and take up of preventable health services, such as the sight testing service, for disadvantaged or hard to reach groups, as well as those most at risk of treatable eye conditions such as older people.

7. People need information not only about the availability of services but also the benefits of services or treatments. Many people are unaware that a sight test can detect other health problems, such as diabetes, high blood pressure and even brain tumours. Targeted public health promotion campaigns are therefore important. Public health and reducing health inequalities should not be confined to health policy. Working across government to assist in these campaigns can ensure a more targeted approach. For example, when a person receives is contacted about their state pension or benefits, they should be informed of their entitlement to a NHS Sight Test and of the health benefits of regular sight tests. This would be an effective way to reach people at a very minimal cost.

8. The gravity of the challenge facing the public's eye health has also been well illustrated by Professor Nick Bosanquet in his recent report, *Liberating the NHS: Eye Care—Making a Reality of Equity and Excellence*.²⁹⁸

FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

9. We welcome the Government's aims for a new Public Health Service and for a new role for local authorities in promoting public health. However, we feel that the omission of eye health in the *Healthy Lives, Healthy People* strategy is a major oversight which needs to be rectified by the Department of Health.

10. As previously mentioned, given the levels of avoidable sight loss, placing a huge burden not only on the individual, but also on the NHS and social care services, this major public health challenge must be part of the JSNA and the local health and wellbeing strategies.

ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

11. We support the Government's proposal that screening services, including diabetic retinopathy screening, be commissioned on behalf of Public Health England via the NHS Commissioning Board.²⁹⁹

STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

12. As the Government noted in *Healthy Lives, Healthy People*, the success of the Outcomes Framework will depend on a real shared endeavour at the local and regional level. We support the Government's aim to unlock synergies with the wider role of local authorities in tackling the determinants of ill-health and health inequalities. We also support the proposal to ensure that Directors of Public Health posts are joint appointments between the new Public Health Service and Local Authorities.

²⁹⁷ Access Economics (2009) *Future sight loss UK (1): The economic impact of partial sight and blindness in the UK adult population*

²⁹⁸ Bosanquet, N, *Liberating the NHS: Eye Care—Making a reality of Equity and Excellence*, Dec 2010, Annex 1: Public Eye Health Need—a more detailed analysis, pages 27–32
<http://www.library.nhs.uk/eyes/viewResource.aspx?resid=398122&code=d53b5f8d6ffa145955849a86f586fb74>

²⁹⁹ "*Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health*", Department of Health, Dec 2011.

13. In terms of local eye health services, Local Optical Committees (LOCs)³⁰⁰ are well placed in the community with the necessary public health skills to aid front-line delivery to patients.³⁰¹ Moreover, LOCs must be involved in the planning and commissioning of local eye care services. They will be able to share their expertise and help elected representatives and officials, as well as GP Commissioners, prepare for their roles in public health. This shared endeavour will be vital to improve the eye health of the local population.

14. We would like to see this local partnership in eye care reinforced by a specific indicator that aims to protect the nation's eye health, specifically one to reduce avoidable sight loss as an indicator in Domain 4, "Prevention of ill-health", of the public health outcomes framework.

15. Increasing the uptake of regular sight tests is an evidence based intervention. Our recommended indicator relates to a major public health issue and improving on this would seriously reduce health inequalities. An indicator of reducing avoidable sight loss would be meaningful to the public and the public health workforce, given that losing your sight is as feared, if not more so than, contracting some terminal illnesses such as cancer.³⁰² It would be possible to set SMART objectives, by targeting those most at risk of eye conditions, such as those from BME groups and older people. Progress on monitoring a reduction in the level of avoidable blindness could be measured in the short and medium term by referring to the register of blind and visually impaired people.

16. An indicator to reduce preventable sight loss would indeed promote a life course approach to public health. Regular sight tests, especially for at risk groups, can detect preventable eye conditions and facilitates prompt treatment (which is known to improve outcomes for many eye conditions). Moreover regular sight tests allow people to have appropriate visual correction to go about their daily lives, for example, ensuring drivers have good vision to drive safely. It is also important for people to be encouraged to eat healthily, in order to help prevent diseases such as macular degeneration.³⁰³ It is generally recommended that adults should have a sight test every two years, unless advised otherwise by your optometrist.

17. The impacts of sight loss on older people are well documented, including the role uncorrected visual problems play in falls³⁰⁴ and performance of daily tasks. In addition, access to school screening services has been increasingly squeezed to the point where we now have large numbers of school children with uncorrected refractive error and children growing into adulthood with correctable squint and amblyopia with all the implications this can have for educational achievement and social inclusion.³⁰⁵

ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES

18. We support the proposal that screening programmes, including diabetic retinopathy screening, will be commissioned nationally.

June 2011

Written evidence from the Public Health Directorate, NHS Rotherham (PH 119)

Please find below the collective submission for evidence from the Public Health Directorate within NHS Rotherham. We welcome the opportunity to express our opinions to the Committee and consider the points which follow.

THE CREATION OF PUBLIC HEALTH ENGLAND WITHIN THE DEPARTMENT OF HEALTH

1. We support the creation of Public Health England, but feel that it would be a stronger and more effective organisation if it were independent of the Department of Health. The Health and Social Care Bill is aiming to reduce political micromanagement and ministerial influence in NHS decision making, but establishing Public Health England *within* the Department would appear to go counter to these aims.

2. We support the proposal made by McKee et al (*The Lancet*, 28 February 2011 doi:10.1016/S0140-6736(11)60241-9) to establish Public Health England as a special health authority or an arms length body and for all existing public health staff to be employed within Public Health England with some seconded to work within local authorities. Employment of the existing non medical public health workforce by Public Health England would help ensure the continuity of skills and expertise developed over many years in the

³⁰⁰ LOCs are statutory bodies which were established to represent the views of contractors and eye health professionals locally, as well as to give advice to commissioning groups on optical matters. As expert local committees they are funded entirely by contractors at no cost to the NHS.

³⁰¹ A shared agenda in the new world: The role of GP consortia and public health in improving health and wellbeing and delivering effective health care—Final Report of a National Colloquium, February 2011, page 8 <http://www.sph.nhs.uk/sph-documents/gp-colloquium-final-report-1>

³⁰² Survey carried out by the American Foundation for the Blind (2007) www.afb.org

³⁰³ Macular Disease Society, <http://www.maculardisease.org/page.asp?section=220§ionTitle=Nutrition>

³⁰⁴ Studies have shown that falls can be reduced by as much as 14% when visual impairment is considered as part of a falls reduction plan (Day L, Filders B, Gordon I et al, *Randomised factorial trial of falls prevention among older people living in their own homes*, *BMJ*, 325: 128, 2002)

³⁰⁵ De Zoete, H, *Children's Eye Health, A report on vision screening for Children*, Oct 2007

NHS, avoid the public health workforce being split into silos and create a workforce that is more flexible and responsive to local need.

THE ABOLITION OF THE HEALTH PROTECTION AGENCY AND THE NATIONAL TREATMENT AGENCY FOR SUBSTANCE MISUSE THE PUBLIC HEALTH ROLE OF THE SECRETARY OF STATE

The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies):

3. We support a greater involvement of the local government in public health activity, but in the same way as Public Health England should be free of political interference, so should local public health teams. By transferring public health staff contracts to an independent Public Health England and then second the most appropriate people into the local authority would ensure a greater level of independence and that public health professionals can continue to advocate for the improved health of the population, regardless of the current political control within the authority.

4. The Director of Public Health must retain an influential role in decisions about public health activity and how the ring-fenced grant can be spent. It is important, therefore, that this post is given sufficient authority. Whilst we support the joint appointment of DsPH between Public Health England and the local authorities, we do not feel that in time of significant organisational change, that all DPH posts should automatically be re-recruited, but that contracts be transferred and the joint appointments process be applied as when DPH posts become vacant. If there is a concern that this process could allow ineffective postholders to remain in place, then robust processes should be developed so both employing organisations understand their responsibilities for addressing individual performance management.

5. We support the establishment of Health and Wellbeing Boards as the strategic body to direct public health priorities. We feel that clinical representation from GP consortia should be mandatory (guidance requires consortia representation, but doesn't specify that it include a clinician).

6. The Health and Social Care Bill requires commissioners to "have regard" to the JSNA and health and wellbeing strategy, but we feel that this is too imprecise; a commissioner could legitimately claim to have "had regard" to the documents and still ignore their content. The board should have sufficient authority to demand explanations from commissioners when decisions do not follow the requirements of the JSNA or joint health and wellbeing strategy and require their attendance before the local authority's scrutiny committee. We believe there must be a clear process of signing off both Social Service and GP commissioning plans.

7. The whole of NHS and Social Care funding needs directing to Public Health not simply service provision.

8. The local Health and Wellbeing Strategy should provide an important framework for how the ring-fenced public health grant can be spent to ensure continuity and strategic direction during transition. It would also remove the risk of the grant being diverted to uses with no clearly defined role in improving public health and the reduction of health inequalities.

ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

9. In almost all areas of public health there is a split between elements best commissioned by Local Authorities, those best commissioned by the NHS and those best commissioned by the Commissioning Board. It will be hard to identify where the boundaries should fall between the different commissioners, and could easily result in tensions between commissioners as they attempt to provide a fair, equitable and effective balance of services and outcomes. For example, who is responsible for commissioning pharmaceutical provision required to support a public health programme (such as nicotine replacement therapy for stop smoking services, or long acting reversible contraception for sexual health services) and would its funding sit within the public health ring fence?

10. Further clarity around the future location emergency planning function is needed. Whichever body is responsible for local emergency planning needs to have qualified officers to develop the plans and arrangements and assist the commissioners so that contracts are robust during an emergency. Qualified emergency planning staff need to review contractors' emergency and business continuity plans to ensure they are resilient, compliant and aligned to the business continuity regulations.

THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

11. The most important indicators are those that have the greatest potential to reduce health inequalities. Whilst some will be relevant across the Country, it could be argued that a local authority should be measured on a proportion of locally determined indicators. The final framework should be a compilation of mandatory indicators with a selection of optional indicators to reflect the local need identified within the JSNA.

12. The proposed domains encompass the key areas of public health and reflect health inequalities. A point for clarification regards which organisation with public health responsibility will be leading on, and responsible for the commissioning of activity for each domain.

13. The proposal to share the domain on preventable mortality is a valid suggestion which will require the wider NHS workforce to focus on the prevention agenda, the use of the Prevention and Lifestyle Behaviour Change Competence Framework would be a useful framework for considering in relation to the wider workforce being capable and competent to support this agenda.

ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES (INCLUDING THE HEALTH PREMIUM)

14. Public Health Services:

The Director of Public Health must retain an influential role in decisions about how the funding can be spent during the transition period, and beyond in conjunction with a robust Health and Wellbeing Strategy providing the strategic framework for continuity and negating the risk of funding being diverted to uses with no clearly defined role in health improvement and the reduction in health inequalities.

15. Public Health funding should be retained for health improvement and reduction in health inequalities and not used to bolster existing local authority public health provision, for example environmental health and trading standards enforcement.

16. The Health Premium:

The premium could be structured so that the different outcomes attract different levels of premium, with significantly larger sums associated with the indicators that are more challenging, but demonstrate progress towards reducing health inequalities.

17. The allocation of health premium could also be linked to the delivery of targeted high impact interventions that tackle some of the key issues exacerbating health inequalities in particular communities, based on the needs identified in the JSNA.

18. A note of caution, linking outcomes and the health premium needs to be considered and managed to avoid non-incentivised issues becoming devalued. There is a concern that incentivising some indicators could be to the detriment of others. Similarly, if the JSNA identifies key local priorities for which there is no indicator, consideration needs to be given to how this is addressed.

THE FUTURE OF THE PUBLIC HEALTH WORKFORCE (INCLUDING REGULATION OF PUBLIC HEALTH PROFESSIONALS)

19. Avoid the loss of significant public health expertise (particularly in the sphere of health improvement / health promotion) which is feared as a result of the abolition of PCTs. The public health workforce has already been depleted through the process of reducing management costs in PCTs and could not be further reduced without having a detrimental effect on its ability to carry out the necessary activity. Capacity to deliver will be challenged if we can't recruit and develop our talent.

20. Recognition needs to be given to the wider Public Health Workforce for their skills and professionalism. There is a concern that in the proposed transition to Local Authorities the public health workforce could be seen as surplus to requirements, the Local Government Association response the Public Health White paper made it apparent that the budget was an attractive proposition, not the workforce.

HOW THE GOVERNMENT IS RESPONDING THE MARMOT REVIEW ON HEALTH INEQUALITIES

21. We would hope to see cross party support for the aims expressed in the Marmot Review.

June 2011

Written evidence from Dr Andrew Clark and Dr Cathy Read (PH 120)

EXECUTIVE SUMMARY

- There remains a lack of clarity about what central government expects from local authorities and where accountability lies. This is a key issue in the wider localism debate and we suggest should be addressed in this context.
- We believe the transfer of public health expertise into local government should increase capability and boost the confidence of local authorities in their ability to tackle complex issues of public health and wellbeing. It also presents an opportunity for local communities, through the council, to support the whole of primary care to be more accountable.
- We believe it is important that the director of public health is a direct report to the chief executive.
- Public health teams within primary care trusts currently can play a leading role in improving clinical pathways and clinical services. Moving public health expertise into local authorities could create gaps elsewhere. This needs to be acknowledged and addressed, either by building capacity within the NHS or accessing those skills in local authorities, or possibly, Public Health England.

- We believe the proposed transfer of commissioning responsibility for NHS Health Check Programme and for sexual health services carries significant risks to success.
- The proposed outcomes framework is very important. Key to its successful operation will be the selection of the correct contemporary proxy indicators for future improved health outcomes of less or delayed onset of diseases and much better management of those with established morbidity. Reliable data collection is an issue to resolve.
- The link between public health adult social care and NHS outcomes is useful. It would also be useful to have an equivalent framework for children and young people.
- Relatively few of the proposed indicators in the consultation document are available at a geography lower than local authority. Wherever possible, indicators in the outcomes framework should be available at a lower level as this is potentially more useful to health and wellbeing boards.
- A considerable amount of the approach set out by Sir Michael Marmot is recognisable in Government policy but policy development and implementation of supporting initiatives does not appear to be even across the key objective areas.

DR ANDREW READ AND DR CATHY READ

1. Andrew Clark trained at the Middlesex Hospital in London. He was a GP principal in a group practice, a GP tutor and a District Health Authority Board GP member. As Senior Medical Officer in the NHS Executive his main role was supporting the development of the national GP contract, focussing on changes to GP out-of-hours care. He has worked as a consultant and director of public health, including time as the Public Health Director of the North West Cervical Screening Quality Assurance Reference Centre. Currently Deputy Director of Public Health for NHS Yorkshire and the Humber, his role includes the provision of public health support for performance management and professional advice to the serious untoward incident team. He is the SHA clinical lead for the national screening programmes, the NHS Health Check programme and specialist public health aspects of health protection.

2. Cathy Read FFPH has 15 years experience of public health in the Yorkshire region. She is currently Consultant in Public Health at NHS Yorkshire and the Humber, focusing on health inequalities and sexual health. She previously held various jobs in medicine and spent 10 years working as a journalist and editor. She has contributed to research on social capital and health and access to health care and is an Honorary Senior Clinical Lecturer at Sheffield University.

THE PUBLIC HEALTH ROLE OF THE SECRETARY OF STATE

3. The stated intention to focus on cross-government action for public health is welcome, particularly if this is informed by the full scope of the Marmot Review and is not limited in practice to issues like obesity—important though this is. It will be interesting to see how the cross-cabinet committee mechanism and the new public health focus of the Department operate in relation to the reform of the benefits system, and informs policy development in key public health issues such as alcohol, food and transport for example.

4. On accountability, there remains a lack of clarity about what central government expects from local authorities and ultimately responsibility. We are aware this is one of the knotty problems of the whole “localism” debate and is exercising many others, including the Public Accounts Committee and the Communities and Local Government Committee. We note that the latter has suggested the development of a constitutional settlement as a potential way forward and suggest that the respective roles and responsibilities of the Secretary of State and local authorities in relation to public health should be part of these discussions.

THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

5. The move to return leadership to local authorities is welcome. We believe it strengthens capacity and capability to respond to the challenge, particularly in relation to action on health inequalities. Having a much-enhanced level of public health expertise in-house should offer greater scope for more systematic action on the social determinants of health as well as in relation to the commissioning and scrutiny of clinical services.

6. We believe the knowledge, skills and expertise of directors of public health and their teams can make a positive contribution to the functioning of the wider council—techniques such as health needs, health impact assessment and equity assessments, for example, their approach to the use of evidence of effectiveness, evaluation skills, their knowledge and understanding of clinical environments.

7. We believe this should increase capability and boost the confidence of local authorities in their ability to tackle complex issues of public health and wellbeing. It also presents an opportunity for local communities, through the council, to support the whole of primary care to be more accountable in a way that has simply not been possible before, in respect of their service provision, use of resources such as hospital planned and unplanned referrals and prescribing costs and practice population outcomes in early diagnosis and long term condition management.

8. Given the sensitivity and complexity of the above we are very concerned that some of this potential is much less likely to be realised if the director of public health does not have sufficient seniority to access and

influence lead members and chief officers across the organisation. We believe it is important that the director of public health is a direct report to the chief executive.

9. In relation to joint strategic needs assessment and effective health and wellbeing boards and strategies, we would like to draw attention to a small but significant data issue. It will be a real advance if public health teams can have access to up-to-date outcome data from practices. One regular frustration is reliance on “old” QOF data for planning, which was devised as payment system for GPs. In public health terms an important element of securing better health will be much better outcomes in populations with long term conditions such as diabetes, cardiovascular, and respiratory diseases etc. We are aware of some exciting pilot work in Lancashire and the Black Country and elsewhere. In these areas practices are using common software in relation to long term condition management and mid life health checks that supports better management by the practice, allows their primary care trusts to undertake data analysis at population level and offers great prospects for improved planning and management support systems for people with long term conditions within individual communities.

10. While we believe there is a need for greater clarity on local to national accountability, we are also aware of much debate around accountabilities to and between member of health and wellbeing boards. Equally important will be how the local health and social care providers interact and support each other. This includes the very important contribution from the voluntary sector and unpaid carers. The presence of Health Watch England will add to this.

ARRANGEMENTS FOR PUBLIC HEALTH INVOLVEMENT IN THE COMMISSIONING OF NHS SERVICES

11. Most GPs are not trained in public health and most of their professional career is spent dealing with individuals and their health problems. Their previous involvement in NHS commissioning such as GP Fund holding has usually been centred on commissioning of specific procedures such as hernia repair, hip replacements etc. At the time these systems were evolving into a broader more population approach to NHS commissioning through GP Multifunds, Primary Care Groups and Primary Care Trusts. However none of these commissioning models have been significantly public health focussed. They have not been required to and so are not used to taking a population focus. In our experience in Yorkshire and the Humber, GP consortia members recognise this and initial thinking is that they will probably look to the director of public health for some level of advice and support.

12. What is probably less widely seen is the contribution public health teams within primary care trusts currently make to improving clinical pathways and clinical services. eg diabetes management in Barnsley, circulatory disease in Sheffield, the earlier detection of lung cancer in Doncaster and glaucoma in Leeds.

13. Moving all public health expertise into local authorities could create gaps elsewhere. This needs to be acknowledged and addressed, either by building capacity within the NHS or accessing those skills in local authorities, or possibly, Public Health England (PHE). In addition, the source of specialist public health elements of the, so far, largely unspecified GP Consortia Commissioning Support provision. However there are real risks to maintaining the speciality’s current high quality and value for money by dispersing a relatively scarce public health expert resource in this way.

14. It would be sensible if best use was made of accredited public health specialists in local PHE and in the DPH teams to cover these areas. In this regard it is so far unclear how the NHS Commissioning Board (NHSCB) and DH Policy teams will be obtaining its specialist public health expert advice.

15. This analysis indicates that best economies of scale and maintenance of a wide range of high quality public health specialist expertise to support commissioning in these different arenas could well require joint appointments between PHE and Local Authority Public Health Teams. This would build on existing examples of effective integrated commissioning such as Sheffield’s commissioning group for long term conditions, which draws on expertise from public health, working with acute and primary care, or the neighbourhood adult health teams, which integrate commissioning for health and adult social care in Leeds.

ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

16. We do believe the proposed transfer of commissioning responsibility for NHS Health Check Programme and for sexual health services carries significant risks to its success.

17. The NHS Health Check is a new and complex universal system to prevent, or delay the onset of, or diagnose early vascular diseases in the target population. It is essentially a systematic case finding programme very analogous to the current national screening programmes. Commissioning strategies to deliver a cost effective and safe service are still in their infancy. Commissioning the NHS Health Check Programme, in a manner that gets it successfully and safely established, should remain within the purview of the NHS Commissioning Board at least until the completion of full roll-out in 2017.

18. The proposed fragmentation of sexual health commissioning runs counter to considerable recent efforts and some success in integrating sexual health provision. Fragmented commissioning is not efficient and could result in either duplication or gaps in service for vulnerable people. These are highly specialised clinical services which local authorities do not have experience of commissioning. If they are going to buy in services they may duplicate effort where supra-local authority commissioning could be more efficient. From our

experience even specialist PCT staff have benefited from a range of intermediate tier level support and strategic leadership from the HPA, SHA, NCSP and DH. Sexually transmitted infections do not respect local authority boundaries and it is critical to have a supra local authority perspective as well as understanding variation within a local area. Services must be open access and universal and not subject to the preferences of local politicians facing difficult funding decisions. This would erode the founding principles of the NHS, worsen health inequalities and would almost certainly breach the requirements of the Equalities Act as some of those most vulnerable and able to benefit from appropriate outreach services belong to the protected groups. In our experience strong local sexual health networks which are clinically led are critical to making progress and controlling sexually transmitted infections. A commissioning model which harnessed this energy and expertise would strengthen rather than weaken the current approach. If Public Health England were given responsibility for sexual health and delegated this locally to an appropriate commissioner, meeting specified quality standards, then this could get around concerns that some local authorities may not do the job well.

THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

19. We welcome the principle and regard it as very important, while appreciating that this is an area where there is much work to be done. The key, in our view, is for the selection of the correct contemporary indicators for future improved health outcomes of less or delayed onset of diseases and much better management of those with established morbidity. A key issue to be resolved is how to reliably collect the necessary data.

20. The link between public health adult social care and NHS outcomes is useful. It would be useful to have an equivalent framework for children and young people, reflecting the significance of services and actions to improve their health and development, the contribution improvement here will make to the reduction of inequalities and reflect the role of the directors of children's services in local health and wellbeing boards.

21. Relatively few of the proposed indicators in the consultation document are available at a geography lower than local authority. We would like to suggest that, wherever possible, indicators in the outcomes framework should be available at a lower level eg post code, as this is potentially more useful to health and wellbeing boards, in understanding and reducing inequalities within their areas. This approach could also create a stronger link between local strategies and the outcomes framework nationally.

22. We have been able to produce profiles on the wider determinants of health for each upper tier local authority in Yorkshire and Humber, containing slope indices of inequality. These show the degree of inequality within a locality on the topic and where inequality is relatively greater. Indicators covered include all age, all cause mortality, early years foundation stage development, child poverty, educational achievement at GCSE, long term unemployment, job vacancies, civic participation, housing condition and fuel poverty.

23. Again we believe the potential of GP systems to support and complement this "lower level" analysis is significant. Such an approach could well be found to be of great importance to GP consortia as they tackle their health improvement programmes to secure the very significant reductions in planned and unplanned care that the NHS QIPP³⁰⁶ programme demands.

ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES

24. We are pleased at the recognition that, in the past, public health has often been "raided" to fund other parts of the NHS, but we are aware of the anomaly of ring fencing when the direction of travel is generally to remove ring-fences from local authority budgets. More worrying is the potential that the ring-fenced budget alone is seen as the public health budget, rather than the transfer of what we calculate the NHS currently spends on direct public health services and not reflecting local authority spend on the wider determinants such as housing.

25. These are all public health programmes based on population based data, hence the importance of public health expertise in its commissioning.

THE FUTURE OF THE PUBLIC HEALTH WORKFORCE

26. Many colleagues have a role in public health but we believe it is important that the high quality of public health specialist expertise is maintained and improved. The mandatory nature of professional accreditation for specialist public health practice must be maintained. This needs to continue to be delivered by current regulatory processes being used by whoever employs the public health specialist. PHE should have responsibility, along with the Faculty of Public Health, for assuring the high quality of specialist public health practice through common recruitment processes as well as regular appraisal and revalidation systems.

HOW THE GOVERNMENT IS RESPONDING TO THE MARMOT REVIEW ON HEALTH INEQUALITIES

27. Sir Michael Marmot presented his findings to senior leaders in local government and the NHS across Yorkshire and the Humber. His arguments struck a strong chord with many and over the following months many have used the full Marmot framework to take forward their work on inequalities. These include Barnsley, Calderdale, Rotherham, and Sheffield.

³⁰⁶ Quality, Innovation, Productivity, Prevention

28. The Government stated that the public health white paper set out how it wished the Marmot Review evidence to be taken forward. A considerable amount of the approach set out by Sir Michael Marmot is recognisable in Government policy, for example the cross government working and the focus on social justice. Some recommendations of the review have emerged as prominent elements of policy, for example, the welcome expansion of health visitor numbers and the roll out of the Family Nurse Partnership programme.

29. However, policy development and implementation of supporting initiatives does not appear to be even across the key objective areas. For example, we have heard local evidence about the increasing numbers of families under financial stress and increasing numbers experiencing fuel poverty. A recent study by Salford University, on behalf of Leeds City Council, found that on measures such as level of indebtedness, ability to save, use of non-mainstream credit, areas with average levels of household income surveyed in 2010, were found to be more financially excluded than deprived areas studied in 2004.³⁰⁷

June 2011

Written evidence from HK Consulting (PH 121)

HK Consulting specialise in strategic commissioning and partnerships between the NHS, local authorities and wider voluntary and private sector partners to drive improvement. We welcome this opportunity to submit evidence to the Health Select Committee's inquiry into public health.

1. EXECUTIVE SUMMARY

HK Consulting broadly support the Government's proposals that place responsibility for local health and wellbeing and the reduction of health inequalities within local government, and are strongly supportive of the Government's proposed role for the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies. HKC agree public health is a vital but often neglected aspect of the National Health Service; the financial constraints on public sector spending, coupled with an ageing population mean that it is more important than ever to identify opportunities for early intervention, effective methods of prevention, and innovative investment and delivery mechanisms.

HKC does however have concerns about local partners' ability to realise the full potential of the process without adequate support and capacity. The level of current development and capacity building support offered to the new leaders through transition appears inadequate compared to the scale of the challenges. Our experience shows that without effective leadership and support, this new opportunity to address entrenched health inequalities and poor outcomes through the development of new partnerships is unlikely to be properly exploited.

2. JOINT STRATEGIC NEEDS ASSESSMENTS

2.1 HKC supports the new central role of the Joint Strategic Needs Assessment to public health investment but has concerns about how ready public health teams are—especially in light of organisational changes—to realise the system-wide expectations now placed on them and the JSNA.

2.2 Through their JSNA, a leading cohort of areas have created shared, evidence based strategic priority setting processes through their JSNAs, asked tough questions about poor outcomes and system failure, driven real change across public services demonstrated by improved outcomes. Many areas have shown sophisticated high-level needs assessment are not only manageable but realise tangible benefits across the wider statutory and non-statutory sector, extending beyond the traditional realms of health and social care.

2.3 In contrast, a significant number of areas have struggled to provide quality insight into poor outcomes and local priority issues around health and wellbeing. The JSNA has struggled to connect with existing strategic planning and commissioning processes and has little or no impact on decision-making outside traditional health and care settings. This is often a result of poor leadership, limited resources, and siloed working, and historically was exacerbated by competing demands of divergent regulatory frameworks.

2.4 HKC considers this is a critical time for public health where the opportunity to lead a process that helps to drive a real change and tackles the most persistent of health inequalities is waiting to be seized. However, low morale and a reduction of capacity and status of many public health professionals brought on by organisational change may make the local JSNA and Joint Health and Wellbeing Strategy (JHWS) processes a poisoned chalice for those "in the day job". Without the necessary tools, learning processes and improvement programmes, the increasingly contentious and political nature of priority setting processes may prove overwhelming for officer-level staff. It is clear the Department of Health, national improvements agencies and others need to continue to provide support to help areas to fully realise the opportunities of the new system.

3. PUBLIC HEALTH OBSERVATORIES

3.1 HKC considers public health observatories to be an integral part of the public health service and recognises the key role they play in collecting the data, intelligence and evidence base that form such an

³⁰⁷ Dayson K and Vik P Evolution of Financial Exclusion in Leeds since 2004 Leeds 2011.

integral part of the strategic approach needed to address persistent health inequalities. HKC is concerned about the reduction in the core contribution for each observatory and the removal of funding for the Association of Public Health Observatories.

3.2 A reduction in funding would impact on skills and capacity of public health observatories to support public health delivery, encourage the perverse consequence of the duplication at a local level and miss big picture analysis. There is also a danger the skills and capacity of Public Health Observatories in developing specialised public health best practice and evidence of effectiveness will also be lost.

4. PUBLIC OUTCOMES FRAMEWORKS

4.1 Policy makers must remain cautious that outcomes frameworks across health, social care and public health do not become a goal in themselves and tick box exercise; a lesson from the past is that siloed national level assessment frameworks ride roughshod over the necessary “give and take” at the heart of robust local partnerships and integrated working. There must therefore be crystal clarity that local priority setting generated by quality JSNA/JHWS processes have clear parity with national targets where there is an incontrovertible local narrative. However, in HKC’s view the fundamental question of local versus national persists; government and policy-makers must show absolute commitment to recognising legitimacy of local decision-making alongside national outcomes frameworks.

4.2 Further, HKC considers the importance of alignment between of the Outcomes Frameworks for adult social care, the NHS and public health to be paramount to guard against competing interest and divergent criteria across the system. HKC understands that different services face competing priorities and accountability structures and it is important the new outcomes frameworks are sufficiently complementary so as to support and facilitate enhanced integration and shared priorities. There must be sufficient interplay between the public health outcomes framework and the NHS and adult social care frameworks to allow partners to work together in an effective and innovative way.

5. RESPONDING TO MARMOT

5.1 HKC considers the new and central role for the JSNA and JHWS and the duty to commission with regard to them will help progress the recommendations of the Marmot Review. The increasingly prominent role of the community and voluntary sector in the JSNA/JHWS processes should ensure the voice of hard-to-reach and seldom heard groups is heard and considered in strategic planning and commissioning.

6. CONCLUSION

6.1 HKC supports the Government’s view that persistent health inequalities are best addressed via strategic commissioning informed by a JSNA and JHWS. It is right the strategies are produced by a health and wellbeing board that brings together all health, public health and social care commissioners to agree overarching priorities and subsequent actions.

6.2 HKC is, however, concerned that policy-makers are pushing ahead with a process that transfers greater decision-making and public budgets to the local level without any evidence of a clear risk management strategy (ie mapping the strengths and weakness of the proposed new system and its leaders, logging the major likely risks and identifying the necessary investments and actions to mitigate them, such as priority areas for skills enhancement.) We believe this would be unthinkable in any equivalent restructuring in industry. It is our view that the current development and capacity building support offered to the new leaders through transition is inadequate and, unless addresses, risks another decade of failure to tackle poor outcomes and persistent health inequalities.

June 2011

Written evidence from Terrence Higgins Trust (PH 122)

1. The public health ring fence will be under considerable strain from the outset and we would welcome more clarification on how this funding will be distributed and what safeguards will be put in place to protect the ring fence.

2. THT would welcome further assurances that the relevant commissioning expertise will be available within local authorities to deliver on sexual health. We would particularly support transferral of existing commissioning expertise from the health service into local authorities, where appropriate, in order to ensure a level of continuity of provision.

3. We would like further clarification of how politicisation of decision making will be guarded against within the new structures for public health commissioning and in particular whether Directors of Public Health will be given sufficient decision making powers and seniority to avoid potential conflicts.

4. Fragmentation of commissioning cannot be allowed to result in divisions in service delivery. There will need to be national leadership in terms of outcomes and minimum service standards, as well as, guidance

approaches and best practice. For this reason then we would strongly urge the retention of three proposed HIV and sexual health outcomes.

5. We would welcome further consideration of how and where regional, supra-local or sub national commissioning may be the most appropriate vehicle for delivery and the mechanisms by which this can occur.

6. The level of surveillance that is currently provided by the HPA must be maintained and developed by Public Health England. We would welcome a specific commitment to guarantee the continued provision of:

- Specialist and reference services for sexually transmitted infection (STI) microbiology.
- Submissions by local services of the range of data required for national surveillance.

7. We would recommend that a stakeholder/patient involvement approach to Public Health is equally important to that applied to NHS service provision and the independence of Health Watch should be prioritised.

1. INTRODUCTION

1.1 Terrence Higgins Trust (THT) is the UK's largest HIV and sexual health charity, with 28 service centres across England. We are a campaigning and membership organisation which advocates on behalf of people living with or affected by HIV or poor sexual health.

1.2 As a service provider we work in a variety of settings and in a range of partnerships. We deliver community based clinical services such as chlamydia screening and rapid HIV testing in areas across England with the aim of augmenting service provision and tackling health inequalities. In addition we also work in various partnerships at local and national level to deliver health promotion and STI prevention campaigns and initiatives which target populations most at risk of HIV and poor sexual health.

1.3 We welcome the Committee's Enquiry into Public Health and believe that it is timely in terms of the current consideration of the Health and Social Care Bill and the Government's Listening Exercise on Health Reform. THT has been largely supportive of the proposed direction on Public Health. We welcome the emphasis which the reforms have placed on Public Health as a priority and the commitment to ring fenced funding for its development. There are some areas however, where we would welcome further clarification and we will focus on these in our submission.

2. Public Health Ringfence

2.1 We welcome the ring fencing of the public health budget to discourage short-termism and reductions in health promotion work. Over the last 10 years THT has consistently found evidence,³⁰⁸ through surveying of clinical staff and commissioners, of money being diverted away from sexual health, to meet deficits in other areas. The current economic climate, and the pressure to identify savings, means that the safeguarding of investment in public health will be essential to securing long term benefits for individuals, communities and the NHS.

2.2 We would however, welcome clarification on how the proposed £4 billion budget will be broken down. Current costs of sexual health services are estimated at around £700–£750 million: potentially between 17% and 20% of the £4 billion budget for public health. The HPA received approximately £240 million in direct Government funding in 2009–10, whilst £514 million is currently spent on central immunisation programmes. These figures represent 6% and 13% of the projected budget respectively. The White Paper also states that the equivalent of 15% of the QOF will be devoted to Public Health and will be managed through the Public Health England budget. We have heard cost estimates of £1 billion for the QOF, requiring a potential £150,000, or 4% of the public health spend.

2.3 Public Health England will also be subject to running cost reductions and efficiency savings, and set up and restructuring costs could be significant. This comes against a backdrop of significant budget reductions for local government over the next five years. This means that the public health ring fence will be under considerable strain from the outset and we would welcome more clarification on how this funding will be distributed and what safeguards will be put in place to protect the ring fence.

2.4 Whilst we are very much in favour of greater integration of services between areas such as health, social care and education, we are concerned that the current financial situation of local authorities could mean that they could be tempted to categorise a wider range of services under the banner of public health to ensure a more sustained source of funding. We are concerned that the definition of what constitutes public health should not be so broad as to create permeation of the ring fence. We would hope that Health and Wellbeing Boards will be required to ensure that the public health ring fence is being used appropriately and that services such as health protection requirements that are already commissioned via the block grant to local authorities are not considered within the remit of the public health ring fence.

3. Commissioning Routes for HIV and sexual health

3.1 The proposals for HIV and sexual health service commissioning outlined in the White Paper and accompanying document detail a number of new routes for the development and funding of services. We are

³⁰⁸ "Disturbing Symptoms" ed 1–7, Terrence Higgins Trust, BHIVA, BASHH.

concerned that these proposals could amount to a significant fragmentation of services with HIV services being commissioned nationally, potentially by the National Commissioning Board; specialist sexual health services provided by local authorities, community contraception provided by GPs, funded via the GP contract and national prevention initiatives potentially provided via Public Health England.

3.2 Fragmentation of commissioning cannot be allowed to result in divisions in service delivery. At the very least there will need to be national leadership in terms of outcomes and minimum service standards, as well as, guidance on effective approaches and best practice. For this reason then we are strongly urging the retention of three proposed HIV and sexual health outcomes on:

- The under 18 conception rate.
- Chlamydia diagnosis rates per 100,000 young adults aged 15–24.
- Proportion of persons presenting with HIV at a late stage of infection.

4. ROLE OF LOCAL AUTHORITIES

4.1 The reforms outlined in the White Paper propose that integrated sexual health services should come under the remit of local authorities in their new public health role. There is a rational argument that local authorities can make a success of this commissioning as many of the determinants of poor sexual health fall within their remit, for example, social deprivation and sex and relationships education. As such, we are optimistic about the transfer of public health responsibilities to local authorities.

4.2 We are concerned, however, that it has been a number of decades since local authorities have taken the lead on sexual health and in recent times it has been difficult to get some authorities to meaningfully engage on the issue. We would welcome further assurances that the relevant commissioning expertise will be available within this structure. We would particularly support transferral of existing commissioning expertise from the health service into local authorities where appropriate in order to ensure some continuity of provision. It is also essential that accountability mechanisms are in place to guarantee service quality and consistent standards of care.

4.3 The provision of comprehensive and effective sexual health services, including access to abortion, HIV prevention and contraception, is essential for wider public health and cannot be compromised by political processes. Some of this work can be potentially controversial, for example: providing HIV prevention outreach in public sex environments. We believe that decisions on these issues must be made on the basis of public health benefit and not be influenced by political concerns. For this reason then, we would like further clarification of how this will be guarded against within the new structures for Health and Wellbeing Boards, given the potential role of elected representatives on those Boards. In particular, we would welcome a clear indication as to whether the Directors of Public Health will be given sufficient decision making powers and seniority to avoid these problems.

4.4 We support the ADPH's call for Directors of Public Health to be accountable directly to the Chief Executive of the Local Authority, be jointly appointed by Public Health England, and have direct access to councillors.

5. HIV Specialist Services

5.1 Currently specialist HIV services are commissioned via PCTs. These services provide clinical care and treatment to people living with HIV and are frequently hospital based services. They can be stand-alone HIV clinics or co-located within Genito-urinary Medicine (Sexual Health clinics) or Infectious Diseases Units.

5.2 The Public Health White paper outlines plans for these services to be commissioned nationally. This could work to drive up standards of care and the development of centres of excellence. It also avoids handing commissioning to GPs who can be inexperienced in dealing with HIV.

5.3 However, this arrangement does not fully address the need for greater GP and primary care involvement in the provision of HIV patient care. The current model of care is highly specialist and centralised within PCTs. Whilst GPs may generally lack confidence or knowledge on HIV, there is a need to develop their skills and include them more in the delivery of simple aspects of HIV monitoring and care. Over centralisation of services can have serious implications, both in terms of costs to the NHS and in bringing care and self management processes closer to the patient.

5.4 Whilst the proposals for Public Health do not prohibit regional working, there is a lack of detail available on what regional, supra local or sub-national commissioning arrangements could or will look like. For some conditions, regional, or supra-local, commissioning arrangements will be the best means by which to provide services. HIV has only recently been removed from the National Definitions Set and it is therefore likely that commissioning, using regional lead consortia will be most effective way to manage the provision of HIV services. However, we are not clear if this is an option that will be given consideration in the reform process.

5.5 This model would provide a greater balance in terms of securing the benefits of increased local delivery of care and activity with the need to ensure knowledgeable and informed commissioning. The low volume/high cost nature of HIV interventions means that a regional lead approach will also be necessary in order to manage financial risk.

5.6 The proposed new structure will also result in a more complicated arrangement for commissioning HIV services provided from Genito-urinary Medicine. These types of co-located services can provide continuity of care and service provision by bringing together testing, diagnosis, care and partner notification services. Under the proposed structure, Local Authorities will now be responsible for commissioning of the sexual health element, including HIV testing, but the National Commissioning Board could possibly commission the HIV treatment and care element.

6. HIV Prevention and Testing

6.1 Local HIV prevention work and campaigns will be commissioned by local authorities with additional national campaigns work overseen by Public Health England. This does create an issue around the possible fragmentation of prevention working; between HIV treatment commissioned nationally, potentially by the Commissioning Board, prevention and testing work commissioned by local authorities, and national campaigns overseen by Public Health England.

6.2 Whilst the Public Health White Paper does allow for the pooling of budgets and cross border working, established PCT arrangements will need to be dismantled and, even with successful reorganisation, there is a real risk that momentum could be lost. Currently successful cross border commissioning arrangements have been established and developed between PCTs such as the South London HIV Partnership. There is therefore a risk of reverting to duplication of working, lower quality campaigns and higher eventual costs for local authorities.

7. Surveillance and Epidemiology

7.1 We understand that Public Health England will absorb many of the functions currently delivered by the Health Protection Agency. From an HIV and sexual health perspective the surveillance provided by the HPA provides a crucial tool for the development of effective approaches to HIV and STI prevention and detection. The HPAs surveillance in this area is amongst the best in the world and we would encourage the Government to ensure that this quality is safeguarded and indeed built upon in the movement to Public Health England. Quality surveillance and research will also be crucial to the Government's aim to move towards an outcomes based assessment of health services.

7.2 We believe that the proposed structure can work successfully. However, the level of surveillance that is currently provided must be maintained and developed. It will also be essential that the advice and information provided by the agency maintains a strong level of independence. We would welcome a specific commitment to guarantee the continued provision of:

- Specialist and reference services for sexually transmitted infection (STI) microbiology. The expertise for these is not found in NHS laboratories at local level meaning that the functions of the Sexually Transmitted Bacteria Reference Laboratory (STBRL) must be retained within Public Health England.
- Submissions by local services of the range of data required for national surveillance, in order to ensure public health strategic planning is informed by current evidence of need.

8. Accountability and Patient Involvement

8.1 We are unclear about the role which GP consortia will play locally with regards to Public Health provision. We would welcome capacity for decision making within Health and Wellbeing Boards which requires GP consortia to assist with arranged areas of work. Currently Consortia are only required to 'have regard' for the priorities of Health and Wellbeing Boards. If we are to secure greater integration in service provision, then Consortia must have a duty to meaningfully engage with Health and Wellbeing Boards.

8.2 We continue to have some concerns about the profile of patient participation within the plans for Public Health. The move to localism brings the potential for a range of improvements. However, without significant mechanisms for patient and stakeholder involvement there is a risk that services will be determined locally on the basis of how visible groups are. We are particularly concerned about this from the perspective of groups of people within communities who are at increased risk of HIV. These groups are most commonly comprised of gay men and people of African origin who are potentially less likely to be vocal within communities.

8.3 We are concerned that local Health Watches will be hosted by Local Authorities. Given that Local Authorities will have Public Health responsibilities we believe that this may result in a conflict of interest and could compromise local accountability in terms of Public Health functions.

Written evidence from Novartis Vaccines and Diagnostics (PH 123)

SUMMARY

Novartis Vaccines and Diagnostics Limited believes that the UK's current immunisation programme and its surveillance and monitoring is widely recognised as amongst the best in the world. Any reforms should therefore aim to build on this excellent heritage to deliver even better public health outcomes. In particular:

- Successful immunisation programmes are built on the basis of solid epidemiological monitoring and surveillance which assesses disease burden. This surveillance can therefore not only measure the impact of introducing new immunisation programmes, but provide real time effectiveness data on the quality and impact of existing programmes.
- Successful immunisation programmes require high and uniform uptake of vaccines by the population. As such, immunisation and vaccination should continue to be UK-wide and be centrally commissioned, by the NHS Commissioning Board, not by health and wellbeing boards, GP consortia, local institutions or public health authorities to deliver the optimal population benefit.
- Local public health authorities do, however, have an important role to play in increasing vaccine local uptake rates. In particular, our experience of working with community pharmacists suggests that inclusion of wider healthcare professionals in public health delivery can improve healthcare outcomes.
- As the HPA is subsumed into Public Health England, surveillance must remain a top priority and the HPA should be able to continue its research affiliations with non-NHS bodies (whether in the academic or commercial sector). This transition cannot compromise the effectiveness of the monitoring for infectious diseases.
- The Government has already committed that the Joint Committee on Vaccination and Immunisation will remain as an independent advisory board to provide expert impartial scientific advice on vaccination and immunisation.
- The Public Health Outcomes Framework should have uniform vaccination rates as a key Domain 1 indicator.

BACKGROUND

1. Novartis Vaccines and Diagnostics Limited is a leader in researching and developing vaccines. We have the only large scale influenza vaccine manufacturing facility in the UK and are also able to draw upon extensive international experience of public health systems.

2. Immunisation is a crucial part of public health provision. The UK's immunisation programmes have saved more lives in the UK in the last 50 years than any other health intervention, and we believe the UK immunisation programme already delivers effective public health outcomes; reducing morbidity and mortality as a direct result of intervening against infectious disease. For example:

- (a) Since the introduction of the Meningococcal C conjugate vaccine in 1999 cases of Men C in children have reduced by 95%; over 500 deaths have been prevented.³⁰⁹
- (b) Seasonal flu accounts for approximately 8,000 deaths in England and Wales each year; 70–80% of those receiving the seasonal flu vaccine will be protected, while others are more likely to get milder symptoms.³¹⁰
- (c) The UK currently vaccinates against ten diseases of childhood, which have been estimated as saving the NHS 150,000 quality adjusted life years per annum at a cost to society of £6.6 billion. Over the life of the NHS, that would come to almost £400 billion at today's prices.³¹¹
- (d) The Marmot review recently noted that paediatric immunisations in particular are among the most cost-effective ill health preventions.

ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

3. Novartis believes that the integrity of a UK-wide vaccination programme must be maintained. At present, DH's Immunisation Branch, with the Commercial Directorate and the NHS Commercial Medicines Unit (CMU), centrally procure vaccine on behalf of the UK and further maintain responsibility for warehousing, distribution and the supply chain for the tens of millions of childhood vaccines that the UK immunisation schedule requires.

³⁰⁹ No deaths in under 19's last year from meningitis. 21 Apr 2008, Government press release <http://nds.coi.gov.uk/Content/Detail.aspx?NewsAreaId=2&ReleaseID=365685&SubjectId=16&AdvancedSearch=true>

³¹⁰ Seasonal flu by numbers, Government press release 26 Oct 2009 <http://nds.coi.gov.uk/content/detail.aspx?NewsAreaId=2&ReleaseID=407902&SubjectId=16&AdvancedSearch=true>

³¹¹ CMO Annual Report 2007. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_086181.pdf

4. A common immunisation schedule for children and the unified approach to adult vaccination across the four devolved nations provides optimal public health protection. Centrally-organised immunisation is the best way to avoid healthcare inequalities, and ensure uniform coverage for essential vaccinations to deliver the optimal public health benefit.

5. The central tenders also provide the UK exchequer with good value for money (bulk purchase versus smaller purchases at a devolved or primary care organisation level) and we would support the continuation of a centralised tender programme in the case of paediatric vaccines.

6. There is no additional value or benefit gained for the UK population through the fracture or fragmentation of this system down to the devolved nations, or local authorities. Local implementation could result in variations in the provision of an essential public health service—leading to poor control of infectious disease. Under existing arrangements, primary care organisations are obliged to implement National Institute for health and Clinical Excellence (NICE) guidance within three months of its publication, but it is well known that implementation can be patchy and can vary hugely from area to area.³¹² Local commissioning may exacerbate this tendency and introduce public health risks.

7. As such, we firmly support the continued central commissioning of immunisation, now a designated responsibility of the NHS Commissioning Board, and we strongly and urgently advise against giving local public health authorities responsibility for school immunisations—regardless of the eventual format and composition of Health and Wellbeing Boards, or equivalent proposed institutions. The added public health benefit or value this would provide is unclear.

THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

8. While we do not believe that central commissioning of vaccination should be exchanged for local commissioning, local public authorities do have an important role to play in improving public health—and in particular, increasing vaccine uptake. Again, this is irrespective of the eventual format these organisations will take.

9. At present, responses to public health incidents are coordinated between different levels of government, with the Health Protection Agency's Local Health Protection Units leading at a local level. We seek clarity on how new local public health authorities will interact with central structures for health incidents. Regardless of the eventual shape of local authorities' involvement in public health, it is crucial that leadership on this is clearly defined at each level of government.

10. There is currently significant variation in uptake of vaccines and vulnerability to disease, particularly in areas of socio-economic deprivation. For example, evidence suggests that the rates of meningococcal disease have been twice as high in deprived areas, and uptake rates for seasonal influenza vaccination can also vary widely. Local agencies can more effectively target such areas than any national campaign.

11. Novartis further sees opportunities for other healthcare workers, notably pharmacists, to play an increased role in the delivery of some vaccination services, such as travel vaccines and for seasonal flu vaccination in particular. GPs have demonstrated successful delivery of seasonal flu programmes in the over 65 years group (almost 75%) but rates in the at-risk population have remained largely static over the last few years.

12. One potential solution may be to commission community pharmacy to provide this service rather than GPs, the subject of a paper submitted by various pharmacy organisations to the Welsh Assembly Government recently, which argues that making flu immunisation available from community pharmacies is not only welcomed by patients, but has the potential to significantly increase vaccination uptake rates.

13. We believe that there is a willingness amongst the public to take responsibility for its own health, and our experience of working with community pharmacy supports this. Since the launch of our In-Pharmacy Flu Initiative (IPFI) in October 2008, our community pharmacy partners (Tesco, AAH, Lloydspharmacy, Superdrug) have vaccinated over 100,000 patients and we have trained over 2,000 pharmacists in providing flu vaccinations. 1.5 million customers enter UK pharmacies daily, but pharmacists remain an under-utilised health service resource—the extended opening hours, convenience and ability to “drop in” were drivers for customers using our IPFI. If GP consortia are able to commission pharmacies to deliver seasonal flu vaccinations to at-risk groups, we believe that the NHS would be able to increase uptake rates for seasonal flu vaccination.

14. Indeed, of the 2,700 patients who received a flu vaccination from a community pharmacy, 37% suggested they would not have had a vaccination had it not been offered by the pharmacy. It is clear from the evidence base that increasing the availability of flu vaccination and ensuring that vaccination is available at a time and place that meets patient's needs is a key factor in uptake of the vaccination.

THE CREATION OF PUBLIC HEALTH ENGLAND WITHIN THE DEPARTMENT OF HEALTH

15. The UK already has an enviable surveillance and monitoring programme for infectious diseases. Currently, the Health Protection Agency (HPA) in England, Health Protection Scotland and Public Health Wales all routinely monitor and track infectious diseases. This is an essential task:

³¹² Increasing influenza vaccination coverage in recommended population groups in Europe, University of Zurich; 2009, available at: <http://www.eswi.org/userfiles/files/increasing%20flu%20vaccination%20coverage.pdf>

- (a) These systems also identify local outbreaks of infection. This can extend to vaccinating the family and close contacts of an individual who has recently contracted a potentially life-threatening infection.
- (b) Following the introduction of a vaccine, there is continuous monitoring of infection rates and levels to measure the impact of the immunisation programme—focussing on health outcomes such as number of cases of infection
- (c) Any intervention (such as local emergency vaccination) can therefore be targeted to the areas that most need it, and if the incidence of disease rises, the immunisation programme may be re-evaluated and the vaccination schedule changed.

16. As such, it is imperative that the HPA's independent scientific advice is retained when it undergoes its transition into Public Health England. There is a risk that the public loses faith in a body that is seen as close to central Government—the HPA is credible thanks to its independence, and so its evidence must continue to be based on the standards of impartiality, quality and transparency in the new structure.

17. As noted in point (9) above, leadership on local health incidents must be clearly delegated. While the transfer to the new structure is ongoing, it is also essential that any compromise of the surveillance and monitoring programme for infectious diseases is avoided at all costs. HPA staff need certainty, and clarity is essential to support these key personnel who are in the frontline of health protection.

18. The JCVI monitors the effectiveness of the vaccine programme as a whole, looking at vaccine coverage and uptake, and reviews vaccines according to the same health economic criteria that the NICE uses in its health technology assessments. However, it is important to understand that vaccines have particular specificities:

- (a) For the childhood immunisation programme, this means looking at potential interactions with other vaccines, in which month(s) of life to provide the vaccination, whether a catch-up campaign (a temporary extension of the vaccination programme to other age groups in the case of a novel or new vaccine introduction) should be conducted.
- (b) Vaccines are given to entire birth years (as for the childhood vaccination programme—healthy young babies do not have a fully developed immune system)—or according to risk-based strategies. In effect, this means hundreds of thousands of children/adults receive a vaccine so a coordinated approach to the delivery of a programme is essential.

19. Novartis welcome the Health and Social Care Bill's provision for the retention of the JCVI within Public Health England. The makes a valuable contribution to impartial public health evidence and analysis, and should be retained as the body that evaluates novel vaccines and any changes to vaccination programmes for the UK.

20. Public Health England needs to take responsibility for ensuring that GP Consortia are provided with the information, resources and training required to implement immunisation programmes and encourage effective uptake, as well as acting as a centralised resource to support national and local immunisation awareness campaigns.

PUBLIC HEALTH EVIDENCE

21. Novartis welcomes the Government's commitment to establishing a National Institute for Health Research School for Public Health Research. In order to for the institute to make the fullest possible contribution to public health evidence, the NIHR should make its research available to industry and other interested parties. It is essential to collect evidence about attitudes to vaccines and what influences individuals' decisions to get vaccinated, particularly as new vaccines are developed.

22. In light of the commitment to an evidence-based approach to public health we also encourage the Government to publish and update its infectious diseases strategy. Given the pace of development and innovation, an update to *Getting ahead of the curve* (2002) is long overdue, and would make a substantial contribution to information and intelligence on public health and preventative healthcare.

THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

23. Vaccination coverage should be a key part of the Public Health Outcomes Framework. We fully support vaccination coverage as an indicator for Domain 1 (health protection and resilience), as indicated in the Department of Health's January 2011 consultation on the framework.

24. Vaccination is one area that requires absolute equality in access in order for it to be fully effective—thanks to the herd immunity effect, where if a population has vaccination above a certain threshold then non-vaccinated individuals are also protected. This will only be sustained if coverage is uniform. Therefore the outcomes framework needs to establish minimum vaccination coverage levels that are uniform across all local areas, as well as ensuring total equal access to vaccination for all. We see this as a crucial supporting policy for continued national commissioning of flu, as outlined above.

25. The indicators for vaccines should also include vaccination for healthcare professionals which has been relatively poor; only ~20% of all healthcare workers are vaccinated against seasonal influenza in a typical flu season, which puts themselves and their patients at risk of contracting influenza.

June 2011

Written evidence from CHILDREN with CANCER UK (PH 124)

1. ABOUT CHILDREN WITH CANCER UK

1.1 CHILDREN with CANCER UK is the leading national charity dedicated to the fight against childhood leukaemia and other childhood cancers. We fund life-saving research into the causes, prevention and treatment of childhood leukaemia and other cancers and we work to protect young lives through essential welfare and campaigning programmes.

1.2 Childhood leukaemia is the most common childhood cancer and accounts for one third of all childhood cancer cases. Around 500 children are diagnosed every year in the UK and, although treatments have improved dramatically in recent years, sadly 100 of these will not survive and the remainder go through several years of gruelling treatment.

1.3 We campaign to protect children at risk of developing leukaemia and other cancers and seek to raise awareness of the association between leukaemia and high voltage overhead power lines. Electric and Magnetic Fields (EMFs) are produced by electrical power wherever electricity is generated, distributed or used. High voltage overhead power lines produce elevated levels of EMFs.

1.4 We ask Government to protect children and young people by preventing them from being exposed to the potentially harmful EMFs associated with high voltage overhead power lines.

2. OUR CAMPAIGN OBJECTIVES

2.1 Reports suggest that children living within 200m of high voltage power lines from birth have a 69% increased risk of developing leukaemia in childhood (*Draper et al 2005*). The statistical association between EMFs and childhood leukaemia is clear, but the causal mechanism is not yet understood. CHILDREN with CANCER UK funds vital research to improve understanding of this and other causes of childhood leukaemia and other cancers.

2.2 Whilst important research is being undertaken to clarify the association between power lines and an increased risk of developing childhood leukaemia, we believe that the precautionary principle should be applied to the development of homes and schools in relation to existing power lines. Further we believe that, as a minimum requirement, new power lines should be sited away from homes and schools.

2.3 We believe that our campaign fits into the wider debate about the quality of the design and sustainability of our communities, the importance of open spaces and the need to take public health issues in to consideration in planning applications.

3. PUBLIC HEALTH

Public Health England

3.1 We support the creation of Public Health England and recognise the important role it seeks to play in reducing premature death and illness.

3.2 As set out in the White Paper, "*Healthy Lives, Healthy People*", we support ring-fencing of funds for public health and through this, support the Department of Health's recognition that "prevention is better than cure".

Role of Local Government in Public Health

3.3 We support the creation of Directors of Public Health as employed by the Local Authority. We agree that they will be important ambassadors of health issues for the local population. We very much hope that this role will enable Directors of Public Health to lead discussion about how the ring-fenced money is spent to improve health in their communities.

3.4 CHILDREN with CANCER UK believes that public health considerations should be observed in all planning applications. However, more broadly, we think that as part of the development of sustainable communities, it is imperative that public health be given full consideration in the planning and development of our communities.

3.5 We support the premise, as advocated by the creation of Public Health England, that "prevention is better than cure" and urge Directors of Public Health to promote the precautionary principle with regard to the location of high voltage overhead power lines in relation to homes and schools.

3.6 We agree with the Marmot Review, that the empowerment of individuals and local communities is an effective way to deliver public health improvements and that this requires participatory decision-making at the local level.

Abolition of the Health Protection Agency

3.7 We are cautiously supportive of the combination of the public health bodies, such as the Health Protection Agency, under the umbrella of Public Health England, and look forward to future clarification and further information. We hope that Public Health England will seek to integrate the expertise, advice and influence of these organisations to improve public health services.

3.8 We look forward in due course to further information relating to the roles and responsibilities within Public Health England which reflects the work previously undertaken by the Health Protection Agency. In the future we hope that Public Health England will be in a stronger position than the Health Protection Agency has been previously to take a more long-term and strategic view of public health issues.

The Secretary of State

3.9 We look forward to working closely with the Secretary of State throughout the development of the Public Health Responsibility Deal. We support the Secretary of State's ambition to make it easier for people to make healthy choices in their lives.

Data

3.10 We will believe that an important role for Public Health England will be its collation of public health data. From our experience, it can be difficult to access comprehensive data and in some cases can include considerable variation and inaccuracies.

Marmot Review

3.11 We support the six policy objectives identified in Professor Marmot's final report. Of particular relevance to CHILDREN with CANCER UK is the commitment to:

- Give every child the best start in life.
- Create and develop healthy and sustainable places and communities.

3.12 We agree with Professor Marmot that 'delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies'. We support this premise and we look forward to working collaboratively to help deliver these objectives.

3.13 By ensuring that public health issues are given consideration in the development of our communities, we believe that the Government can meet these two policy objectives as identified in the Marmot Review. We urge the Government to give real consideration to our concerns and encourage Public Health England to promote the development of considered and sustainable communities in order to improve public health.

3.14 As mentioned previously, we agree with the Marmot Review's conclusion that the empowerment of individuals and local communities is an effective way to deliver public health improvements and that this requires participatory decision-making at a local level.

4. EVIDENCE

4.1 In 2002 the World Health Organisation's International Agency for Research on Cancer (WHO IARC) defined ELF EMFs as "possibly carcinogenic to humans"³¹³ and classified them as a class 2b carcinogen. Whilst the causes of childhood leukaemia are not well understood, with increasing incidence in the 20th century, it's believed that lifestyle and/or environmental factors may be involved. One such consideration is the Extremely Low Frequency Electric and Magnetic Fields (ELF EMF) that are produced by high voltage overhead power lines.

4.2 A UK study (Draper *et al* 2005) found that children living from a birth address within 200 metres of a high voltage overhead power line had a 69% increased risk of developing leukaemia and those born between 200 and 600 metres had a 23% increase in risk, compared with children born more than 600 metres away. This report, published in the British Medical Journal³¹⁴ and funded by the Department of Health, is the largest single study of childhood cancer and power lines. It used the records of almost 30,000 children with cancer in England and Wales.³¹⁵

³¹³ An Overview of WHO's EMF Project and the Health Effects of EMF Exposure, Michael H Repacholi, Proceedings of the International Conference on Non-Ionizing Radiation at UNITEN (ICNIR 2003), Electromagnetic Fields and Our Health, 20th–22nd October 2003, World Health Organization.

³¹⁴ <http://www.who.int/peh-emf/meetings/archive/en/keynote4repacholi.pdf>

³¹⁵ Childhood cancer in relation to distance from high voltage power lines in England and Wales : a case-control study, Draper *et al*, British Medical Journal Volume 330, 4 June 2005 pp.1290–1293 http://www.bmj.com/cgi/reprint_abr/330/7503/1290.pdf

4.3 The Council of Europe recently called for precaution concerning power lines and the potential dangers of exposure to ELF EMF.³¹⁶ They state: “One must respect the precautionary principle and revise the current threshold values; waiting for high levels of scientific and clinical proof can lead to very high health and economic costs, as was the case in the past with asbestos, leaded petrol and tobacco.” We support this position and urge Government to adopt similar measures.

June 2011

Written evidence from Sheffield City Council (PH 125)

EXECUTIVE SUMMARY

1. We welcome the transfer of PH to local authorities as we think local authorities can do more than the NHS to address the root causes of ill-health and inequalities. We are clear that the transfer of public health responsibility to local government is a positive change and will enable local authorities to utilise their broad service responsibilities to improve public health outcomes for communities and address the wider determinants of ill health.

2. We also feel that the development Health & Wellbeing Boards (HWB) will be a powerful mechanism which will strengthen relationships between commissioners of health care, social care and public health and support the delivery of better health outcomes for communities in Sheffield.

3. However, we are concerned about the implications of centralising health protection arrangements. We feel that isolating one element of emergency planning from wider local arrangements and operating it at a national level which are delivered by all local partners is dangerous and not in the interests of local people. We feel a system of emergency planning should be integrated at a local level—police, local government, fire and rescue, and NHS.

4. We feel it is important that duties should be agreed with GPs to ensure they are accountable to local people for their PH contribution and the outcomes they bring.

5. GPs should have a statutory duty to work with councils on public health, as should Public Health England (PHE).

6. HWBs are essential in the new system and should have the ability to engage with PHE at local level and hold it to account for its effectiveness (limited to locally determined priorities).

7. The Public Health White Paper published by Government in November 2010, does not include any clear designation of responsibility for local population health. Our view is that this should be assigned to Local Authorities and be the responsibility of the Leader of the Council.

8. The suggestion of greater flexibility for PHE in commissioning services conflicts with the localist principles of the Government and we feel that commissioning for public health is best placed at local level (particularly as the emphasis should be placed on spending the majority of public health funding at the local level).

9. There remains a fundamental lack of clarity about the dual accountability of Directors of Public Health (DsPH). We feel DsPH should be accountable to the local council only and local authorities should be trusted to determine how public health leadership is provided in the area and to whom the DPH reports. Dual accountability adds complexity and undermines local democratic accountability for public health decision making.

10. To minimise the risk that public health expertise is lost in the transition, there needs to be better understanding of the TUPE arrangements to enable PCT staff to transfer to councils and/or GP consortia. Whatever arrangements are determined by the council and GPCC, DsPH need to be Member appointments given their status and grading.

11. Greater acknowledgement that many councils have excellent information and research capabilities which can be used for public health related work, indeed a combination of Council and PCT expertise will build centres of excellence, working closely with universities.

12. The focus of the Outcomes Framework, the ringfenced budget and the Health Premium should be addressing the causes of ill health (as set out by Sir Michael Marmot).

13. The formulas used for calculating the public health budget allocation should be “Utilisation” and “Population health measures” (the latter taking within-District inequalities into account).

14. We have serious concerns about the proposed Health Premium. We feel that the Health Premium should be awarded on the basis of progress made and improvement on baseline position, rather than absolute improvements. This would mean that the premium mechanism would recognise the distance travelled by those

³¹⁶ Council of Europe statement:
<http://assembly.coe.int/main.asp?Link=/documents/workingdocs/doc11/edoc12608.htm>

areas with the biggest health inequalities challenges. Otherwise, there is a danger that areas with greater levels health inequality may struggle to make sufficient progress to access the Premium.

15. We note there is a professional lobby amongst some PH specialists to remain outside local government, at least for their employment. We are strongly against this as it would negate the council's responsibility and democratic control of the PH system.

Creation of Public Health England within the Department of Health

16. We have concerns that creating Public Health England as a part of the Department of Health will undermine its independence and hence authority as a source of independent public health advice. We believe that its credibility would be enhanced by establishing it as an independent organisation, similar in status to the current Health Protection Agency.

17. PHE should be required to work with Local Authorities, as should NICE. NICE has done little work with Local Authorities and this requires development to build relationships and understanding which is fundamental if there is to be an effective and efficient delivery of public health services. PHE will have research and information responsibilities but we feel PHE and local authorities need closer relationships with the research and analysis expertise available in universities, not just through academic public health departments, many of which have focussed on a narrow agenda of health services and behaviour. We need to draw upon eg. Departments of Politics, Environmental Science, culture, too. Local and national systems for this are required to facilitate the development of research hubs.

18. We believe that the commissioning of public health services by GPCC and local authorities working together would more effectively meet the needs of communities if it was done at the local level. At present, the proposals contain areas where the commissioning of services is over complicated and ultimately undermined by the centralisation of elements of public health provision. For example, we do not understand the rationale for PHE commissioning public health work for under 5s and HVs—all of this should be done by councils and the GPCC working together.

19. We do not feel that the case has been made to justify greater PHE flexibility and this may conflict with the localist principles of the Government.

The abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse

20. Both the Health Protection Agency and the National Treatment Agency for Substance Misuse undertake vital roles within the Public Health system in England.

21. The NTA has been a key partner and stakeholder in the development of effective treatment and recovery systems. If the National Treatment Agency and the regional support teams to partnerships are abolished; our local partnerships will seek assurance that the positive benefits that the NTA has provided are not lost. We would recommend that a thorough impact assessment is carried out on the decommissioning of the NTA.

22. We are concerned about Emergency Planning being led by PHE. Local Emergency Planning must be embedded across local agencies. We feel that one element being led from a national organisation will severely disrupt our ability to address local emergencies, we consider such an arrangement to be dangerous. In fact we need integration at a local authority level of all services who are "level one responders". We believe that emergency planning is an key local responsibility, currently co-ordinated through local resilience forums. It is crucial that there is clear local NHS leadership for emergency planning and that public health has an integral role in local resilience forums, local authorities and the NHS.

The public health role of the Secretary of State

23. In light of the importance of effective health services to the health of the public, we believe that the current duty imposed on the Secretary of State to *provide* comprehensive health services should not be amended, as is currently proposed in the Health and Social Care bill.

The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)

24. There remains a fundamental lack of clarity about the dual accountability of Directors of Public Health (DsPH). We feel DsPH should be accountable to the local council only and local authorities should be trusted to determine how public health leadership is provided in the area and to whom the DPH reports. Dual accountability adds complexity and undermines local democratic accountability for public health decision making.

25. It needs to be recognised that the public health proposals from Government are as much about councils developing their new leadership role and responsibilities in public health as they are about the physical transfer of public health expertise from the NHS.

26. The role of Public Health England in the appointments process for Directors of Public Health needs to be clarified.

27. To minimise the risk that public health expertise is lost in the transition, there needs to be better understanding of the TUPE arrangements to enable PCT staff to transfer to councils and/or GP consortia. Whatever arrangements are determined by the council and GPCC, DsPH need to be Member appointments given their status and grading.

JSNA

28. Duties should be developed to ensure that strategic leads and commissioners (including GPCC) “have regard” to the JSNA to inform health commissioning decisions.

29. JSNAs must be used to inform local planning. In addition to being agreed by the local Health and Wellbeing Board, they should be approved by the Council’s Cabinet or local Community Assemblies (which are Sheffield’s devolved local area committees).

30. Any guidance or best practice for the JSNA should require local authorities to have regard to the other assessments we are required to complete to understand the wider determinants of health (eg Local Economic Assessment, Child Poverty Needs Assessment, Joint Strategic Intelligence Assessment, Housing Market Assessment). It is crucial that greater linkage is developed between such assessments in order to address the wider determinants of health, as identified by the Marmot Review.

Joint Health and Wellbeing Strategy (JHWS)

31. A locally agreed Health and Wellbeing Strategy is potentially an important driver for public health improvement and the wider development of health and social care services in an area. This must be informed by specialist public health input through the JSNA, the views of local communities, wider needs assessments and profiling (Local Economic Assessment, Joint Strategic Impact Assessment, community profiles). Local commissioners of health, public health and local government services including social care must be held to account for commissioning services which contribute to the implementation of the Strategy.

Arrangements for public health involvement in the commissioning of NHS services

32. Local councils and GPCC should be left to agree the best mechanisms and arrangements for this, the Council will need public health experience for its role in the commissioning of local and social care services, as with GP consortia. The role of PH in these services’ commissioning requires greater clarity and definition.

33. Effective, efficient and accessible health services make a vital contribution to public health and reducing health inequalities. “Health services public health” is the contribution that public health expertise makes to ensuring that health service provision is optimised, and is one of the three strands of public health activity (the other two being health improvement and health protection). It is vital that health services commissioning undertaken by GP Commissioning Consortia is informed by public health expertise, and that there are effective arrangements at local level to achieve this. This could be effected in a number of ways: eg by GPCC employing PH consultants, by seconding PH consultants from Local Authority PH teams, or by GPCC commissioning such input from elsewhere.

34. The resourcing of this element of PH activity needs clarification. If it is deemed to be within the GPCC “running costs”, then GPCCs should be mandated to demonstrate that they have used the resource to access the relevant expertise

35. Effective mechanisms for ensuring that Dental Public Health advice is available to commissioners of dental services must also be established. Current proposals are that Dental Public Health should be a responsibility of local authorities, yet all commissioning of Dental services is to be done by the NHS commissioning board. It is not clear how they will access Dental PH advice.

Arrangements for commissioning public health services

36. We feel that local authorities are best placed to commission local public health services but where Government are insistent on PHE commissioning services, there must be a clear, complementary commissioning approach between local authorities and PHE.

37. We have concerns about where the responsibility for commissioning some public health functions has been allocated in the White Paper. In particular, we feel it is unnecessary to separate the commissioning of public health services for children, as the White Paper states that responsibility for commissioning of services to the under 5s will rest with PHE. This adds unnecessary complexity to the commissioning of public health services for children and families and will undermine “whole household” approaches to improving family wellbeing.

38. We feel that sexual health services including TOPs, DV support, support for families with multiple problems should be commissioned by GPs advised by local authorities and sometimes by joint commissioning.

39. The Public Health White Paper suggests that the majority of public health activity should be spent on local services. Therefore, we feel it should follow that services should be locally commissioned, adhering to the Government's commitment to localism. We believe that local authorities are best placed to commission public health services which are informed by and meet the needs of local communities to improve public health outcomes and tackle health inequalities. The fundamental benefit of empowering local authorities with the responsibility for public health is that local authorities are able to influence and address the wider determinants of health and embed public health priorities in all local government services. This will be inherently weaker if a complicated commissioning arrangement between central (PHE) and local (councils, GPs and Health & Wellbeing Boards) is pursued.

40. We believe that public health outcomes can be enhanced if they are commissioned locally by local authorities and GP Commissioning Consortia working together. For example, we feel:

- GPCC should commission contraception services.
- LAs and GPC should commission nutrition services and support.
- GPCs should commission NHS health checks.

41. We believe that local authorities should be empowered to provide or commission:

- work to address inequalities (especially financial inclusion);
- housing;
- nutrition/food;
- all children's PH activities; and
- substance misuse services—prevention (GPC should commission treatment services).

The future of the Public Health Observatories

42. It is crucial that the considerable public health information and intelligence expertise currently in PCT public health departments is not lost. There is a real danger of this with the uncertainty about employment, TUPE arrangements etc. Some PCTs currently have excellent expertise in research and analysis but Equally there is good knowledge and skills available in PHOs. There should be a split between national and regional level intelligence work that PHOs would be well placed to undertake but that local intelligence work should be the responsibility of the local authority.

43. We would like the Government to give greater recognition of the ability and important role of local authorities in providing district and sub-district level public health information and analysis. Local authorities are uniquely placed to combine public health analysis with wider intelligence and analysis and PHE would find such local focus almost impossible to provide to each local area.

44. As with the wider PH proposals, there is an opportunity here to unite the considerable information and intelligence expertise in PCTs with the research and intelligence functions in local authorities. This would support the further development of comprehensive evidence-based commissioning in public health whilst capitalising on the wider demographic and socioeconomic expertise in local authorities.

45. Greater acknowledgement that many councils have excellent information and research capabilities which can be used for public health related work, indeed a combination of Council and PCT expertise will build centres of excellence, working closely with universities.

The structure and purpose of the Public Health Outcomes Framework

46. The outcomes framework must not act as a top down performance mechanism—that would be a barrier to improvement and undermine localised target setting, innovation and delivery of outcomes

47. We feel that in order to ensure the outcomes framework drives public health improvement, Government needs to:

- ensure geographical aggregates are appropriately aligned and reflect relevant performance/lead arrangements;
- indicators should be relevant to stakeholders (ie members of the Health & Wellbeing Board) and applied appropriately (ie the indicators align to actions that can be taken by the relevant agencies involved);
- make trend data available (and if not available consider re-engineering historical data to facilitate this);
- consider the organisational degree of overlap;
- prioritise local (small) area level analysis; and
- that relevant local PH intelligence staff can access the necessary data (ie will ex-NHS staff based in a local authority be able to access what is currently categorised as NHS data?). As the proposals currently stand, access to data is a considerable barrier to integration of these public health services and we feel that the Department of Health need to be actively trying to address this issue.

48. Focus must be on addressing the root causes of ill health and not just behaviour change. Behaviour change is an important part of the approach to tackling health inequalities and support people to make positive health choices. However, addressing the root causes of ill health, as set out by Marmot, is fundamental to advancing health equality.

49. In our response to the Government's consultation on the Public Health Outcomes Framework, we suggested that the Department for Health should consider the following in order to strengthen the outcomes framework:

- Base the domains on the categories, indicators and evidence contained within the Marmot Report.
- Distinguish clearly between intra and inter district differences (and don't use them interchangeably).
- Consider all axes of inequity.
- Definition of deprivation (presume this will need to be re-based from Census 2011).
- Baseline clearly defined so measuring change from baseline rather than a general improvement (eg measure change in the slope as well as size of the gap).
- Consider level of challenge faced within individual areas.
- Ensure indicator, performance measure and actions that can and should be taken are aligned.
- Measures should be more strongly focused on health inequalities.
- More economic/income indicators (including around stability/quality of employment).

Arrangements for funding public health services (including the Health Premium)

50. It is crucial that major local authorities and particularly those with the largest populations suffering some of the worst health inequalities (eg. the eight Core Cities) are able to work directly with Government and the Department to develop the allocation formula and health premium. This is particularly important in the context of the other significant financial and structural changes that are currently being delivered in the public sector as a whole.

51. Further, we also believe that Government must fully consult Directors of Public Health, Local Authorities, academics with expertise in health inequalities and public health informatics experts in the development of the public health budget formula and the Health Premium.

52. We feel that linking health improvement budgets to progress on the public health outcomes framework would be an effective mechanism to incentivise further achievement and also may provide additional resources to support greater progress.

53. The health improvement budget should be based on need to ensure that areas with the biggest challenges are sufficiently resourced.

Health Premium

54. We have reservations about the proposed Health Premium. It will be a significant challenge to identify a measure of health that is sufficiently robust and responsive to be used as a measure of health inequality at local level and which would respond quickly enough to Public Health activity. Moreover, even if one such were found, the other factors that impact on health inequality (such as widening socioeconomic inequality, internal and external migration etc) are likely to be as influential as any PH activity, so that the Health Premium would not be a fair mechanism for rewarding such activity.

55. There is a danger that those areas with the largest health inequalities will not be able to demonstrate the necessary progress to access the Premium. If the Government decides to implement the Health Premium, then it should be awarded on the basis of progress made and improvement on baseline position, rather than absolute improvements. This would mean that the premium mechanism would recognise the distance travelled by those areas with the biggest health inequalities challenges. Otherwise, there is a danger that areas with greater levels health inequality may struggle to make sufficient progress to access the Premium

The future of the public health workforce (including the regulation of public health professionals)

56. Integrated training and co-development is essential to developing future generations of flexible, informed professionals for whom integrated working is the norm.

57. We feel that further attention needs to be paid to future specialist training arrangements for public health, not only around medical education but also across other professional disciplines and areas of expertise. We are concerned that the proposed dissolution of the Deanery structure and replacement with what are essentially ad hoc arrangements funded by a levy from the employers of specialists (in this case, local government and PHE) will not lead to sufficiently robust and high quality arrangements for PH specialist training in the future. Whatever future arrangements are reached with regard to funding training, it is essential that local government is recognised as a suitable training location.

58. In this workforce context too, we would support the retention of the General Social Care Council to provide specialist regulation for social workers and other social care staff, rather than the proposed merger with the Health Professions Council in or after 2012. While we believe strongly in service integration, we believe that this is most effective when it is the product of joint working between professionals with their own specialist skills, areas of expertise and professional perspectives, and this in turn is best supported by specialist professional regulatory and training bodies, especially in the context of the current Social Work Reform programme and the Munro report.

How the Government is responding to the Marmot Review on health inequalities

59. We welcome the recognition of Sir Michael Marmot's work in the Public Health White Paper and feel that the proposals for health and public health present a real opportunity to address the wider determinants of health.

60. However, we feel that the Marmot report's findings could be used more explicitly, helping to shape the Outcomes Framework and wider Government priorities. As the new PHE is expected to work across Government, we would welcome the development of a cross Government approach to tackle the socioeconomic determinants of poor health rather than seeing it siloed in the Department of Health.

June 2011

Written submission from Alliance Boots (PH 126)

SUMMARY

- Alliance Boots supports the creation of Public Health England (PHE) as part of the Department of Health. PHE will need to have equal status with other parts of the NHS and high-profile leadership in order to put public health at the heart of the newly structured NHS in England.
- PHE should take a lead in setting national specifications and standards for public health services that are to be delivered locally across England.
- Community pharmacy should be recognised as a key provider of public health services in England. Evidence shows that where the public has a choice of provider for such services, it chooses pharmacies.
- Health and Wellbeing Boards should be created as set out in the Health and Social Care Bill and should include representatives of providers of public health services and of national primary care professions (such as pharmacy, ophthalmology and dentistry).
- Clear lessons have been learnt about commissioning and providing public health services. It is now time to apply these across England.
- The explicit linking of the NHS, social care and public health outcomes frameworks is overdue and is greatly welcomed.
- The Department of Health needs to set out clearly which services it regards as "public health" to avoid funds being diverted by local authorities.

ABOUT ALLIANCE BOOTS

Alliance Boots is a leading international pharmacy-led health and beauty group, employing over 70,000 people in the UK. The group's businesses in the UK include the Boots pharmacy chain and our full-line wholesaler, Alliance Healthcare Distribution Ltd.

Boots UK operates the largest chain of community pharmacies in the United Kingdom. It is synonymous with pharmacy in the public mind and Boots is one of the country's most trusted brands.

Our company has over 2,200 pharmacies in England trading under the Boots brand. These are located in all the places where people live, shop, work and travel, with many open well beyond normal office hours and across weekends.

Boots pharmacies are well distributed across the country. Our chain encompasses those which serve small local communities, including some of the most deprived locations in the country, and health centres through to high streets and those which are part of the largest retail and destination shopping centres. This provides easy access for the widest range of patients and customers.

Boots offers a wide range of services to help improve public health and individuals' lifestyles. These include services delivered through the NHS and our own innovative services combining professional advice and medicines.

The range of public health services provided by Boots pharmacies varies with local commissioning but typically will include smoking cessation, sexual health services, health heart checks, weight management, services for drug users (including supervised consumption of prescribed medicines and needle exchange schemes) and vaccinations.

Through a range of interventions, Boots helps the public engage more effectively in their own health and wellbeing: championing prevention, self-care and healthier lifestyle choices.

1. THE CREATION OF PUBLIC HEALTH ENGLAND

1.1 Alliance Boots supports the creation of Public Health England (PHE) as part of the Department for Health. We believe that PHE will provide an important focus and should ensure that public health is at the heart of the newly structured NHS in England.

1.2 In order to achieve this, PHE will need to have equal status to other parts of the new structure, such as the NHS Commissioning Board. PHE will need to be independent and have a high-profile leader who is prepared to speak out on key public health issues and work effectively with other Departments across Government.

1.3 PHE should take a lead in setting national standards and specifications for public health services to be delivered across England.

1.4 It is vital that the NHS responds quickly and effectively to the public health challenge. Clear lessons have been learnt from existing schemes and pilots; it is now time for PHE to apply these across England. Doing so will save the NHS money in both the short and long term.

2. THE ABOLITION OF THE HPA AND NTA

2.1 Alliance Boots sees the proposed abolition of the Health Protection Agency (HPA) and the National Treatment Agency for Substance Misuse (NTA) as arms-length bodies as a retrograde step that should be urgently reconsidered.

2.2 In our view, both organisations have made effective contributions to public health.

2.3 The HPA demonstrated its role in being an active first-responder to public health emergencies during the initial stages of the 2009 H1N1 influenza pandemic. It is unclear to us how this centrally coordinated function would be maintained under the new arrangements. This is especially crucial given that public health emergencies could happen in any part of the country without warning.

2.4 The NTA has helped spread best practice among local drug and alcohol action teams (DAATs), ensuring that there is comprehensive provision of drug misuse services across England. These services benefit public health, cut crime and reduce health and social care costs.

2.5 Pharmacies are heavily involved in providing services to drug misusers. Around half of all Boots pharmacies in England (1,271 of 2,244 stores) provide such services, which include regular dispensing of opiate substitutes as well as other public health interventions.

2.6 Given our comments on the need for greater standardisation for public health services across England [Para 1.3], we are concerned that the abolition of the NTA would lead to greater variation or a dilution of standards in these low-profile areas.

2.7 We urge the Committee to ask Ministers to reconsider and to maintain the HPA and NTA as distinct and separate public health bodies.

3. THE PUBLIC HEALTH ROLE OF THE SECRETARY OF STATE

3.1 We believe that the aim for future Secretaries of State to have a much greater focus on public health is a laudable one.

3.2 However, we feel that the Secretary of State will need to demonstrate how he can detach himself from the day-to-day politics of the NHS in order to focus on the long-term, population-wide aspects of public health.

4. THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

4.1 Overall, we support plans to devolve public health responsibility to local government. Local authorities are better placed to give priority to public health matters, many of which are affected by other local issues such as environment, housing, transport and employment.

4.2 However, we believe that this move should be done within a framework of national service specifications and standards. This would avoid unnecessary duplication of effort or the repetition of work previously done for the NHS by PCTs and consequently would prove a more cost-effective way of delivering services.

4.3 The Department of Health needs to set out clearly its definition of public health and, in particular, which services it expects should be funded from the public health budget being allocated to local government.

4.4 Failure to do this clearly will lead to the Government's attempt to raise the profile and impact of public health services being undermined. Funding for services could simply be diverted away towards other public services, such as environmental health, which could also claim to be "maintaining the public health" (see also comments under Sections 8 and 9).

5. HEALTH & WELLBEING BOARDS

5.1 Alliance Boots is in favour of Health & Wellbeing Boards (HWBs) being created in the manner envisaged by the White Paper and the Health and Social Care Bill. This would see them becoming committees of local authorities on which commissioning consortia have representation.

5.2 We believe that the alternative proposal put forward by the Health Select Committee in its recent report³¹⁷ would actually serve to downgrade the role and impact of public health under the NHS reforms. Merely giving local authorities representation on commissioning bodies would not raise their influence, especially if GPs retain overall control of the commissioning process. Such arrangements would weaken the ability of local authorities to hold consortia to account over their public health roles.

5.3 HWBs will have a statutory duty to include representatives from local authorities and commissioning consortia. We believe that they should also include representatives of providers of public health services and of professions delivering NHS primary care services through national contracts (other than GPs), such as pharmacy, ophthalmology and dentistry. The Bill should be amended appropriately.

6. JOINT STRATEGIC NEEDS ASSESSMENTS

6.1 Commissioning consortia need to be held to account for their input to Joint Strategic Needs Assessments (JSNAs) and the delivery of Joint Health and Wellbeing Plans (JHWPs).

6.2 This is why we support HWBs being committees of local authorities. Without this independence, the boards will not have enough independence to hold consortia to account.

6.3 All primary care contractors and providers of public health services should be consulted formally over JSNAs and JHWPs, and their comments taken account of.

6.4 Pharmaceutical Needs Assessments (PNAs) form a key part of JSNAs. PCTs were required by law to update their PNAs by February 2011. Further regulations setting out how PCTs should use PNAs to make decisions about new services and applications for new pharmacies (known as “control of entry”) have been delayed by up to two years, despite having been drawn up by expert advisory panel representing all stakeholders.

6.5 The Committee should ask Ministers to bring forward the new pharmaceutical services (control of entry) regulations immediately.

7. ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

7.1 Moving the commissioning of public health services from PCTs to local authorities gives the Government a real opportunity to make a step change in the way these services are delivered and the impact they have on the population’s health.

7.2 In order for this to happen, a full range of national service specifications and standards must be agreed for the key public health services. This will support effective public health delivery, reduce bureaucracy and prevent unnecessary costs being incurred.

7.3 *Health promotion and communication*—As a major retailer, we know that a coherent message is vital to customer understanding and service uptake. Developing clear national standards allows for the coordinated promotion of services to the public using a range of media and avoids duplication of effort or mixed messaging.

7.3.1 The National Audit Office found that PCTs were using up to 45 different marketing campaigns across the country for the same service (National Chlamydia Screening Programme).³¹⁸ Such “local inefficiencies and duplications” meant that the programme had “not delivered value for money”, the NAO concluded.

7.3.2 Healthy Living Pharmacies in Portsmouth have achieved good results using advertising on local radio and newspapers and the sides of buses. These are not expensive platforms.

7.4 *Training and accreditation*—Having national standards also allows a much larger pool of trained workers to be created. Local requirements for training and accreditation simply create small pools of trained staff, making service continuity difficult and reducing flexibility for national operators. Having a single agreed standard allows providers to train all their staff to the required level, allowing faster roll-out and making it easier to maintain service continuity.

7.5 *Local needs*—National standards would allow local authorities to build on a national framework of existing good practice, rather than having to design services from scratch, while taking local needs and priorities into account. They could also build on existing local knowledge and infrastructure for public health services. Community pharmacy is a clear example of this: pharmacies have been providing public health services for over 20 years and there is clear evidence of what works, how to deliver it and its value.³¹⁹

³¹⁷ Health Select Committee inquiry on “Commissioning: further issues”, April 2011 (HC 796–1).

³¹⁸ “National Chlamydia Screening Programme”, National Audit Office, November 2009 (HC 963).

³¹⁹ “Contribution of community pharmacy to improving the public’s health: review of published literature 1990–2007 (Report 7)”, Pharmacy Health Link, 2009.

7.6 *Co-ordination*—A clear set of national standards will also help with joint working between local authorities and commissioning consortia on issues which have both healthcare and public health impact, such as services for drug users or for sexual health.

8. PUBLIC HEALTH OUTCOMES FRAMEWORK

8.1 The explicit linking of the public health outcomes framework with the frameworks for the NHS and social care is long overdue and is greatly welcomed.

8.2 Domain 2 of the public health outcomes framework covers “tackling the wider determinants of ill health: tackling factors which affect health and wellbeing”. Some of the proposed indicators under this heading are very wide-ranging, including poverty, youth justice, unemployment, violent crime and road casualties.

8.3 We are concerned that this wide focus for the framework may lead to dilution of efforts to tackle core public health issues such as smoking and obesity (see Section 9, below).

9. ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES

9.1 The Government’s commitment to provide ring-fenced public health funding is a major step towards improving these services.

9.2 The Department of Health needs to set out clearly which services it regards as being “public health” for the purposes of this funding (see comments under Section 8, above).

9.3 Having a clear definition will give clarity to public health providers and commissioners about the level of investment that will need to be made in improving facilities or training staff.

10. COMMUNITY PHARMACY AND PUBLIC HEALTH

10.1 The Government should recognise community pharmacy as a main provider of public health services under the reformed arrangements for the NHS in England. Clinical public health services are those which involve the supply of a medicine or other intervention alongside professional advice, such as nicotine replacement therapy for smoking cessation.

10.2 Pharmacies are widely distributed and *easily accessible*. They cross the crucial boundary between NHS healthcare and the wider community—exactly the area that public health services seek to address.

10.2.1 By using community pharmacies to provide flu vaccinations, the Isle of Wight³²⁰ was able to reach a much larger group of “at risk” patients in the under-65 age group (36% vs 17% using normal vaccination route of GP surgeries and clinics). This was attributed to the greater accessibility and convenience for this age group of community pharmacies, with their longer and weekend opening hours. “Plurality of providers at different locations will maximise outcomes and benefits for patients,” an analysis of the service concluded.

10.3 Results from the Isle of Wight, the Healthy Living Pharmacies scheme in Portsmouth,³²¹ and the national Public Health Service delivered through all community pharmacies in Scotland,³²² show clearly that when they have a choice of service provider, *people choose pharmacies*:

10.3.1 In Scotland, prescribing of nicotine replacement therapies (NRT) as part of smoking cessation attempts almost doubled between 2008 and 2010 following the introduction of a national service through community pharmacies. By the end of 2010, nearly two-thirds (63%) of all quit attempts were being made through pharmacies, and over three-quarters in some Health Board areas.

10.4 Boots UK is already a major provider of public health services. However, the fragmented nature of public health service commissioning through PCTs means that, at best, only half of our pharmacies in England are offering a full range of services. This needs to change if the Government is to achieve its desired outcomes for improving the health of the nation.

10.4.1 During the 2010–11 flu season, Boots privately vaccinated 70,994 patients at their request in its pharmacies.

10.4.2 In the year to March 2011, Boots helped over 81,000 customers with their attempts to stop smoking, of which over 36,000 were successful (45%).

10.5 In conclusion, we believe that through PHE setting clear national standards and service specifications for commissioning public health services, the Government would empower community pharmacy and have a major impact on the health of the population.

June 2011

³²⁰ “3D commissioning”, NHS Isle of Wight, gold medal winner for pharmacy services commissioning, 2010 Acorn Awards, NHS Alliance.

³²¹ “Healthy Living Pharmacies”, NHS Portsmouth, silver medal winner for pharmacy services commissioning, 2010 Acorn Awards, NHS Alliance.

³²² ISD Scotland, prescribing of smoking cessation interventions, March 2011 (www.isdscotland.org/isd/4636.html)

Written evidence from Crisis (PH 127)

SUMMARY

- Crisis, the national charity for single homeless people, welcomes the Government's commitment to tackling and reducing health inequalities through improved public health services.
- The Government's new public health strategy must take particular account of the needs of vulnerable or excluded people, including homeless people.
- A greater emphasis on prevention of health conditions and wider availability of health advice and information could have real benefit for homeless people.
- We welcome the role of local government in promoting integration between health services and other services, including housing and homelessness.
- Health and Wellbeing Boards have a lot of potential, but it is important that their membership includes key stakeholders from the housing, homelessness and voluntary sectors.
- Commissioning public health services at local authority level may hinder partnership working and collaboration across boundaries.
- The Public Health Outcomes Framework is welcome, but could be amended to make the indicators more sensitive to the problems caused by homelessness.
- We support the introduction of a health premium, but would like to see more information about how it will work in practice.
- Payment by results poses real risks for more vulnerable groups, and should be properly evaluated before it is implemented across the health service.

HOMELESSNESS AND PUBLIC HEALTH

1. Homeless people experience serious health inequalities. Sleeping rough or staying in hostels, overcrowded, temporary or substandard accommodation can have a damaging effect on a person's physical wellbeing. Mental health problems are very prevalent and can be both a cause and consequence of homelessness.

2. The average age of death for a rough sleeper is only 42,³²³ compared with the national average of 76 for men and 79 for women. Common health problems include respiratory conditions, with one in ten people diagnosed with TB having a history of homelessness, foot conditions and dental problems, many of which are preventable. 32%³²⁴ of clients of homelessness services in England have mental health needs. 35%³²⁵ of those sleeping rough in London have mental health needs and 18% have a mental health need combined with a substance misuse issue (dual diagnosis).³²⁶ Rough sleepers are 35 times more likely to commit suicide than the general population.³²⁷

3. Homeless people often place a low priority on their own health, as more immediate concerns like food and shelter can take over. This means that health problems often go untreated and escalate into more serious conditions, requiring emergency or acute care.

4. Crisis has long campaigned for widened access and improved health services for homeless people. However, alongside this, a greater emphasis on health promotion and preventative care could be of real benefit to homeless people.

5. We recommend that public health promotion and information is accessible to all, and that public health professionals actively target vulnerable groups, such as homeless people. Health information sessions and leaflets should be made available within homelessness services, such as hostels and day-centres. Health information should also be tailored to meet the needs and priorities of vulnerable groups, ensuring it is relevant and useful to them.

6. Consideration must be given to there being a range of ways for public health professionals to engage and communicate with homeless people in order to provide public health information. There is certainly a place for accessible written information, such as leaflets and posters, and this should be made available in places frequented by homeless people such as existing homelessness services. However, written information will not always be effective in communicating health messages, not least because some homeless people and other vulnerable groups have problems with literacy or do not have English as a first language. Other ways to communicate could include, for example, "peer to peer" education, where homeless people help to educate others about issues such as preventing common health conditions, or drop-in information sessions.

THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

7. We welcome the decision to require each local authority to have a Director for Public Health and the fact that their budget will be ringfenced.

³²³ Crisis (2006) *Still Dying for a Home*.

³²⁴ Homeless Link (2009) *Survey of Needs and Provision (SNAP)*.

³²⁵ Crisis (1996) *Still Dying for a Home*.

³²⁶ Broadway (2009) *Profiling London's Rough Sleepers*.

³²⁷ Crisis (2009) *Mental Ill Health in the Adult Single Homeless Population: a review of the literature*.

8. We welcome the proposals to give these Directors responsibility for increasing integration and partnership between public health and other services, such as housing, transport and social care, in order to help prevent ill health and reduce health inequalities. It is important that knowledge and best practice on working with homeless people is shared between different agencies.

9. We are generally supportive of the introduction of Health and Wellbeing Boards, but it is important that they are easily accessible and representative. They should certainly be strongly encouraged to engage with the voluntary sector and make use of their expertise. We would ideally like to see membership being opened up to third sector partners so they can fully contribute. Frontline agencies working with homeless people, and homeless people themselves, are very well placed to offer advice on the need for public health initiatives in their local areas.

10. We would also recommend that those involved in housing and tackling homelessness are included in the Health and Wellbeing Boards, such as the strategic lead for housing within the local authority. This will help to enable a joined up and holistic approach to commissioning services.

ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

11. Whilst we recognise there could be merit in the move to commission public health services at local authority level, we would advise some caution.

12. Although the current PCT structure is not perfect, many trusts have built up significant bodies of knowledge in commissioning health services, particularly in public health, for vulnerable people. It is vital that this expertise is not lost.

13. For some specialised public health initiatives, budgets could be pooled and services jointly commissioned on a regional or sub-regional basis. Some may not be required in every local authority area, but on a regional or sub-regional basis there is likely to be a need. This is particularly important in large cities such as London where people frequently move between boroughs and can find it hard to access continuing support. It also provides an efficient way for commissioners to invest in higher cost services for a relatively small number of patients without risking either duplication or gaps in provision.

PUBLIC HEALTH OUTCOMES FRAMEWORK

14. The Public Health Outcomes Framework includes a wide range of health determinants and indicators and covers many important areas. We would suggest that the following indicators are included to provide an even more comprehensive structure.

15. We strongly support the inclusion of indicators based on housing and poverty. Currently only statutory homelessness figures are included as an area for improvement. Whilst this is welcome, there are many vulnerable, homeless people who are not included in these figures. Many single homeless people sleep rough or live out of sight in hostels, bed and breakfasts, squats or on family and friends' sofas and all of these vulnerable housing situations can impact on health.

16. Consideration needs to be given as to how to count people in these situations who are often not included in official statistics. This could include rough sleeper counts, statistics for people deemed homeless but not in priority need, hostel bed spaces, numbers of people in temporary accommodation, and consultation with local housing and homelessness service providers.

17. We believe it is important to build in some recognition that homeless people are particularly likely to live with preventable health conditions. In tackling many of the indicators, such as emergency readmissions, local authorities will need to specifically address ways in which they can support homeless people to access the treatment they need at the right time to prevent relatively minor health conditions snowballing.

18. We would suggest that an indicator on mortality rates among people with no fixed abode is included. Due to the extremely low life expectancy for rough sleepers, it is important that local authorities tackle mortality of homeless people as a priority.

ARRANGEMENTS FOR FUNDING PUBLIC HEALTH AND THE HEALTH PREMIUM

19. We are generally supportive of the move to tackle health inequalities using the health premium. However, further details will be needed on how the health premium is to be calculated before we are satisfied that it will really reward councils working with the most vulnerable people.

20. Decisions as to which areas will receive the highest funding levels must include an assessment of housing need and homelessness. Vulnerable housing and homelessness can be hard to measure, so wide indicators such as the demand for homelessness services and number of hostel bed spaces should be used.

21. We have some concerns about the use of payment by results, both for public health services and in the wider NHS.

22. It is often hard to measure outcomes when working with particularly vulnerable people. There must be a recognition that some people will have further to go to achieve good health, and that good health will mean different things to different people.

23. It is therefore particularly important that appropriate indicators are developed and worked into the outcomes framework to take these difficulties into account and ensure that health premium funding is truly based on the progress local authorities are making in working with more vulnerable patients.

24. Payment by results is to be introduced in a number of other areas, such as rehabilitation of offenders, but it has not yet been properly evaluated. It is important that further evaluation takes place in order to determine whether payment by results is effective in obtaining the desired outcomes in health.

June 2011

Written evidence from the Royal College of Nursing (PH 128)

1.0 INTRODUCTION

1.1 The Royal College of Nursing (RCN) issued a full response to the Department of Health's White Paper consultation on public health, *Healthy Lives, healthy future* and its corresponding documents on the Outcome Framework and Commissioning in March 2011. In these responses the RCN stated that it welcomed the renewed focus upon public health and that a new Public Health Service would be established with a focus on disease prevention and evidence based approach to improve health behaviour. However, the RCN has many concerns with the proposals for public health, not least the pace of change and the lack of mandated nurse involvement in commissioning of all health care services, including public health.

2.0 EXECUTIVE SUMMARY

2.1 It is vital that clearer lines of responsibility and accountability are mandated between the various actors and agencies created by the reforms. There must be clear mechanisms by which the tax payer can hold ministers to account, as well as those responsible for commissioning, delivering and overseeing care.

2.2 The RCN supports the focus on outcomes if it is sufficiently flexible to allow for local responses, whilst providing a robust public health framework to allow for comparisons and bench-marking. It is important that as well as high level outcomes there are also intermediate and short term outcomes in order to measure progress over time.

2.3 Nurses have an invaluable insight into the practical issues of service delivery, including advice on value for money, efficiency, and effective and quality care provision.

2.4 RCN members are overwhelmingly concerned that the allocated grant to Local Authorities would not be protected despite Government assurances. Coterminosity with local authority boundaries would alleviate many of the complexities of funding arrangements.

2.5 The Health Premium will require careful planning and the results of piloting should help inform decision making of future premium allocations. Rewarding those who demonstrate the greatest gains may disadvantage those localities with fluctuating populations, which mean that there is a steady influx of disadvantaged people whilst the more affluent leave the locality.

2.6 Health and Wellbeing Boards have the potential to offer a central platform for all concerned and if adequately prepared and supported, should facilitate joint commissioning arrangements.

2.7 The RCN welcomes the Government support for the Marmot review but believe that in the period since February 2010 there could have been more proactive work carried out by the Government to reap the benefits of the Marmot Review Team's recommendations.

2.8 Public Health Observatories (PHOs) provide invaluable information in regard to the health of the nation. PHOs have been able to present national and local statistics providing valuable information as the basis for policy and strategy to tackle health inequalities and public ill health.

3.0 OVERVIEW OF REFORMS

The RCN strongly urges the Government to adopt a phased approach to implementing new arrangements. This includes a full evaluation phase, sharing best practice and building on what is already known about good commissioning and delivery of services.

3.1 The RCN is also concerned about the pace of change in these times of financial constraint, and in particular how the move to Public Health England and Local Authority responsibility will impact upon the coherence of public health services. The transition will necessitate the integration of staff, systems and cultures if it is to succeed. The RCN believes that the proposed timetable is too ambitious and urges that appropriate support mechanisms are in place to support staff during the transition and that sufficient time is allowed for the new systems to become embedded.

3.2 The RCN Frontline First campaign has shown the effect the efficiency savings are having upon the NHS workforce, with 40,000 posts already earmarked for removal. Such cuts to the workforce cannot fail to effect standards of care and service.

4.0 ROLE OF THE SECRETARY OF STATE

The RCN is uneasy with the proposed arrangements of accountability including that of the Secretary of State within the Health and Social Care Bill. It is vital that clearer lines of responsibility are mandated between the various actors and agencies created by the reforms. Questions remain over the transition of the Department of Health to the Department of Public Health, local government responsibilities, and with the governance arrangements of Public Health England.

4.1 There must be clear mechanisms by which the tax payer can hold ministers, as well as those responsible for commissioning, delivering and overseeing care, accountable for government funded services. As the proposals currently stand the RCN does not believe the system is sufficiently robust.

5.0 OUTCOMES FRAMEWORK

The RCN supports the focus on outcomes within a framework that is sufficiently flexible to allow for local responses, whilst providing a robust public health framework to allow for comparisons and bench-marking. This approach should help to ensure that populations across England are not disadvantaged through poor commissioning, poor delivery or inappropriate allocation of resources. Consideration should be given to outcome accountability and how shared responsibility will be managed between the NHS, Public Health England, Local Authority, GP Consortia, individuals, government and industry.

5.1 It is important that high level outcomes also have intermediate and short term outcomes in order to measure progress over time. The introduction of an outcomes framework will need time to embed and to produce reliable outcome data. Given that health outcomes may not change significantly in the short term, consideration should be given to the development of intermediate indicators.

5.2 Outcomes should reflect the presence of health and wellbeing in the population, and not only the absence of disease or mortality. Outcomes should be rooted in the wider social determinants of health, and health protection outcomes should include inequalities and prevention indicators.

5.3 Public engagement and ownership are critical to the success of the public health agenda. Without public awareness, understanding and ownership, change is unlikely to be achieved. Nurses working in the community can play a key role as community champions and ambassadors. Nurses are also often the first point of contact for early intervention with individuals who, for example, smoke, have alcohol dependency issues and who are obese. This is one of the reasons why the RCN asserts that nurses should be involved at every stage and level of the design, commissioning and implementation of health services including public health.

5.4 Evidence suggests³²⁸ that a focus on early year's development and positive family experience is vital to a lifetime of good physical and mental health. A holistic service including midwives, practice nurses, the family nurse partnership programme, health visiting services and Sure Start centres play a key role in this. Outcome measures should take into account the progression from early years development to long term overall population health and recognise the role that nursing services can play in this.^{329 330}

6.0 COMMISSIONING

RCN members surveyed as part of the RCN's White Paper response overwhelmingly (81%) expressed the view that they lacked confidence that the voice of nursing would be taken account of in commissioning arrangements. Many senior nurses have gained considerable commissioning experience while working within Primary Care Trusts and this talent must be retained in the new public health arrangements and NHS. Nurses with experience of working in the community have an understanding of community health issues, the primary prevention of disease, and issues relevant to child and adult health. Such experience, knowledge and skills will be essential within the new commissioning and public health arrangements and that the unique perspective of nursing expertise in public health leadership and commissioning will provide a holistic view of the patient and the care pathway.

6.1 The RCN has previously stated its concern that increased localism may lead to fragmentation of public health services between different localities, exacerbating the "postcode lottery". With an increasing number of commissioning groups being established with their own boundaries and patient populations, this is further increased. The NHS is currently well placed to take a strategic overview of health inequalities and identify

³²⁸ Department of Health (2009) Healthy Child Programme *Pregnancy and the first five years of life*

³²⁹ HM Government (2011) Early Intervention: the next steps, An Independent report to her Majesty's government, Graham Allen MP <http://media.education.gov.uk/assets/files/pdf/g/graham%20allens%20review%20of%20early%20intervention.pdf> (Accessed 28.2.11)

³³⁰ HM Government (2010) The Foundation Years: Preventing poor children becoming poor adults, The report of the independent review into life chances, Frank Field <http://povertyreview.independent.gov.uk/media/20254/poverty-report.pdf> (Accessed 28.2.11)

need across a wide area. The RCN believes the proposals as they stand will not allow for this strategic oversight, and the reforms must change to reflect this.

6.2 Nurses have an invaluable insight into the practical issues of service delivery, including advice on value for money, efficiency, and effective and quality care provision. For example, health visitors, midwives and school nurses are an excellent public health resource and should be used to inform commissioning and to work closely with local public health teams.

6.3 Nurses are well placed to stand back and view care pathways, take a holistic perspective on clinical issues and effectively support commissioners in service design. The shift from a target-driven to an outcomes-driven public health service cannot happen without significant involvement of nurses in commissioning. There should be high level nursing involvement during the design, development and delivery of any reforms to healthcare services and healthcare commissioning. Nursing leaders play a pivotal role in helping to close the gaps between hospital, community and social care and hold vital skills and knowledge which should be harnessed within commissioning arrangements. This will help ensure the delivery of integrated and seamless care to patients.

7.0 FUNDING AND PUBLIC HEALTH ENGLAND

Respondents to an RCN member survey at the time of the Public Health White Paper expressed support for the creation of Public Health England and the proposal for ring fenced budgets to be the responsibility of Public Health England. However, a number of concerns were also highlighted. These included concern that the allocated grant to Local Authorities would not be protected (76%).

7.1 At this time of financial constraint across the public sector, the RCN is concerned that although public health funding has been ring fenced, responsibility for allocation of that budget has moved to the Local Authorities. Local Authorities' budgets are facing a reduction by 25% over the next four years. There is a real risk of this budget being squeezed and services outside of the remit of public health being funded out of this budget. This must be guarded against with detail of how ring fencing this budget will happen in practice.

7.2 Many PCTs are currently having to manage overspend, which could leave the new commissioning consortia vulnerable. The scale of cuts to existing PCT commissioning, quality improvement, information management and technology, finance and HR functions, will also leave commissioning consortia vulnerable and less equipped to take over their proposed roles. This is likely to prove a risk to business continuity for the local health economy, in terms of providing a service to the local population.

7.3 In considering the partnership of commissioning consortia and their role as public health providers and advisors to the Health and Wellbeing Boards and Local Authorities, it must be noted that commissioning based purely on the general practice 'list' will not capture the needs of the whole population as it will also include socially excluded people. The RCN is also concerned that with the advent of "any willing provider" and ability to register with a GP of their choice, the normal geographical boundaries upon which data is collected and decision on need made, will in future be flawed.

7.4 In order to aid effective commissioning and allocation of resources, consideration should be given to the alignment of consortia with local authority boundaries or their ward boundaries. Local Authorities have significant insight about their populations, which they use to inform local public service provision, and it is sensible to integrate this existing knowledge with general practice intelligence. Coterminality with local authority boundaries would alleviate many of the complexities of funding arrangements.

7.5 If public health is seen to be separated from the wider NHS functions then there is a danger that there will be budgetary tensions between public health and the NHS over who funds what services.

7.6 In social care such tensions have been seen to ultimately have a detrimental impact on the care patients receive. Care staff have to manage the issues that delays in funding create, such as bed blocking, as well as having to deal with the time-consuming "assessment industry" and form-filling that is a result of the funding divisions. The RCN urges the Government to carefully consider how it will ensure that such problems do not become a feature of the new public health structure and associated frameworks. There is risk attached to the proposed separation of the public health budget from the NHS. It is important that both Local Authorities and the NHS also continue their good work in addressing public health issues, disease prevention and health promotion and play a significant ongoing role outside of the ring-fenced budget.

8.0 HEALTH PREMIUM

The Health Premium will require careful planning and the results of piloting should help to inform the robust decision making of future premium allocations.

8.1 Whilst the RCN welcomes the recognition that the Health Premium needs to incentivise health improvements across a local authority's population so that inequalities are reduced as overall health improves, we have some concerns over its application.

8.2 Rewarding those who demonstrate the greatest gains may disadvantage those localities with fluctuating populations, which mean that there is a steady influx of disadvantaged people whilst the more affluent leave

the locality. Therefore the formula for the premium must be sensitive enough to calculate for gross inequalities both in variance of population and variance of capability and capacity of the public health team. There is also a need to consider all aspects of public health in the various communities. Rural communities may be more static than those within urban areas, especially major inner city areas, where population movement and migration is a factor.

8.3 Health Premiums need to be designed to reflect the often long-term nature of improvements in addressing inequalities.

8.4 The Health Premium must apply to the greatest health need within a locality, and cannot be a blanket measure as each locality will have different challenges. The structure of Health Premium should:

- Incentivise the provision of services which are targeted toward the hard to reach.
- Reward multi-sector integration and collaboration.
- Tackle areas where crime is a problem for local people.
- Target areas where people historically die prematurely.
- Be evidence-based on the research evidence for achievable public health intervention.
- Target intergenerational cycles of deprivation through a focus on children and young people.

9.0 HEALTH AND WELLBEING BOARDS

HWBs will need to retain impartiality and independence from competing commissioning and provider forces. They do however, have the potential to offer a central platform for all concerned and if adequately prepared and supported, should facilitate joint commissioning arrangements.

9.1 With the development of HWBs the RCN believes the Government must build on examples of best practice of established and successful joint working between Local Authorities and the local NHS through existing joint strategic needs assessments. Acknowledgement of the different cultures of the NHS and local government should not be underestimated, and plans to assist and support the development of a shared culture and professional language would be helpful.

9.2 The RCN welcomes the proposal that 15% of the GP Quality Outcomes Framework is aligned to public health, however, we are concerned that there appears to be no guarantee that “advice” from the HWB and Directors of Public Health (DsPH) relating to public health imperatives will have to be addressed, or sanctions applied if they are not.

10.0 MARMOT REVIEW

The RCN notes the Government’s support for the report by the Marmot Review Team, *Fair society, healthy lives*³³¹, the independent review of health inequalities in England. We agree that tackling health inequalities must remain a top priority. The recommendations made by the Marmot Review Team go well beyond the traditional parameters of health care and the health service, and recognise the importance of wider social, environmental and economic policies. Local Authorities will be well placed, if appropriately funded, to tackle certain social and environmental factors which contribute to health inequalities. However, the RCN believes that the responsible departments within the national Government must also ensure that proposed reforms to the labour market and welfare system do not worsen health inequalities.

10.1 Cuts to housing benefit, incapacity benefit and welfare could have an impact on the health and wellbeing of some of the most vulnerable members of society. Whilst it is recognised that some individuals misuse the benefits system, there are many who genuinely depend on it to maintain a minimum standard of life and ensure a minimum standard of health³³².

10.2 If cuts are made to the funding of Local Authority projects which are targeted in these areas, which is a likelihood given the current economic environment, we could feasibly see the aggravation of local and national health inequalities.

10.3 Whilst empowerment, “nudge” and social marketing all have a role in encouraging voluntary behaviour change, population approaches and national regulation can be both extremely effective and sometimes necessary (eg the banning of smoking in public places and the compulsory use of safety belts). The RCN notes that although the focus of the Public Health White Paper is on evidence based practice and service design, the evidence base for “nudge” is weak³³³.

10.4 The RCN welcomes the Government’s support for the Marmot review but believes that in the period since February 2010 there could have been more proactive work carried out by the Government to reap the benefits of the Marmot Review Team’s recommendations.

³³¹ Marmot Review Team (2010) *Fair society, healthy Lives*, Strategic review of health inequalities in England post 2010 <http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf> (Accessed 28.2.11)

³³² <http://www.dwp.gov.uk/docs/lha-faq.rtf> (Accessed 28.2.11)

³³³ Thaler R, Sunstein C. *Nudge: improving decisions about health, wealth, and happiness*. New Haven, CT: Yale University Press, 2009.

11.0 DIRECTORS OF PUBLIC HEALTH (DsPH)

DsPH will have a critical role in the leadership and management of public health services, and initiatives. They must retain the authority and independence to advise and guide public health decisions. It is concerning that there remains a lack of clarity regarding the decision making capacity and autonomy of DsPH and the RCN recommends that these posts should function at director level within Local Authorities. In order for the Directors of Public Health (DsPH) to fulfil their role there must be a direct line of accountability to from the Director to Local Authority Chief Executive level.

11.1 The Faculty of Public Health is generally accepted as the “guiding body” for public health and that the voluntary UK Public Health Register is the Nursing and Midwifery Council or General Medical Council regulatory equivalent. Public health is a speciality that embraces many disciplines including nursing. Applicants for consultant or director of public health positions (including nurses) must demonstrate that they are registered and that they meet Faculty standards. Interviews for these posts must follow the same standards³³⁴ regardless of the discipline of the candidates. The RCN agrees that any candidate that meets these standards is eligible for appointment to consultant or director of public health positions and that these posts should have equity in pay and conditions of employment.

12.0 PUBLIC HEALTH OBSERVATORIES

The RCN is concerned for the long term future of PHOs beyond the Government commitment to funding up until 2011–12. PHOs provide invaluable information in regard to the health of the nation.

12.1 PHOs have been able to present national and local statistics providing valuable information as the basis for policy and strategy to tackle health inequalities and public ill health. Without this sound information it will become more difficult to formulate effective policy and improve health outcomes. As well as the uncertainty around the future of PHOs, national trend data including indicators to demonstrate the effectiveness of behaviour change strategies is being lost as the “Place” and “Tell us” surveys are discontinued.

12.2 The NHS Information Centre has also announced that it plans to stop funding the *General Lifestyle Survey* run by the Office of National Statistics. This survey provides data on smoking and alcohol consumption attitudes and behaviour, two of the most damaging public health problems within society today.

June 2011

Further written evidence from the Royal College of Nursing (PH 128A)

Following the Government’s response to the NHS Future Forum Report, the Royal College of Nursing (RCN) has issued this further submission to the Health Select Committee.

PUBLIC HEALTH ENGLAND

The RCN was pleased to see that the NHS Future Forum had listened to concerns raised by the RCN in regard to the independence of Public Health England (PHE), as originally proposed in the Public Health White Paper and legislated for by the Health and Social Care Bill. The RCN sees the establishment of PHE as an executive agency and Non-Departmental Public Body, as a positive move. However, we await the full details and extent to which PHE will be independent. The RCN also awaits further detail on the structure, governance and funding arrangements of PHE.

85% of the public health workforce will transfer in to PHE on NHS terms and conditions with access to the NHS pension scheme. RCN members have been clear that they do not want to be involved in compulsory transfers to Local Authorities. The RCN is yet to see formal proposals in relation to the employment of PHE staff, but we would argue strongly that PHE should employ staff on NHS pay, terms and conditions and that all staff should continue to have access to the NHS pension scheme. To introduce any other pay, terms and conditions package would create a barrier to future staff retention and employment and could potentially lead to equal pay claims.

At this time of financial constraint across the public sector, the RCN is concerned that although public health funding has been ring fenced, responsibility for allocation of that budget has moved to the Local Authorities. Local Authorities’ budgets are facing a reduction by 25% over the next four years. There is a real risk of this budget being squeezed and services outside of the remit of public health being funded out of this budget. This must be guarded against with greater detail of how ring fencing this budget will happen in practice.

TRANSFER OF FUNCTIONS AND WORKFORCE TO LOCAL AUTHORITIES

As public health commissioning responsibility shifts from the NHS to Local Authorities, the RCN has concerns with how the transfer of staff between employers is managed.

There are ongoing discussions about the transfer of functions and staff from the NHS to Local Authorities, yet it has not been made clear which public health professionals will be involved. The RCN is clear that

³³⁴ http://www.fph.org.uk/faculty_guidance (Accessed 28.2.11)

regardless of the scope or nature of the transfer, there should be parity across the profession and equality of treatment of the public health workforce. Developing a two-tier workforce or multi-tier transfer process would be detrimental to the success of these teams.

The success of public health is that the workforce is a multi-professional team of doctors, nurses and other professionals with public health qualifications. The move to Local Authority responsibility for public health should not undermine the success and effective working of these multi-professional teams.

RCN members working in public health are clear that they value more effective and closer working relationships with Local Authorities. However, they do have some serious concerns and reservations about the impact these changes will have on their employment status, pensions, pay, terms and conditions, career and professional development.

NHS pension, pay, terms and conditions and NHS employment are vital tools for the recruitment and retention of highly skilled and qualified professionals. Retaining NHS employment supports effective professional training, development and flexible movement of staff across the sector. Transferring staff to Local Authorities, and the loss of access to a national pay, terms and conditions package and the NHS pension scheme, will create a barrier to staff movement and career development and will have a detrimental impact on the future development and skills of the public health workforce.

The RCN believes that there are a range of employment models, which are currently being used to support integrated working within public health, and that these should be promoted as good practice. The RCN believes that these employment models offer Local Authorities, the NHS and public health staff the opportunity to work in an integrated way, while removing professional and career barriers for public health staff. The RCN would want to have the opportunity to explore and promote these models further with the NHS and Local Authorities.

PUBLIC HEALTH OBSERVATORIES

The RCN, in its original submission to the Health Select Committee inquiry on public health, stated its support for the vital role that Public Health Observatories (PHOs) carry out. PHOs are able to present national and local statistics which provide valuable information as the basis for public health policy and strategy. Without this sound information it would be more difficult to formulate effective policy and improve health outcomes. As such the RCN welcomed the recognition that the Government's response to the NHS Future Forum gives to PHOs but would like to see more information as to how the merger of PHOs and the National Treatment Agency will work in practice.

July 2011

Written evidence from Dr Mark Lim (PH 129)

SUMMARY

1. This is a personal contribution from a Public Health Specialty Registrar solely on the issue of Public Health Workforce, in particular those in Public Health Specialist Training.
2. Doctors undertaking Public Health Specialist Training have previously worked in Senior House Officer, House Officer or Foundation Year posts for between two and five years after qualification. They then apply and enter Public Health Specialist Training which takes five years. For example, the contributor entered medical school in 1998 and is due to complete Public Health Specialist Training in 2012.
3. The contributor believes that there are opportunities to improve the current outlook for those completing Public Health Specialist Training during the transition.
4. The contributor believes that Public Health Specialist Training is totally viable in a system where health improvement and health protection takes place in Local Authorities. The health system must, however, ensure that certain mandatory elements of training and experience (healthcare public health and health intelligence) are still accessible, to meet requirements for Specialist Registration with the General Medical Council.
5. The contributor has summarised the rationale for Public Health Specialist Training, as there has been little specific reference to this in other publications.

MAIN SECTION

1. About the contribution:
 - (i) Although the contributor is co-chair of the British Medical Association Public Health Medicine Registrars' Subcommittee, this is a *personal contribution on the subject of Public Health Specialist Training* within the context of the Public Health Workforce.
 - (ii) The contribution also follows up the concerns around training voiced by Professor Lindsey Davies at the first session of this inquiry.

2. The most pressing issues are:

- (i) The number of Specialist Registrars *completing training* is rapidly outstripping the availability of substantive consultant jobs; the ratio will be approximately 4:1, if the situation remains similar to the financial year just gone.
- (ii) During the financial year ending 2010–2011, 23 Specialty Registrars were appointed to substantive consultant posts, 22 were appointed to short term posts as locums, 10 did not get appointments or did not complete training and a further 12 were in their “grace period” (a short term contract extension). Those not receiving substantive consultant posts in 2010–2011 will, during 2011–2012, be in competition with a further 52 completing training during that year.
- (iii) There are at least four types of organisation that might claim or disclaim responsibility for this situation. The Deaneries currently employ Specialist Registrars through host organisations and are primarily responsible for ensuring they are trained well; the Department of Health leads work on transition work in relation to health improvement and health protection which affects employment prospects radically, and of course they were responsible for *Modernising Medical Careers* in the first instance; Primary Care Trust clusters currently employ the majority of Consultants in Public Health; Strategic Health Authorities tend to have workforce directorates that engage in regional public health workforce planning to varying extents.
- (iv) Specialist Registrars currently within training have a specific set of skills and experiences that they must acquire during their training, else fail to meet General Medical Council requirements for Specialist Registration. Currently, the majority of these are obtained in within the commissioning and health improvement functions of Primary Care Trusts, local Health Protection Units, Public Health Observatories and Universities. The future health system must ensure that equivalent opportunities exist during the transition and in successor organisations; in particular it is not yet clear where Specialist Registrars in Public Health will be able to acquire ‘healthcare public health’ skills and health intelligence skills. These skills have been described in detail by submissions to the previous inquiry into Commissioning.

3. How I would like the Health System to Respond

- (i) An explicit recognition that for those doctors who are about to complete Public Health Specialist Training, the winding down and abolition of the *entire class* of major employing organisations *poses a problem that is unique to the specialty* and not faced by doctors in hospitals.
- (ii) That whilst Deaneries are in the process of being replaced by Provider Skills Networks and Health Education England, *one* organisation should have clear and ultimate responsibility for exploring the issues in relation to those completing Public Health Specialist Training during the transition. If the new Public Health system is unable to accommodate all those it has trained at taxpayer expense, I would like that conclusion to have been drawn after a big, open and comprehensive effort to avoid this scenario.
- (iii) If and when a system of Provider Skills Networks overseen by Health Education England is established, it has to be crystal clear who is ultimately responsible for workforce planning. I would suggest that within the Government’s proposed structure, this should be Health Education England.
- (iv) At present, Deaneries ensure that elements such as healthcare public health and health intelligences remain available as experiences during the transition. If and when Deaneries are abolished, I would like to be clear who would be responsible for maintaining this availability.

4. Benefits of Public Health Specialist Training

- (i) As with any medical specialty, any industry or the armed forces, the key is to recruit people with the correct skills, background knowledge, experience and commitment. It is vitally important that the public health workforce continues to recruit doctors. Medical entrants to public health will have had a grounding in human biology and clinical experience that gives them knowledge, perspective and passion for public health.
- (ii) Every doctor will have spent a substantial proportion of their career working in a multidisciplinary team. Through their clinical experience they will recognise, facilitate and support the key and massive contributions of non-medical colleagues.
- (iii) There is however a difference between “knowing that something should done” and “knowing how something should be done”. The following three sections give examples in health improvement, health protection, and healthcare.
- (iv) Excessive alcohol consumption, and the harm done to our society as a result, is a complex problem. As well as being recognisable champions for the community’s health, doctors have the potential to use their experience of the way in which patients with alcohol abuse problems present themselves to improve the way in which society (a) supports these people to reduce their drinking and (b) establishes appropriate referral and treatment pathways. Specialist training will unlock this potential, by instructing the doctor on a wide range of relevant skills that will allow him or her to utilise this knowledge and experience. In this instance, he or she would learn how to (a) quantify the harm done by alcohol (b) construct effective programmes aimed at preventing alcohol misuse (c) calculate the capacity or other specifications required of alcohol misuse services at every level

- (d) evaluate existing services for effectiveness and value for money. Training will also provide the doctor with other more generic skills that are necessary to make these efforts successful, notably the ability to lead local teams, establish a strategy, work with partners and communicate effectively through the media.
- (v) For a disease which is infectious and can be prevented by a vaccine, a doctor will know the biology of the virus or bacteria, how affected patients appear and what the treatment is. Public Health Specialist Training will enable a doctor to ascertain how infectious a disease is, how it should be monitored within a population (such as a school or a town) and what measures need to be taken at a population or individual level to prevent its spread.
- (vi) For a complicated intervention or service, such as bone marrow transplantation, a doctor will have a knowledge of the diseases that would require such a service. Public Health Specialist Training will give the doctor the necessary skills to (a) calculate the likely need for such services (b) estimate future need for such services based on technological, population and policy changes (c) assess, in terms of overall effectiveness and value for money, the different options for providing that service (d) formulate evidence-based indicators, such as outcome measures that will make the provider accountable to the commissioning community or organisation.

June 2011

Written evidence from the Advisory Group on Contraception (PH 130)

1. EXECUTIVE SUMMARY

1.1 The Advisory Group on Contraception (AGC) is pleased to have the opportunity to contribute to the Health Select Committee's inquiry on public health. The AGC is made up of leading clinicians and advocacy groups that have come together to discuss and make policy recommendations concerning the contraceptive and sexual health needs of women. Given the current policy focus, which has been skewed towards teenagers, the AGC has decided to focus on post-teen women to ensure that the contraceptive needs of all women, whatever their age, are met. A full list of members of the AGC is available in Appendix 1.

1.2 We believe that comprehensive, open access sexual and reproductive health services play an important part in delivering improved public health by preventing ill health, improving wellbeing and addressing inequalities. It is therefore crucial that improvements in sexual and reproductive health services are given adequate focus and attention within the new public health service, and during the Committee's inquiry.

1.3 In particular, we believe it is crucial that open and equal access to sexual and reproductive services is maintained and that people are able to have a genuine choice in the services and types of contraceptives available to them.

1.4 We have provided evidence to the areas where we feel able to constructively contribute the most to the inquiry and would like to make the following recommendations in our submission:

- 1.4.1 Local sexual and reproductive health advisory groups should be established to bring together providers and specialist healthcare professionals to advise NHS and public health commissioners.
- 1.4.2 Public Health England should take steps to put in place safeguards to ensure the ring-fenced public health budget is spent on appropriate public health initiatives.
- 1.4.3 The Department of Health should take steps to ensure the establishment of a sexual health tariff for contraception services as soon as possible.
- 1.4.4 Public Health England should set out plans to develop national frameworks for the commissioning of effective public health services.
- 1.4.5 Public Health England should regularly review the quality of the indicators selected and carry out research to identify those indicators which will be best suited to deliver on the principles set out in the Public Health White Paper.
- 1.4.6 Public Health England should consider the use of Patient Reported Experience Measures (PREMS) in reporting outcomes for public health services, including sexual health and reproductive services.
- 1.4.7 Information on the number of healthcare professionals trained to fit and remove different types of long-acting reversible contraception (LARC) should be collected by health professionals' regulatory bodies and reviewed by Public Health England to ensure that there is sufficient provision in all parts of the country.
- 1.4.8 Public Health England should work with relevant stakeholders to establish national standards of competency for healthcare professionals delivering contraceptive services.
- 1.4.9 The Department of Health should provide clarification on how workforce training for public health services will be funded within the new structures.

1.5 Should you require any further clarification please do not hesitate to contact our secretariat. The meetings of the Advisory Group on Contraception have been organised and funded by Bayer. The secretariat for the AGC is provided by MHP Communications, whose services are also paid for by Bayer.

2. FUTURE ROLE OF LOCAL GOVERNMENT

2.1 While the AGC supports the devolution of responsibilities for public health to ensure that services are responsive to the needs of local communities, we believe that an important role remains at a national level for Public Health England and the NHS Commissioning Board in ensuring that local authorities are supported in commissioning high-quality integrated, comprehensive services for sexual and reproductive health.

2.2 Public Health England should be responsible for establishing national models for contraceptive pathways which could then be tailored by local authorities to the needs of their area. It should be the duty of Directors of Public Health to ensure that comprehensive and integrated sexual and reproductive services are commissioned and that referral pathways between them are in place.

2.3 Under the public health reforms, health and wellbeing boards and the proposed clinical senates will have an important role to play in ensuring that there is effective co-ordination between community contraceptive services commissioned by local authorities and contraceptive services commissioned by the NHS Commissioning Board and provided in general practice. That is why it is important that there is adequate clinical involvement in health and wellbeing boards.

2.4 We would ask the Committee to consider recommending that sexual and reproductive health advisory groups and clinical networks are well established in each local area, bringing together providers and specialist healthcare professionals to advise GP commissioning consortia, Directors of Public Health and health and wellbeing boards on the commissioning of sexual and reproductive health services.

2.5 We would ask the Committee to consider recommending that local health and wellbeing boards hold patient stakeholder events to understand the population's needs and preferences.

2.6 The Joint Strategic Needs Assessment (JSNA) will be an important duty of health and wellbeing boards. Health and wellbeing boards should have access to the following information on sexual and reproductive health in order to undertake a comprehensive JSNA which will underpin effective commissioning decisions:

- 2.6.1 Public health surveillance data.
- 2.6.2 Outcome indicators.
- 2.6.3 Patient experience information.
- 2.6.4 Financial data.
- 2.6.5 Data on the quality of existing services.
- 2.6.6 Governance information.

3. ARRANGEMENTS FOR COMMISSIONING AND FUNDING PUBLIC HEALTH SERVICES

3.1 The AGC supports the proposal to ring-fence public health spending from within the overall NHS budget. Our experience has been that in the past the additional funding for improving contraceptive services allocated to PCTs has not been protected and it has therefore been hard to monitor the deployment and outcomes of this funding. We also believe that the health and wellbeing board is the correct place to bring the ring-fenced public health budget together with other relevant local authority budgets.

3.2 We believe there will need to be adequate safeguards in place to ensure that the devolved ring-fenced public health budget is spent on true public health initiatives and is not used to subsidise other areas of local authority responsibility.

3.3 The Committee should consider recommending that Public Health England takes steps to put in place safeguards to ensure the ring-fenced public health budget is spent on appropriate public health initiatives, including clinical initiatives.

3.4 Public Health England will play an important role in ensuring the effective use by local authorities of public health funding by providing data to allow an analysis of the link between spending and outcomes. This will help to highlight the savings that can be achieved from investment in contraceptive services—including LARC methods—while at the same time support the health service in meeting the £20 billion of efficiency savings required by 2015. For example, it is estimated that every £1 spent on contraceptive services saves the health service £11.³³⁵

3.5 To ensure that quality services are able to achieve good levels of investment we would advocate for the use of tariffs rather than block contracts. This will help to incentivise good quality services which achieve the desired outcomes for patients and users.

3.6 The establishment of a tariff for sexual health services must be completed without delay in order to safeguard quality as the Department of Health's principle of any willing/qualified provider. We are concerned at the delay in the development of the sexual health tariff and urge the Department of Health to ensure that it is finalised and implemented at the earliest opportunity. In order to ensure that the quality of sexual and reproductive health services is protected we believe it is important that the sexual health tariff is set at a fixed

³³⁵ Department of Health, *Findings from the Baseline Review of Contraceptive Services*, May 2007

price, rather than a maximum, and that willing providers should compete on quality. The tariff should also make provision for cross-border recharge and increase patient choice about where they receive service provision.

3.7 The Committee should consider recommending that the Department of Health take steps to ensure the establishment of a sexual health tariff as soon as possible and that the points raised above are taken into consideration when doing so.

3.8 We support the proposal to allow “any willing/qualified provider” to deliver public health services. In order to make sure that quality is not compromised when multiple providers are competing to deliver services, and to ensure a basic level of uniformity across the country, we would support the development of national frameworks and standardised service specifications for public health services, led by Public Health England.

3.9 These frameworks would set out minimum standards which must be met by organisations when bidding to provide services to achieve the outcomes expected from a quality public health service. A number of guidelines and standards for contraceptive services have already been developed and tested and should provide a starting point for any future work.

3.10 The Committee should consider recommending that Public Health England develops national frameworks for public health services—including for contraceptive and sexual health services—to support the commissioning of effective local services.

3.11 In order to make sure that the new structures of the health service work for both the NHS and public health there are a number of systems which need to be put in place to ensure that NHS commissioning is underpinned by the appropriate public health advice to deliver positive outcomes:

3.11.1 *Communication*—there must be direct channels of communication between Public Health England and the NHS Commissioning Board, as well as between GP commissioning consortia and health and wellbeing boards.

3.11.2 *Data collection and analysis*—collecting standardised, high quality data that can be analysed at national, regional and local levels will allow commissioners to make informed public health commissioning decisions. These data about services and outcomes will be critical to demonstrating the impact of different commissioning decisions on quality, safety and efficacy of patient care. The development and implementation of software support for community sexual and reproductive health services is very tardy. It is not currently possible to compare contraceptive services provided by GPs and Contraception and Sexual Health (CaSH) services, since different data sets are collected and not all of these data sets are made publicly available.

More meaningful and comparable data on contraceptive services (in all settings) are necessary since they are critical to ensuring integration of care across the NHS and public health and to implement any tariff. Research is needed to establish robust and balanced outcome measures for contraceptive services and data collection systems to measure these. These data will also allow providers to scrutinise their competitors and make decisions about which services they should be delivering and the optimum service delivery model for the locality.

3.11.3 *Joint Strategic Needs Assessment*—local commissioners should be required to undertake an assessment of the sexual health and contraceptive needs of their local population through JSNAs. As the JSNA is developed in partnership between the local authority and GP commissioning consortium (and other partners) this is an extremely useful vehicle to ensure that NHS commissioning is underpinned by public health advice. This must include an understanding of access to contraception across all providers for local women.

4. STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

4.1 The AGC supports the establishment of a Public Health Outcomes Framework to sit alongside the NHS Outcomes Framework to support effective co-ordination of responsibility for health outcomes. Whilst 80% of contraceptive services are provided through general practitioners, there is a variety of sexual and reproductive service providers in local communities. It is important that integration of these services, particularly for patients, is encouraged and supported through the Outcomes Framework, and that it is used as a lever to ensure that providers in all settings are delivering consistently high quality sexual and reproductive health services.

4.2 Sexual and reproductive health services contribute to all of the domains in the proposed Public Health Outcomes Framework:

4.2.1 *Domain 1*—Sexual and reproductive health services provide health protection from sexually transmitted infection outbreaks.

4.2.2 *Domain 2*—Unintended, unwanted pregnancy and STIs including HIV can have a long-term impact on life chances and health inequalities.

4.2.3 *Domain 3*—The promotion of good sexual and reproductive health helps to improve wellbeing.

4.2.4 *Domain 4*—Effective sexual and reproductive health services prevent unintended, unwanted pregnancy and ill health.

4.2.5 *Domain 5*—In the most serious cases, sexual and reproductive health services can prevent people from dying prematurely from sexually transmitted infection or reproductive complications.

4.3 We welcome the Public Health White Paper's commitment towards ensuring a life-course approach to public health and believe this is an important approach when setting out to improve health outcomes for individuals across society. However, we do not believe that all the proposed indicators promote this approach.

4.4 Sexual and reproductive health affects women of all ages and, as such, the AGC believe it is vital that indicators within the Outcomes Framework reflect this in order to ensure they are not skewed to a particular group of people. As a result we advocate the inclusion of an indicator in Domain 3 on unintended, unwanted pregnancy for women of all ages. This would cover both abortion and maternity care.

4.5 Public Health England should also undertake research to identify a balanced set of specific outcome indicators for contraception, in order to ensure none of the indicators selected create a perverse incentive. For example, too strong a focus on the rate of abortion alone as a measure of contraceptive outcomes may lead providers to discourage women from having an abortion, thereby compromising their right to choice.

4.6 The Committee should consider recommending that Public Health England regularly reviews the quality of the indicators selected and carries out research to identify those indicators which will be best suited to deliver on the principles set out in the Public Health White Paper.

4.7 One of the key measures for the success of contraceptive services is whether the people using them feel that they have had a positive experience and felt supported in managing their sexual health needs and exercising their choice.

4.8 That is why the AGC would recommend that PREMs for contraceptive services are used as a proxy for contraceptive outcomes. A standardised questionnaire will need to be established to allow consistent and comparable data to be collected on patient experience of contraceptive services.

4.9 We would ask the Committee to consider recommending that Public Health England looks at the use of PREMs in reporting proxy outcomes for public health services, including sexual and reproductive health services.

5. FUTURE OF THE PUBLIC HEALTH WORKFORCE

5.1 The AGC believes that there is an ongoing need for improved data collection on the sexual and reproductive health workforce. There is currently no audit or register of the number of health professionals qualified to fit each type of LARC. This information is important in allowing commissioners to ensure that they have a sufficient workforce to meet local needs.

5.2 The Committee should consider recommending that information on the number of healthcare professionals trained to fit and remove different types of LARC should be collected by health professionals' regulatory bodies and reviewed by Public Health England to ensure that there is sufficient provision in all parts of the country.

5.3 We are concerned about the Department of Health's proposals for the provision of workforce education and training to be made the responsibility of individual providers to fund and organise. There is already a shortage of healthcare professionals trained to provide and fit all forms of contraception, and we are worried that this problem will be exacerbated by the proposed changes to responsibility for training provision. It is imperative that there is a co-ordinated approach to training supported by sufficient funding.

5.4 We believe that there is a need for Public Health England to work with the NHS Commissioning Board to establish national standards of competency for healthcare professionals delivering contraceptive services that would form the basis of requirements for local training provision. These standards will need to take account of the different types of healthcare practitioner delivering contraceptive services. Faculty of sexual and reproductive health already outlines standards for training provision and competency levels.

5.5 For example, the same qualification would not be appropriate for a practice nurse counselling and fitting an intra-uterine contraceptive in a general practice setting and for an abortion surgeon fitting an intra-uterine contraceptive under general anaesthetic. A framework of different levels of competency will therefore be required to take account of different roles.

5.6 The Committee should consider recommending that Public Health England works with relevant stakeholders to establish national standards of competency for healthcare professionals delivering contraceptive services.

5.7 We are concerned that, currently, funding of training is not explicitly included in the activity which will be paid for from the ring-fenced budget. In order to give women a choice of the full range of contraceptive services it is essential that training is provided for all healthcare professionals involved in delivering contraceptive information and care, including on how to fit and remove long-acting reversible contraceptive methods. If training is not going to be funded from within the ring-fenced budget then it is essential that it is made clear where funds will come from to pay for such essential training.

5.8 The Committee should consider recommending that the Department of Health clarifies how workforce training for public health services will be funded within the new structures.

APPENDIX 1

The members of the Advisory Group on Contraception are:

- *Dr Anne Connolly*, General Practitioner, The Ridge Medical Practice and Clinical Lead for Women's and Sexual Health, NHS Bradford and Airedale.
- *Ann Furedi*, Chief Executive, bpas.
- *Baroness Gould of Potternewton*, Chair of All Party Parliamentary Group on Sexual and Reproductive Health in the UK, and Co-Chair of the Sexual Health Forum.
- *Dr Kate Guthrie*, Consultant Gynaecologist, Hull Community Healthcare Partnership.
- *Natika Halil*, Director of Information, FPA.
- *Ruth Lowbury*, Chief Executive, Medical Foundation for AIDS and Sexual Health (MedFASH).
- *Tracy McNeill*, International Vice-President and Director of UK and West Europe, Marie Stopes International.
- *Jennifer Owen*, Senior Commissioning Manager, NHS Halton and St Helens.
- *Jill Shawe*, National Association of Nurses for Contraception and Sexual Health.
- *Dr Connie Smith*, Central London Community Healthcare NHS Trust.
- *Dr Anne Szarewski*, Clinical Consultant, Honorary Senior Lecturer, Centre for Cancer Prevention, Wolfson Institute of Preventive Medicine and Associate Specialist, Margaret Pyke Centre.
- *Dr Chris Wilkinson*, Lead Consultant, Margaret Pyke Centre.

Written evidence from Dr Alison Merry (PH 131)

1. I am extremely concerned that the proposals in the Bill will fragment, weaken and ultimately destroy the speciality of public health and will thereby put the health of the public at risk.

2. The proposals will fragment the public health workforce, disrupt the public health system and services, including the ability to effectively respond to an emergency or epidemic situation and undermine public trust and confidence. They will disrupt training in public health and adversely affect recruitment and retention of qualified public health specialists.

3. Public health encompasses three domains: health improvement, health protection and health services. 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. If supported by sufficient resources, public health interventions can improve and extend the lives of many thousands of people, saving the NHS and society millions of pounds.

4. It would be possible to mitigate these risks by:

4.1 THE THREE DOMAINS OF PUBLIC HEALTH

Embedding all three domains of public health throughout the system, including commissioning. Ensuring the health and wellbeing of people, protecting their health, and reducing health inequalities requires an effective and resilient public health system, which *integrates all three domains of public health* (health protection, health improvement and health services). The system also requires defined responsibilities and clear accountabilities, effective levers for change, and a sound and trusted evidence base.

4.2 PUBLIC HEALTH ENGLAND MUST BE AN NHS BODY

Establishing Public Health England as *an NHS body* providing independent and trusted advice, and employing all public health specialists—and seconding them to local authorities. This would:

- 4.2.1 Ensure that local authorities are supported by expert, embedded public health teams who are employed by Public Health England and seconded to local authorities to work as part of the local Director of Public Health's team, and seconded to other organisations such as commissioning bodies where public health expert advice is necessary.
- 4.2.2 Ensure public and professional trust and confidence in the expertise Public Health England provides is vital. Creating PHE as an NHS body would establish it as an independent, authoritative source of public health expertise whilst still providing the Secretary of State with a clear line of sight. This would also allow the health protection function to continue essential grant/commercially funded research work—which will not be possible if as proposed it becomes a DH directorate. An independent PHE would be protected to some extent from political or other influence, perceived or actual.

4.3 DIRECTORS OF PUBLIC HEALTH

The Director of Public Health must be qualified and registered and must be positioned within the local authority as an influential, strategic leader responsible for managing the ring-fenced public health budget, and providing public health advice and expertise locally, including to commissioning consortia.

- 4.3.1 Currently, the Bill does not does not require a Director of Public Health to be qualified. This must be rectified urgently in order to safeguard the public.
- 4.3.2 It is essential, particularly from a public protection perspective, that public health specialists, including DsPH, are trained and registered to specialist level in public health.
- 4.3.3 The Director of Public Health also needs to be appropriately positioned with influence and authority within the local authority (ie with direct access to the Chief Executive and cabinet and members), otherwise, he/she will not be in an appropriate position to influence in order to improve or protect the health of the local population. The DPH should be the principal advisor on all public health matters to the LA, including its elected members and the Health and Wellbeing Board (on which the DPH should have a statutory appointment), across all aspects of LA activity.

4.4 PUBLIC HEALTH AND DENTAL PUBLIC HEALTH SPECIALISTS

Public health specialists are trained and qualified to assess the health needs and aspirations of their population. They work across the three public health domains, and make decisions that affect the health of tens of thousands of people. DPHs are the strategic leaders for public health in their area, providing—through their annual report—independent analysis of the health needs of their local population and, equally important, a critique of how well those needs are being met and what more is required. It is vital that these functions continue in the new system. The Bill currently states that the DPH should produce an annual report on the health of their population but there is no explicit duty for it to also describe their health needs and extent to which these are being met. This should be rectified.

4.5 PUBLIC HEALTH AND DENTAL PUBLIC HEALTH INPUT TO COMMISSIONING.

The NHS reform programme proposes that the commissioning of health services becomes the responsibility of GPs, through the formation of local commissioning consortia. GP organisations have acknowledged that commissioning health services for entire populations rather than individual patients requires public health skills, expertise and knowledge. It is critical that public health expertise informs all commissioning decisions—and that commissioners have access to timely, reliable and relevant information and analysis. To meet this need, there must be a registered public health specialist, on the Board of every health commissioning organisation—including the NHS Commissioning Board, able to access additional expertise from local and national experts when this is needed. There should also be a duty placed on commissioning organisations, including GP consortia, to work with DPHs and their public health teams on all commissioning decisions to ensure the health needs of their communities are met. It is also important that commissioning groups and consortia work closely with clinical consultants, nurses and allied health professionals to ensure a truly integrated system of healthcare provision.

4.6 Furthermore the system must:

- 4.6.1 secure the continuation of public health training alongside other medical specialties to ensure the long-term viability of the profession;
- 4.6.2 support a sustained period of stability to enable the new system to deliver the ambition of the reform and;
- 4.6.3 ensure effective public health practice through a detailed understanding of the local context, dependent upon good working relationships, built on trust and mutual respect.

5. Public health is everybody's business—but it requires specialist knowledge and leadership to be effective, to save lives and to reduce disease, disability and dependence.

6. To maintain momentum and reduce health inequalities, it is essential that public health measures are sustained, developed and enhanced, that they are properly resourced and that they are led with authority and expertise.

7. In an era of austerity, a firm government commitment to public health makes sound economic sense. There is a wealth of evidence to demonstrate that effective public health interventions can reduce the need for expensive health and care services. Public health expertise within the health services is also essential if the escalating costs of low benefit health technologies are to be controlled and health services commissioners are to have the knowledge to implement the most effective and lowest cost services.

8. It is important now, more than ever, that public health continues as an attractive specialty to both doctors, dentists and individuals from backgrounds other than medicine. Public health is a competency based specialty and this must be maintained in line with other specialties. There is concern that, for example, LAs do not have the training structures or workforce plans in place to support the development and assessment of the necessary public health competencies across the workforce.

9. It is also vital that in the new system, specialty registrars undertaking public health training have access to the full range of public health experience and settings (such as local health protection units, provider trusts, local authorities) in order to fully develop their specialist public health competencies.

10. To ensure public and profession confidence, public health training must continue to be organised and provided alongside that for other medical specialities with similar arrangements for recruitment, standard setting and quality assurance.

June 2011

Written evidence from the People in Public Health (PH 132)

This submission is based on evidence from the People in Public Health³³⁶ research study at the Centre for Health Promotion Research, Leeds Metropolitan University.

Key points relevant to the inquiry are:

- Greater community involvement in the delivery of public health is vital. Evidence³³⁷ shows that involved, active communities can help tackle inequalities, design better services and improve health.
- The challenge of embedding community involvement in mainstream public health is in danger of being neglected—it seems to be “falling off the agenda”. This is despite the public health White Paper emphasising its importance.
- Government policy needs to give this issue a higher priority. A systematic response is required if communities across England are going to be able to seize the opportunity to become involved in public health. Supportive systems and structures are essential for action.

1. THE IMPORTANCE OF COMMUNITY INVOLVEMENT

The importance of local communities in public health was emphasised throughout the White paper “Healthy Lives, Healthy People”. It said “*we need to think ... about how to empower people and communities to make healthier choices in their lives*” (p12) that we need to “*harness efforts across society*” (p22) and that “*we are turning to local communities to devise local solutions which work for them*” (p38).

Evidence from the People in Public Health study supports this aspiration.³³⁸ An involved, engaged community has many public health benefits. It can help services tackle health inequalities because community members can play a major part in finding solutions to local problems and they can reach out to people who face barriers to maintaining their health. Involving people can improve the health of individuals, lead to better designed public services able to address the root causes of ill-health; and provide gateways to wider participation, new life skills, further education and employment.

We also believe that the time is right for this to happen. This is because:

- The Big Society idea is extremely relevant for health.
- A number of practical approaches have been piloted and proven to work on the ground^{339, 340}— in some cases there is evidence that it saves costs in the long run.³⁴¹
- We have reached the point where there is now a critical mass of UK research to support and inform local action.

2. ACHIEVING COMMUNITY INVOLVEMENT

Healthy Lives, Healthy People did not discuss how community involvement would be achieved. The People in Public Health study identified many examples of good practice—yet these are often reliant upon committed individuals and, with some notable exceptions, still exist in pockets rather than being embedded in mainstream public health. The challenge is to scale the activity up and make it a “normal way of doing business”.

³³⁶ “People in Public Health—a study of approaches to develop and support people in public health roles” was funded by the NIHR Service Delivery and Organisation Programme (project number 08/1716/2006) and reported in 2010. The research provides an evidence base for how services can recruit and support members of the public involved in delivering public health programmes. Further information from: <http://www.leedsmet.ac.uk/health/piph/>. The views and opinions expressed herein are those of the authors and do not necessarily reflect those of the Department of Health.

³³⁷ This study included a systematic scoping review of 224 publications relating to lay health workers, three national expert hearings, and the establishment of a register of interest plus five case studies. Interviews were conducted with 90 individuals providing services and 46 service users.

³³⁸ This study included a systematic scoping review of 224 publications relating to lay health workers, three national expert hearings, and the establishment of a register of interest plus five case studies. Interviews were conducted with 90 individuals providing services and 46 service users.

³³⁹ Walking for Health in 2010 had 11,000 active walk leaders, many of whom are volunteers, who last year led over 4,000 walks with 677, 885 attendances.

³⁴⁰ In Yorkshire & Humber, there are 12,000 volunteer community health champions who have promoted health with 70,000 people into communities and work places as part of the Altogether Better programme. www.altoghethebetter.org.uk

³⁴¹ The Community Development Foundation report: “Catalysts for Community Action and Investment: A Social Return on Investment analysis of community development work, based on a common outcomes framework” provides evidence that every £1 a local authority invests in community development, there is £6 of value from volunteering.

Evidence from our study is clear; community involvement does not and will not happen spontaneously. Supportive systems and structures are essential for action. Community Health Champions, featured in the White Paper (p43) and winners of the Prime Minister's Big Society Award, are examples of this. Their 12,000 health champions are part of a much larger programme (Altogether Better) and are supported by local project staff.³⁴²

These supportive systems need longevity; it takes time, commitment and consistency to establish sustainable community activity. Grassroots organisations cannot be “forgotten” then expected to re-emerge as necessary.

3. POTENTIAL THREATS TO COMMUNITY INVOLVEMENT

The People in Public Health team carefully considered the White Paper and observed subsequent discussions in light of the evidence collected. We feel that community involvement has increasingly fallen off the agenda, despite it being given much emphasis in the White Paper. We feel that currently there are significant threats both to current good practice and the rolling out of good practice. These are that:

- Community involvement is becoming overshadowed by other changes within the public health sector.
- Practitioners' attention and resources are being diverted by organisational change.
- Funding for structures to support community involvement will be lost or become erratic.

4. RECOMMENDATIONS FOR HEALTHY LIVES, HEALTHY PEOPLE

It is evident that, more needs to be done to ensure that the aspiration of increased community involvement in health becomes a reality. The policy recommendations emerging from our study are:

- *A systematic response.* If communities across England are going to be able to seize the opportunity to become involved in public health, then a systematic response is needed at across all levels of the health service. The Department of Health's volunteering strategy (2010) is a good start.³⁴³
- *Commissioning can be used as a way of building a local infrastructure of delivery organisations* to support community development and volunteering. Short term funding cycles undermine community action so therefore commissioning should be based on an understanding of the wider, long term benefits of involving members of the public.
- *Investment in local support systems.* There needs to be some investment to support effective implementation—people need someone to contact and perhaps help them overcome barriers to volunteering, they need training that will build their confidence to undertake new roles, they need light touch support and someone to turn to if issues arise.
- *Government policy* needs to ensure community involvement gets an increased level of focus. Without this the substantial benefits possible from this approach will not be delivered.

June 2011

Written evidence from The National LGB&T Partnership (PH 133)

SUMMARY

- The National LGB&T Partnership is a member of the Department of Health Strategic Partner Programme, working to highlight the inequalities and needs of LGB&T people and communities across Government and the statutory sector.
- Health inequalities suffered by lesbian, gay, bisexual and trans people remain largely marginalised in public health and are not given the same level and amount of focus as other protected characteristic groups, such as ethnicity.
- The continuing lack of evidence around the public health of LGB&T people represents a major entrenched barrier to the discovery and meeting of their needs.
- All health and social care services should collect the sexual orientation of their service users.
- LGB&T voluntary and community sector preventative activities are being disproportionately cut at local levels.
- In order for GPs and other statutory sector professionals to contribute to better public health, the relationship between healthcare staff and LGB&T communities must be improved as a matter of urgency.
- Public Health England needs to co-ordinate a national level response to the public health issues facing LGB&T communities, in partnership with LGB&T service delivery organisation in the voluntary and community sectors.

³⁴² Walking for Health in 2010 had 11,000 active walk leaders, many of whom are volunteers, who last year led over 4,000 walks with 677, 885 attendances.

³⁴³ Volunteering: involving people and communities in delivering and developing health and social care services, 2010, Department of Health.

- High quality LGB&T specific services are unsustainable over a purely local footprint.
- The time lag between any new ring fenced public health monies for local government, and the highly challenging funding environment as we move through 2011/12, needs to be recognised for the under-resourced LGB&T sector.
- In order for the Big Society to succeed, commissioners need to broaden their understanding of value to include social value.
- There should be a mandatory inclusion of all the protected characteristic groups in the JSNA process.
- The health premium should identify or at least be calibrated to reflect the real experiences of LGB&T people.

INTRODUCTION

1. This report provides feedback from the National LGB&T (lesbian, gay, bisexual and trans) Partnership, a member of the Department of Health Strategic Partner Programme. The National LGB&T Partnership is an England-wide group of LGB&T voluntary and community service delivery organisations that are committed to reducing health inequalities and challenging homophobia and transphobia within public services.

2. The National LGB&T Partnership members intend to positively influence the policy, practice and actions of Government and statutory bodies, in particular the Department of Health, for the benefit of all LGB&T people and communities across England.

3. The National LGB&T Partnership will ensure that health inequalities experienced by LGB&T people are kept high on the Government's agenda and that best use is made of the experience and expertise found within the LGB&T voluntary and community sector. The National LGB&T Partnership is also establishing a National LGB&T Stakeholder Group which is open to interested groups, organisations, service providers and individuals, giving a direct voice to the LGB&T sector. See <http://www.lgf.org.uk/the-national-lgbt-partnership/> for more information.

GENERAL COMMENTS

4. The National LGB&T Partnership is concerned that health inequalities suffered by lesbian, gay, bisexual and trans people remain largely marginalised in public health, despite a growing body of evidence demonstrating that LGB&T communities are disproportionately affected by many of the national priorities for public health. 'Healthy Lives, Healthy People' states:

"[Britain has] among the worst rates of sexually transmitted infections recorded, a relatively large population of problem drug users and rising levels of harm from alcohol. Smoking alone claims over 80,000 lives every year. Experts estimate that tackling poor mental health could reduce overall disease burden by nearly a quarter"

5. The continuing lack of evidence around the public health of LGB&T people represents a major entrenched barrier to the discovery and meeting of these needs. Addressing this lack of evidence appears to be of a low priority despite the strong indicative evidence that exists:

- LGB people are more likely than heterosexuals to say their health is poor: more likely to experience tension and worry; to abuse drugs; to smoke; suffer from asthma; or to be victims of sexual abuse³⁴⁴, and this is evidenced anecdotally for the trans population among the cases seen by TREC and GIRES.
- Men who have sex with men account for two thirds of HIV infections occurring in the UK in 2010.³⁴⁵
- 35% of trans adult people report having made at least one suicide attempt prior to accessing the treatment they are seeking³⁴⁶.
- 23% of the gender variant young people referred to the UK's sole treatment centre have engaged in self harm/overdose³⁴⁷.
- LGB people are significantly more likely to have taken an illicit substance in the last month, compared to the general population.³⁴⁸
- 72% of trans people have experienced harassment in public with the result that 21% avoid going out in public due to fears for their safety.
- 29% of [trans] respondents experienced verbal harassment whilst at work.

³⁴⁴ Conron, Kerith J., Mimiaga, Matthew J., Lander, Stewart J. (2010), A Population-Based Study of Sexual Orientation Identity & Gender Differences in Adult Health, *American Journal of Public Health* (Jun 2010)

³⁴⁵ Health Protection Agency (2010) 'United Kingdom new HIV diagnoses to end of December 2010'

³⁴⁶ Reed, B., Rhodes, S., Schofield, P. and Wylie, K. Gender Variance in the UK: Prevalence, Incidence, Growth and Geographic Distribution (2009) GIRES

³⁴⁷ Di Ceglie, D., Freedman, D., McPherson, S., & Richardson, P. (2002). Children and adolescents referred to a specialist gender identity development service: clinical features and demographic characteristics. *International Journal of Transgenderism*

³⁴⁸ The Lesbian & Gay Foundation and University of Central Lancashire (2011), 'Part of the Picture: Year One Initial findings' (to be published)

6. All health and social care services should therefore collect the sexual orientation of their service users so better and more complete evidence can be used to increase the impact of public health campaigns amongst LGB populations, or be used to inform targeted campaigns. The resources required to start this monitoring would save money in the medium and long term. For trans people a more urgent need is to assess the attitudes of healthcare staff towards them as fellow employees or service users.

7. Many member organisations of the National LGB&T Partnership engage in preventative activities, but despite the strong message of support for both prevention and the voluntary and community sector, voluntary and community sector preventative activities are being disproportionately cut on the ground.

8. For example, the Lesbian & Gay Foundation's gay and bisexual men's HIV prevention and sexual health programme across Greater Manchester receives £650,000 per year from the 10 Primary Care Trusts in Greater Manchester. The scheme involves the distribution of targeted HIV prevention and sexual health promotion in a variety of methods, HIV and STI testing services, outreach and the distribution of over 600,000 condoms and 600,000 sachets of personal lubricant. The HIV related cost to the health services over a single person's lifetime is estimated to be over £300,000³⁴⁹. Despite this obvious financial argument for the HIV prevention and sexual health programme, it has already been cut by up to 100% by some of the PCTs in Greater Manchester. Greater protection for this sort of work is essential for both LGB&T communities and for the future resource implications for health and social care services.

9. Inequalities arising from sexual orientation and gender variance are not given the same level and amount of focus as other protected characteristic groups, such as ethnicity. This can be seen throughout many strategic public health documents such as the equalities impact assessment for the funding and commissioning routes for public health, and the Marmot review itself.

10. It needs to be recognised that ethnicity, gender and disability are far better established in the minds of policy and decision makers as sources of inequality and disadvantage. The lack of evidence relating to sexual orientation and gender variance is identified but there seems to be a lack of consensus within the highest levels at DH, NHS and local authorities that this lack of evidence is a major barrier to securing equal access to services for LGB&T communities. The National LGB&T Partnership would like a commitment from the highest levels that the level of data collected on sexual orientation and gender variance of staff and service users, including staff attitudes, will be increased to match the level of data collected around other protected characteristics.

11. In order for GPs and other statutory sector professionals to contribute to better public health, the relationship between healthcare staff and LGB&T communities must be improved as a matter of urgency, and training around LGB&T issues must be prioritised:

- One in five trans people have found their GP to be unhelpful.³⁵⁰
- 99% of teachers witness homophobic abuse on at least a termly basis.³⁵¹
- 20% of health care professionals admit to being homophobic.³⁵²
- Only one in three older LGBT individuals believes their health professionals to be positive towards them³⁵³

12. The new commissioning architecture represents both challenges and opportunities for the LGB&T voluntary and community sector. The National LGB&T Partnership would like to see Public Health England co-ordinate a national level response to the public health issues facing LGB&T communities, in partnership with LGB&T service delivery organisation in the voluntary and community sectors. In engaging with these communities, the Department of Health needs to recognise that, although there are many voluntary groups that provide them with support, these groups are typically small and acutely under resourced. This is particularly the case for the 125 trans specific groups³⁵⁴, who are almost entirely invisible.

13. The National LGB&T Partnership welcomes the greater involvement of local government in public health, if local voluntary and community groups and marginalised communities are both explicitly involved in the process. LINKs and the proposed local HealthWatch have valuable roles to play, but their involvement is not a replacement for engagement with, and inclusion of, LGB&T communities and LGB&T service delivery voluntary and community organisations.

14. While commissioning will be the means by which most services are procured, it should be remembered that where investment is relatively small, a grant may be ultimately more cost-effective in terms of administrative burden on all sides, than a full procurement and commissioning process.

15. Tendering and procurement processes should be designed in partnership with the civil society sector, in order that they meet the needs and resources of all stakeholders. The National LGB&T Partnership would like

³⁴⁹ "HIV in the United Kingdom: v2009 Report", 2009, Health Protection Agency. The total cost of 3550 new HIV infections is estimated to be £1.1 billion.

³⁵⁰ Whittle, S. Turner, L. and Al-Alami, M. (2007), *Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination*.

³⁵¹ *Prevalence of Homophobia survey*, Oldham Division of NUT, 2008

³⁵² Stonewall (2007), *Sexual Orientation Research Review*

³⁵³ Heaphy B., Yip A. and Thompson D. (2004), *Shaping futures: LGBT people growing older*, p5

³⁵⁴ See www.TranzWiki.net

to see a pragmatic approach taken to model contracts with community providers. Requirements for performance measurement and management should be proportionate and not “one size fits all”. Partnership arrangements in the civil society sector should be supported and encouraged by all bodies in the new architecture.

16. Contracts for community providers would ideally include full cost recovery. It should also be recognised that the involvement of voluntary and community organisations is itself is a capacity building function and that contract timescales should be a minimum of three years, but preferably more.

17. The National Partnership welcomes the recognition that sub-national or supra-local commissioning can take place, but is concerned that this might not be supported or encouraged at the highest levels in the new architecture. High quality existing specialist LGB&T services that are currently funded at these levels, as well as future innovations, may be put at risk because of the proliferation of commissioning bodies, none of which may see such services as their particular responsibility.

18. LGB&T voluntary and community organisations face major problems in demonstrating their value because of the lack of sexual orientation and gender identity monitoring of public service users—for organisations working to support LGB&T people the lack of information about LGB&T people’s issues and needs is a major barrier to discovering and meeting those needs, and makes evidence difficult to produce for a section of the community that is largely ignored by central and local Government datasets, the 2011 Census and local public service monitoring data.

19. The time lag between the new ring fenced public health monies for local government, and the highly challenging funding environment as we move through 2011–12, needs to be recognised for the under-resourced LGB&T sector. The OCS Transition and DH Financial Assistance funds are welcomed but may not meet the funding shortfalls of the LGB&T voluntary and community sector. The National LGB&T Partnership recommends and extension of these funds into at least the 2012–13 financial year.

20. Social value is an important component of the value voluntary and community sector organisations such as the members of the National LGB&T Partnership can add when delivering frontline services, or when advising local or central Government to deliver mainstream services in a way that is more LGB&T inclusive. The National LGB&T Partnership welcomes and supports the Public Services (Social Enterprise and Social Value) Bill.

21. In order for the Big Society to succeed, commissioners need to broaden their understanding of value to include social value. The members of the National LGB&T Partnership have a growing number of highly dedicated volunteers, so a recognition of the value any volunteer input may have when commissioners are making decisions, would be welcomed. The continued existence of organisations such as the members of the National LGB&T Partnership which are unique in their strong links to “hard to reach” LGB&T communities as well as to Government allows a rare conduit of information and support to flow between these groups and Government who are often extremely separate.

22. The member organisations of the National LGB&T Partnership are reported by service users as to be one of the first points of contact for them when they have been at a crisis point in their lives. This specialised LGB&T crisis support needs to be supported by new commissioning arrangements and valued for the life and cost saving mechanism that it is.

23. The role of Joint Strategic Needs Assessments has been strengthened in the new system. There should be a mandatory inclusion of all the protected characteristic groups in the JSNA process.

24. There needs to be careful consideration of what proportion of total public health funding is earmarked for the health premium. The premium must take account of work targeted at marginalised LGB&T communities who suffer doubly from inequality and a lack of robust public health evidence. LGB&T people may also be more likely to be homeless, as a result of homophobic and transphobic harassment. This then impacts upon their health and mental health when homeless, or in poor housing, or in housing with care/support. There is an unintended risk that the premium, given the challenging economic climate, will ensure that the focus is only on the most ‘mainstream’ of public health concerns.

25. The National LGB&T Partnership believes that the health premium should identify or at least be calibrated to reflect the real experiences of LGB&T people. There is an unambiguous body of evidence that many of the most common and significant public health challenges that we face disproportionately impact upon LGB&T people. These include higher rates of:

- HIV and Hep B infection in gay and bisexual men.
- Alcohol dependence in LGB&T people.
- Smoking among LGB&T people.
- Common mental health problems such as anxiety and depression in LGB&T people.
- Self harm and attempted suicide among LGB&T people.
- Domestic and Familial Abuse.

Written evidence from Professor John Ashton, Director of Public Health, NHS Cumbria (PH 135)

EXECUTIVE SUMMARY

- Public Health England should be the focus for all public health activity ensuring no fragmentation across the three domains of public health. All public health staff should be employed by this body with structured arrangements between commissioning organisations and local government underpinning the approach.
- There must be clear line of sight from national to local arrangements for health protection and strategic planning of health protection arrangements should be embedded into the Joint Health and Wellbeing Strategy.
- Public health is the business of all of government and each department needs to adopt a public health/prevention orientation.
- Health and Wellbeing Boards are the primary focus for democratic accountability in health in the local area and must have powers to sign off GP Consortia Plans for the local area.
- Public health involvement in the commissioning of NHS services should be mandatory with strong relationships between Public Health England and GP Consortia.
- Oversight of all public health commissioned services needs to be from within the same organisation ie Public Health England.
- High quality intelligence and communications with good locality structures provide the best way of achieving evidence led solutions, applying more effort in areas of greater need and reducing health inequalities. A reduction of this capacity would be a retrograde step.
- Localities should be given the freedom to determine their own outcomes in respect of health and wellbeing in accordance with an assessment of needs and assets.
- Health premiums should not be inadvertently rewarding areas of affluence where improvements would be made anyway. This would serve to widen the inequality gap.
- The proposed ring-fenced budget is generally welcomed but should be defined clearly and protected to deliver against those defined areas. The budget should also be sufficient to meet the purpose.
- Credible independent expert public health professionalism should be maintained through specialist training and knowledge
- The Marmot review into health inequalities must be understood across all government areas

1 *The creation of Public Health England within the Department of Health*

1.1 The three domains of public health (health protection, health improvement and health services) are the central pillars to an effective system. Public Health England as currently proposed runs the risk of fragmenting these three domains. Much has been done in recent times to achieve joined up thinking, strategic oversight, performance management and effective co-ordinated delivery. To improve this approach all three domains must remain together within the remit of the new body. The range of agencies involved in public health under the proposals is complex and potentially confusing for both the general public and the partners who need to be engaged in order to be effective.

1.2 Public Health England acting as the overarching structure using secondment arrangements could work in the following areas:

- Health protection (infectious diseases, environmental hazards and emergency planning)—local Health Protection Units could be established as part of public Health England.
- Health improvement (lifestyles, inequalities and the wider social, economic and environmental influences on health)—local teams working in both tiers of local government but responsible to Public Health England.
- Health services (service planning, commissioning, audit, efficiency and evaluation)—Public Health England secondments into locality commissioning teams.

1.3 To enable this to take place Public Health England must be established as a special health authority or as an executive agency.

2 *The abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse;*

2.1 A key strength of the HPA has been the robust arrangements for centralised expert advice and handling of national issues, but in our experience this has been to the detriment of their provision of local services. In Cumbria, as described in our 2011 Director of Public Health Annual Report, we have established a strong in-house Health Protection Team. This would usefully serve as a national model.

2.2. With regard to the National Treatment Agency, allowing local areas to determine their own responses to their own problems is the most effective way to tackle substance misuse. Integrating the NTA into Public Health England makes an important and necessary link between substance misuse, prevention, harm reduction and recovery.

2.3 There must be clear “line of sight” from national to local arrangements for health protection. Local health protection and emergency planning arrangements should not be moved upwards from the Director of Public Health to leave responsibility only for those functions that are the responsibility of the local authority.

2.4 The strategic planning of local health protection must be integrated into the Joint Health and Wellbeing Strategy, based on the Joint Strategic Needs Assessment.

3 The public health role of the Secretary of State;

3.1 The public health focus of the secretary of state is of extreme importance. Not only will this serve to ensure that prevention is adequately resourced and that health care systems adopt a prevention orientation, in addition the secretary of state can influence in other areas of government. With a true public health and prevention focus this could mean acting as an effective advocate for public health in the following areas: housing, environment, alcohol/licensing, tobacco control, transport policy, crime and education. Public health is therefore the business of all of government as much as it is the business of all of society.

4 The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)

4.1 Local government has influence over many of the determinants of health and is a suitable setting to deliver health improvement through the range of services it provides. However as previously described this potentially fragments the three key domains of public health. Public Health England as the employing body for all public health staff could second public health teams to local authorities (potentially at all levels in two tier areas) to influence change within the context of all three domains and not restricted to the area of health improvement as currently described.

4.2 Future systems must not be fixated on the provision of personal services. Whilst the White Paper introduces the idea of transferring some public health services into local government, it is in the area of public health leadership where maximum effect can be achieved. Local authorities who embed public health principles in their organisations can integrate these principle with their community leadership role to mobilise the assets of citizens and other sectors to improve and protect population health.

4.3 A focus on leadership rather than service delivery is further important as many of those services are no longer directly provided by local authorities (eg Housing, transport, recreation, schools, food and water hygiene). Therefore the place to influence and mobilise services in the future should be the Health and Wellbeing Board which itself should not be solely the under the remit of local authorities. Whilst the democratic accountability through elected member representation is welcomed there is a need to develop multiple local methods of accountability to diverse constituents of interest.

4.4 The Director of Public Health must be able to give independent professional advice across all three domains having direct accountability to the Chief Executive of the upper tier local authority and direct access to the political leadership in the authority.

4.5 The power to sign off local commissioning plans must first sit with the Health and Wellbeing Board who will have the most accurate view on whether those plans satisfy the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. These two key documents must influence and drive the commissioning of services in the local area and must demonstrate to the local population that local need is being addressed. We must ensure that alongside any assessment of need there is an emphasis on the need to map assets so that we do not simply design and shape services to address need but that needs are met through mobilising the assets within communities.

4.6 There needs to be understanding of how public health outcomes are linked to other agreed outcomes in related areas such as economic development, regeneration and sustainability. The close links between health, worklessness, deprivation and environmental factors must not be lost through silo working in Health and Wellbeing Boards. Strong links will be necessary with the Local Enterprise Partnerships and other bodies engaged in regeneration in areas where health inequalities are wider.

4.7 Two tier local government gives particular challenges. It would be helpful if guidance also reflected the complexities of working within such a structure although the freedom to determine arrangements locally is welcomed.

5 Arrangements for public health involvement in the commissioning of NHS services

5.1 Public health involvement in commissioning should be mandatory and any commissioning organisation should demonstrate how it has taken account of specialist public health advice and available intelligence. This should run right through the system from national down to locality arrangements. There is not enough public health involvement in commissioning and proposals which divert staff into either local government or Public Health England will make that even more difficult to achieve. We have to also ensure that any future system enables us to be much better at using public health skills to performance manage and evaluate any commissioning changes.

5.2 Public health teams are hubs of partnership working for health in a given area linking clinical expertise to the work of a range of organisations who work in complementary and directly related fields. There are significant opportunities not realised in the proposals for GP consortia related to the development of Community Oriented Primary Care and Asset Based Community Development through more explicit collaborative approaches between Local Government and Primary Care. Public health teams are well placed to lead this agenda and to ensure its integration into wider commissioning objectives.

5.3 Whilst Public Health England can deliver on the prevention agenda, it cannot do it alone. Health services need to adopt a strong prevention orientation throughout their commissioning cycles to enable demand for health care to be managed into the future, therefore strong relationships need to be built and maintained between Public Health England and GP Consortia.

6 Arrangements for commissioning public health services

6.1 The proposals as they stand place the commissioning of public health services within a range of leadership structures from local government, Public Health England, the GP consortia and the NHS Commissioning Board. There is need for proper co-ordination of all aspects of public health to ensure need is met, assets are mobilised in an efficient way and duplication does not occur.

6.2 There would be far less risk to any of the above if all aspects of public health services had a direct co-ordinated relationship within Public Health England

7 The future of the Public Health Observatories

7.1 Intelligence is the lifeblood of any good public health system. Observatories have given a rich picture of the health of our communities at a range of spatial levels that simply would not be possible within localities. This high level population view has enabled comparison between similar areas and has led to the sharing of good practice which in turn has led to better outcomes for communities.

7.2 The development of Public Health Observatories at regional and local level, together with the range of products that have informed organisations and systems have been of immense value. This approach enables us to target scarce resources, particularly in areas of greater inequality. Public health expertise in evidence based decision making and prioritisation is key to ensuring services are efficient and commissioned according to need and evidence of what works. We consider it essential that future approaches will contain no less than what currently exists in terms of the focus on intelligence. It is critical that the expertise built up through intelligence networks at all levels is not lost. It is also essential that any future arrangement builds on the good relationships established between observatories and their constituent public health departments.

7.3 Observatories have proved their worth to the public health and wider partnership system; they are objective, knowledgeable and trusted sources of expertise. Without the range of high-quality expertise and support from public health observatories, much of the work carried out by practitioners and, indeed, local authorities, policy makers and the wider community would not be carried out without a sound evidence base. This will be even more important in a system where enhanced Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies are driving the agenda.

7.4 Effective public health intelligence must work hand in hand with high quality localised communications. The role of communications in effecting lifestyle behaviour change is significant as is the role in major emergencies, pandemics and other issues associated with protection of our communities' health. Social marketing and health information need to be targeted and specific to ensure maximum uptake of public health messages therefore locally directed communication arrangements using very specific knowledge of our communities, are essential.

8 THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

8.1 There are a large number of indicators mentioned in guidance received to date. Past experience has shown that it can be difficult to maintain focus on that number across the range of agencies we will need to work with. We would therefore hope to be able to prioritise a smaller set of indicators based on the issues identified through the JSNA process in Cumbria.

9 Arrangements for funding public health services (including the Health Premium)

9.1 The proposed ring-fenced budget is generally welcomed but should be defined clearly and protected to deliver against those defined areas. The budget should also be sufficient to meet the purpose. The definition should be clear about which elements are inside and outside the scope of the budget.

9.2 Whilst broadly supporting the proposals for a system which stretches performance, there are some elements of concern in the health premium proposal. Previous experience from developing Local Area Agreements has shown that pump priming new initiatives and tying in reward elements has helped partners maintain focus. We believe however that any health premium system must be focused on reducing inequalities rather improving performance or rewarding good performance. It should also not require an onerous data

collection approach nor reward improvement that occurs as a result of broader changes (eg overall increases in affluence in some parts of the country)

9.3 Good performance is harder to achieve in deprived areas which may exacerbate the gap in health inequalities. Even in more affluent rural areas issues like screening may suffer from reduced uptake due to geographical sparsity and access to services. Future systems should enable areas with particular difficulties such as these to be prioritised to improve faster.

10 *The future of the public health workforce (including the regulation of public health professionals)*

10.1 The public has a right to be confident in public health regulation and procedures. Specialist Public Health professionals are involved in decisions which affect morbidity and mortality which require a defined and regulated skill set. Whilst it makes sense to assert that “public health is everyone’s” business and that many interests can become involved in improving health, this requires specific specialist leadership which must be developed within a formal framework and regulated through an agreed system of continuous professional development. Statutory regulation is the most effective way to ensure this takes place.

10.2 The importance of credible public health advice cannot be underestimated. This can only be maintained through specialist training and knowledge which the general public can respect and have confidence in. This is especially important in health protection and crisis situations but is equally important across the other domains of public health.

11 *How the Government is responding to the Marmot Review on health inequalities*

11.1 The Marmot Review gave a comprehensive picture of health inequalities and how organisations should work much further upstream to tackle inequality. Concepts such as the health premium may serve to widen inequalities especially with elderly and vulnerable groups. Other areas of government policy need to understand Marmot to ensure that their policy areas do not inadvertently widen inequality. Tackling health inequalities is the business of all of government not just the Department of Health and as such Marmot needs to be understood across all departments.

12 CONCLUSION

Public health professionals are committed to protecting and improving health and wellbeing and reducing inequalities. There is recognition of the need to work with many different organisations to achieve our agreed outcomes but the key to success is in leadership and ensuring that leadership is as easy to understand and engage with as possible. Fragmenting the leadership and service provision of public health across multiple organisational boundaries is at best confusing and at worst will not help local areas to deliver on their agreed outcomes.

This “once in a generation” chance to reform public health may undermine the successes achieved in recent times in developing partnerships, collaborating and working towards a single system for public health. Due consideration must be given to keeping the three domains of public health together to ensure that public health thinking and a prevention orientation permeates through all parts of the system.

June 2011

Written evidence from Blackburn with Darwen (PH 136)

We welcome the opportunity to respond to the Health Select Committee inquiry into public health. Our response is in two sections—the first covering specific issues identified by the Committee and the second covering an additional issue which we feel needs to be highlighted.

1. BACKGROUND

NHS Blackburn with Darwen Teaching Care Trust Plus, only the second of its kind in the country, was established on 1 April 2010 and has ensured the integration of health and social care commissioning across the local health economy. The health service and local authority have a history of strong and vibrant partnership working in Blackburn with Darwen (BwD) and our latest radical initiative places us at the leading edge of the national health and local government integration agenda,

The Care Trust Plus arrangement now formally allows us to come together to ensure that first class services are delivered in a more efficient manner that will support improved health outcomes for local people.

We have a very strong public/private/third sector and Blackburn with Darwen’s Local Strategic Partnership (LSP) was established in the late 1990s to work co-operatively for the common good of the borough, recognising that more could be achieved by a partnership approach than by agencies operating on their own.

2. EXECUTIVE SUMMARY

- NHS Commissioning and GP commissioning consortia requires public health intelligence, advice and specialist input to implement the population approach and to bring about real change and commitment.
- Public health budgets in the most deprived and poor health outcome areas of the country must be protected and enhanced.
- We would like to see a more structured approach to Marmot's evidence.
- We are concerned with the proposals for a nationwide communications and engagement service.
- Opportunity for local solutions need to be given the time to develop.

3. SPECIFIC ISSUES IDENTIFIED BY THE COMMITTEE

3.1 *The future role of local government in public health*

- The Borough is significantly challenged in terms of poor health determinants particularly in relation to housing, educational attainment, worklessness and adult skills levels. Effective action against these long term health outcome challenges requires BwD to develop an integrated public sector response and for this reason the Borough is a Community Budget Pilot.
- We need to ensure regular interactions, joint working and enhanced accountability for the H&WB Board since this has been very powerful locally in BwD in terms of shared ownership of priorities, eg cancer, alcohol
- Merger of public health and the Council will bring considerable benefits and this will create an opportunity for Public health to be a strong guiding/challenging force for improving health and wellbeing outcomes within Local Authorities
- The Joint Strategic Needs Assessment (JSNA)/Integrated Strategic Needs Assessment (ISNA) remains a vital tool in service planning across all agencies and enabling planning to happen in a joined-up way. The role of the Joint Intelligence Unit (JIU) is key in delivering this as are other integrated working agendas through the Health and Wellbeing Strategy.

3.2 *Arrangements for public health involvement in the commissioning of NHS services*

- It is vital that the strong links that have been forged between NHS and public health are not lost in the changes and we are concerned that there will be fragmentation of commissioning public health prevention/interventions services, eg screening, vaccination and immunisation. This leads to a further concern of where/how public health influences such decisions, i.e. if the NHS NCB commissions such services.
- *BwD recommendation*—Wider health and social care professionals involvement will benefit the GPCC eg pharmacists, dentists, social care professionals, nurses, hospital consultants, *public health representative*.
- *BwD Recommendation*—That all existing community children's health services are integrated into the local public health service.

3.3 *Arrangements for commissioning public health services*

- Adequate capacity is needed to meet Public Health functions. For example PCTs Prevention spend that will transfer to Local Authorities should be sufficient to meet the challenges proposed by the Public Health Outcomes Framework (they are not likely to be on current proposals).

3.4 *The structure and purpose of the Public Health Outcomes Framework*

- The PH Outcomes Framework fits well alongside the frameworks for NHS and Adult Social care; the issue now will be ensuring that all three frameworks are considered alongside each other and that this is incorporated into local performance reporting frameworks.

3.5 *Arrangements for funding public health services (including the Health Premium)*

- There is a need to ensure that already challenged boroughs are not penalised further and that deprivation is taken into account for health premiums allocation.
- The national funding formula should be based on need rather than an average of all areas, especially where areas are investing higher than average currently for future improved health outcomes.

3.6 *The creation of Public Health England within the Department of Health*

- We feel that independence of Public Health England is crucial and PHE needs to be outside of DH.

3.7 *How the Government is responding to the Marmot Review on health inequalities*

- The current policy rhetoric supporting Marmot Review is completely at odds with what is actually happening eg areas and groups with the greatest health inequalities are being hit hardest by funding cuts.

3.8 *The abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse*

- There is a need to ensure that there is local innovation in addition to nationally driven objectives.
- Again independence for these agencies should be outside of DH—as per PHE.

3.9 *The future of the public health workforce (including the regulation of public health professionals)*

- Public Health England should employ Public Health Professionals.
- Public Health Directors should be senior posts accountable to the LA Chief Executive if they are going to sufficiently influence anything meaningful in terms of resource allocation to health improvement.
- (BwD PH Director is already accountable to LA Chief Executive).

4. ADDITIONAL ISSUE

National Communications shared service

- We have a well-established shared communications and engagement service in Blackburn with Darwen between the Care Trust Plus and Borough Council that builds on the partnership and single management of both organisations.
- We are concerned that while the proposals for a nationwide communications and engagement service are not policy based and are not specifically included in the published NHS reform, they are being rapidly driven forward.
- *BwD recommendation*
 - In addition to this the DH Social Marketing Strategy outlines “more will be done at a local level; the centre will do only those things which it alone is best placed to do” therefore if local health economies wish to locally target/innovate/engage with social media messages then DH cannot and will not do this.
 - Therefore locally owned communications is actually best practice.

June 2011

Written evidence from Cool Milk (PH 137)

INTRODUCTION

1. Cool Milk welcomes the Health Select Committee Inquiry into the Public Health White Paper: *Healthy Lives, Healthy People*. We would be pleased to assist the Committee with any further information, as requested.

SUMMARY

- Milk is widely recognised by health professionals for its high nutritional value and ability to contribute to positive health outcomes.
- The free nursery milk scheme currently applies universally to all children in child-care settings under the age of five. Subsidised milk is available to children aged 5–11 years old.
- The provision of milk in nurseries and schools provides health and social benefits particularly for the youngest children.
- Local authorities will play a crucial role in promoting healthy living amongst children as part of its new public health remit.
- The Department’s proposed Public Health Outcomes Framework should be broadened to acknowledge the crucial role of milk in supporting public health which would help Directors of Public Health in measuring the proportion of children in nurseries and schools who are likely to receive their daily intake of a range of nutrients.
- In line with the Marmot recommendation which states “that to reduce the steepness of the social gradient in health, actions must be universal”, the scheme would benefit from free nursery milk becoming universally available to all children up to the end of reception class—currently, classes are divided according to those children who have reached the age of five and are ineligible—and those children who are under five and are eligible.

COOL MILK

2. Established in 1998, Cool Milk is one of the UK's leading school milk suppliers, working in partnership with local authorities and early years groups to supply free and subsidised school milk to children in pre-schools, nurseries and primary schools.

3. Cool Milk is dedicated to making free and subsidised milk easier for schools, nurseries, local authorities and parents, whilst promoting the important health benefits and learning opportunities that school and nursery milk offers.

4. Cool Milk relieves the administrative burden of school and nursery milk provision (including arranging deliveries, accountancy, reclaiming of subsidies and invoicing). In doing so, we ensure that milk reaches the classroom from local dairies whilst freeing up the educators to get on with educating. Cool Milk provides every school and many nurseries with a fridge to ensure that all milk is served at the correct temperature, as well as providing any other supporting materials to run the scheme in the nursery or school.

PROVISION OF MILK IN NURSERIES AND SCHOOLS

5. Currently the Department of Health finances the universal provision of free school milk to children under five in childcare settings. It remains very popular with the public not only because of milk's substantial nutritional value, but also because the universality principle ensures that it benefits both the socially disadvantaged and broader societal groups.

6. At present, children under five years of age are entitled to free milk, with a subsidy of three and a half pence for children over five years. Of this subsidy, two and half pence is funded by the European Union, with the remaining penny funded by the UK government.

7. Administration of supplying milk to young people, accountancy and invoicing has usually been undertaken by either individual schools or, in the case of larger local schemes, by the local authority. Such systems suffer from two immediate problems—firstly, the addition of substantial demands to existing workloads (or alternatively, the designation of staff for this purpose). Secondly, the subsidies can be difficult and time consuming to reclaim.

THE BENEFITS OF SCHOOL MILK FOR CHILDREN

8. Milk is a naturally good provider of a whole range of nutrients essential to growth, development and maintenance of the human body and contains no artificial preservatives or colouring.

9. Relatively small quantities, (such as 189ml) can provide a significant proportion of daily nutrient requirements. In particular 189ml of milk provides a child with over half his daily calcium and phosphorous requirements. Both these minerals are essential for the healthy growth of bones and teeth. Milk is also a source of "high biological value" protein which means it provides us with all the essential amino acids that the body cannot make itself.

10. Among its many benefits, milk is known to support robust immune systems through its vitamin A content; and provide the recommended daily allowance of vitamin B12. Rehydration and re-energising are aided by the nutrient content of milk, supporting the improvement of concentration and memory function, to assist overall educational performance.

11. The National Advisory Panel for Food and Nutrition in the Early Years recommended that children consume three portions of milk a day. With many children only consuming milk at home during breakfast and dinner (and in many cases, no milk at all), the provision of milk in nurseries and schools is vital.

12. In addition, parents and teachers report a positive impact of "milk time" on young children, the positive peer influence on fussy eaters, and that there are many other social benefits, particularly for the youngest children, in terms of communal eating, sharing, pouring, table manners etc.

Public Health White Paper

13. Cool Milk supports the White Paper's statement that taking better care of children's health and development could improve educational attainment and reduce the risks of illness, tooth decay, unhealthy lifestyles and premature death.

14. The proposed Public Health Outcomes Framework which accompanied the publication of the White Paper aims to provide a tool which would allow an objective assessment of health issues and inequalities facing a local area.

15. This Framework could be strengthened through the inclusion of an indicator assessing the uptake of milk amongst young people within the classroom. Such an indicator would enable an appraisal of the effectiveness of the measures that have been employed to improve the health of young children. It would allow local Directors of Public Health to have an accurate measure of the proportion of children in their area who are receiving their daily intake of a range of nutrients through milk.

16. The Department of Health already collects data relating to the number of children and school in each local authority making use of the free nursery milk scheme, making the measurement of this proposed indicator easily achievable. Such an indicator would also be easily understandable by both public health professionals and the general public.

17. This data, coupled with information about rates of obesity, will enable public health professionals to identify particular areas within their community where children are at a particular risk of not receiving essential nutrients for their development. Most importantly, it will allow local health professionals to take action to ensure that the uptake of free nursery milk and subsidised milk in schools increases.

UNIVERSAL ACCESS TO FREE NURSERY MILK AND IMPROVING TAKE-UP

18. The Marmot review highlighted that focusing solely on the most disadvantaged children will not reduce health inequalities sufficiently. Whilst currently all children under the age of five in nursery settings (or reception class if they are under the age of five) are eligible for free nursery milk, the principle and practise of universality needs to be maintained.

19. Equally, the current cut-off point means that children in reception class stop receiving free nursery milk on the day of their fifth birthday. Our experience suggests that this is often very divisive within children's settings and that nursery and reception class teachers are put off from using the free nursery milk scheme as a result. It is therefore clear that the uptake of free nursery milk schemes would be higher if the Government sought to expand it to cover ALL children up to the end of reception class.

20. In conclusion, Cool Milk would like the Committee to recognise the positive role milk can play in children's development, which we believe is secured through the universal provision of milk to nursery school children. Cool Milk believes that in order to continue supporting children in this way, the Government's Public Health structures must continue to support the free milk scheme. This can be facilitated through by including an indicator measuring consumption in the Public Health Outcomes Framework and by extending eligibility for free milk to all children in their reception year at school.

June 2011

Written evidence from the British Dental Association (PH 138)

INTRODUCTION

1. The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. Its 23,000-strong membership is engaged in all aspects of dentistry including general practice, community/salaried services, Dental Public Health, the armed forces, hospitals, academia and research and includes students.

2. The BDA strongly welcomes the objective of improving public health. We support the vision of a shift from treatment towards prevention of ill-health and the recognition of Professor Sir Michael Marmot's view that the wider social determinants of health must be addressed in order to tackle inequalities. The change in focus must also be underpinned by specific measures to prevent avoidable illness, and supported by an appropriately-staffed NHS-based public health workforce.

3. We welcome the specific recognition of Dental Public Health in the White Paper. This must translate into inclusion in local priority and strategy setting in all areas of the country, requiring full integration of Dental Public Health with other health and social care structures and continuing dialogue between professionals.

4. The strengthening of public health outlined in the White Paper is supported. As Dental Public Health is a small specialty, it is important that Consultants in Dental Public Health are able to work in the most effective way across the three public health principles of health protection, health improvement and health services. Whilst it is essential there is Dental Public Health input into Local Authority Joint Strategic Needs Assessments (JSNA), the majority of dental commissioning will be with the NHS Commissioning Board, where it is even more important to give advice. We feel that this can only be carried out from within the NHS and so support the model of a public health agency.

5. The BDA responded to the three government public health consultation exercises in early 2011.³⁵⁵

6. The BDA, along with a reference group of Consultants in Dental Public Health, has produced a document outlining our vision for the future of dental public health which is attached at Annex A.

7. We note that a sound strategy already exists for developing the Dental Public Health workforce in England, and we urge the Government to draw on this in consolidating its plans for the new arrangements.³⁵⁶

³⁵⁵ <http://www.bda.org/dentists/policy-campaigns/research/government/leg-regs/pub-health-reform/>

³⁵⁶ Improving oral health and dental outcomes: developing the public health workforce in England http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_115512.pdf

THE CREATION OF PUBLIC HEALTH ENGLAND WITHIN THE DEPARTMENT OF HEALTH

8. Both the BDA and the BMA support a model which would see a single NHS public health agency assume responsibility for all public health specialist staff. This organisation would cover the three domains of public health practice—health protection, health improvement and public health support for commissioning.

9. It is essential that the Committee considers the impact of the creation of Public Health England alongside the NHS Commissioning Board, GP consortia, the transfer of budgets to local authorities and how this impacts on the public health workforce. It is likely that the creation of new NHS and civil service branches will result in unnecessary complication and the potential fragmentation of public health services, which must be avoided. It is essential that a robust strategy for the design, commissioning and delivery of all public health services is developed in collaboration with Consultants in Dental Public Health.

10. There is a lack of clarity on how dental public health will be integrated with other areas of public health and social care, particularly in view of the stated aim to adopt a life-course approach. We would welcome opportunities to work with the Department of Health on this. Proper integration of Dental Public Health will require expert input on all Health and Wellbeing Boards, to ensure that local oral health issues are represented in every JSNA and therefore in the joint health and wellbeing strategies. We advocate the inclusion of Consultants in Dental Public Health on Health and Wellbeing Boards to provide this. In cases where direct membership might not be possible, Health and Wellbeing Boards must be required to seek expert input from Dental Public Health specialists in identifying strategic priorities.

THE ABOLITION OF THE HEALTH PROTECTION AGENCY AND THE NATIONAL TREATMENT AGENCY FOR SUBSTANCE MISUSE

11. The transfer of the Health Protection Agency (HPA) to the Department of Health would render its function significantly reduced, to the detriment of the existing public health workforce. Approximately half of HPA's income is self-generated through research grants and commercial activity, and becoming part of the civil service will bring an end to these essential income-generating activities. This will inevitably result in a reduction in staff numbers, capacity and capability.

12. It is essential that relationships between HPA and the public health workforce are maintained, and this should be a core consideration when functions are transferred. We have significant concerns that we have already lost considerable expertise since changes to local structures began in 2010. It is imperative that structures are developed that facilitate the delivery of the public health strategy, rather than further fragmenting it.

THE PUBLIC HEALTH ROLE OF THE SECRETARY OF STATE

13. It is vital that the Secretary of State maintains statutory responsibility for protecting the health of the population. The new public health strategy forms a fundamental part of the Government's ambition for the modernisation of the health service, and we have reservations about the separation of health and public health, and the consequent division of accountability of the Secretary of State, and how this then relates to commissioning and funding.

14. Alongside the role of the Secretary of State, it is essential that healthcare Chief Officers are given a public health role. We were disappointed that *Healthy Lives, Healthy People* did not include a specified role for the Chief Dental Officer in the design and delivery of the public health strategy, despite making mention of the role of the Chief Medical Officer. It is essential that the Secretary of State maintains a strategic role across the healthcare professions in relation to the three domains of health protection, health improvement and health services, and how they fit into the wider NHS strategy.

The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Wellbeing Strategies) Arrangements for public health involvement in the commissioning of NHS services

15. Local government will play an important role in the delivery of the public health strategy, and this must be underpinned by the advice and guidance of an expert public health team. There must be a duty for local authorities to work with Consultants in Dental Public Health when developing the JSNA and Wellbeing Strategies to ensure that local needs are identified and addressed. Oral health must be a mandatory component of the JSNA.

16. It is essential that Directors of Public Health have a primary duty to their populations, and we support the BMA's view that this would require that they: prepare an independent annual professional report on the health of the population; act as an advocate for public health within all areas of the local authority; undertake health impact assessments of local authority policies, programmes and services; provide professional public health advice (rather than the corporate local government view) to other public bodies active within the area.

17. As at paragraph 10, we advocate the inclusion of Consultants in Dental Public Health on Health and Wellbeing Boards to provide expertise on oral health issues.

18. Most importantly, it is essential that a legislative framework is developed in collaboration with consultants in all areas of public health to avoid the need for local authorities to make ad hoc arrangements. Protected budgets and a clear strategy are required to ensure that consultants in dental and healthcare public health are able to best serve the needs of their local populations.

ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

19. As all dental services (this includes primary, secondary and specialist) will be commissioned by the NHS Commissioning Board, it is essential that the commissioning of these services is supported by a dentally qualified team, and not passed to any other healthcare specialty. These teams should be led by Consultants in Dental Public Health and would further support commissioning.

THE FUTURE OF PUBLIC HEALTH OBSERVATORIES

20. We support the BMA's view that Public Health Observatories (PHOs) must be supported if the Government is to achieve its vision of assessing and improving the performance of local public health programmes. The dental observatory in the North West provides important information for the specialty, and it is essential that this work continues.

THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

21. Overall, the BDA is satisfied with the structure and purpose of the Public Health Outcomes Framework, but made recommendations to include further outcomes for Dental Public Health in our response to the consultation exercise earlier in 2011.

22. The proposed oral health indicator for five-year-old children will promote collaborative working between health and social care professionals locally, and between family members. Sound oral health at age five is dependent on the prior establishment of good diet and effective oral hygiene routines, requiring engagement of all the child's carers. (This should also produce secondary benefits for family members, who are likely to lead by example when teaching the child good oral hygiene practice.) Consistent messages and support from midwives, health visitors and any other professionals coming into contact with children and their carers prenatally and during infancy are also essential. A further oral health indicator relating to older age groups would also encourage local partnerships across health and social care.

23. The BDA commends the Government's aspiration to reduce the incidence of dental decay in children aged five years, with the caveat that there will not be a significant change in outcomes unless interventions occur from a much earlier age. Dental decay is strongly linked to social deprivation, and the BDA advocates that the Scottish ChildSmile³⁵⁷ programme be rolled out across England, if this aspiration is to be achieved.

24. The scheme has achieved its target of 60% of children aged seven showing no signs of dental decay, and the programme is currently under review to establish firmly its effectiveness. Early indications show that the results will be positive, and the BDA recommends that Government monitor these outcomes and consider the impact of implementing the scheme in England.

ARRANGEMENTS FOR THE FUNDING OF PUBLIC HEALTH SERVICES (INCLUDING THE HEALTH PREMIUM)

25. We cautiously approve the basic principle of a ring-fenced public health budget, although we would like more information on how the dental public health budget will be calculated and allocated. We have concerns, however, about whether the ring-fenced money will be spent only on public health activity or will also cover salaries for local authority staff employed in public health teams. The financial situation of local authorities was not addressed in the consultation on funding and commissioning routes for public health as part of the *Healthy Lives, Healthy People* white paper consultation exercise, although they are facing real term cuts in Government funding of 26% between 2010–11 and 2014–15. This translates, on average, to a reduction of 7.25% per year. We are concerned that this will have severe implications for the delivery of public health. The impact assessment for the proposals indicates that any funding will be transferred from PCTs to local authorities for the transference of function from the NHS, and we need assurance that the service will not suffer as a consequence of a reduction in resourcing.

26. Whilst we strongly support the commitment to a reduction of inequalities and advocate a focus on vulnerable groups in society, we do not agree with the proposed health premium as a means to achieve this goal. A health premium should not be required if funding is correctly allocated in the first instance, with appropriate weightings that take account of inequalities.

27. We have concerns about how the ring fenced budget will be calculated and how the Department has formed early estimates that the spend on public health could be over £4bn. We ask the Government to publish the evidence base that supports this figure. Our concerns arise because not all public health money is easily identifiable—for example, funding for training of epidemiologists is found locally, but we believe it is important in the new system that it should be funded centrally. We seek clarity on the total budget for dental public health to ensure that it is adequate to provide the required functions and can be safeguarded.

³⁵⁷ <http://www.child-smile.org.uk/>

THE FUTURE OF THE PUBLIC HEALTH WORKFORCE (INCLUDING THE REGULATION OF PUBLIC HEALTH PROFESSIONALS)

28. We recommend that a commitment be made to ensure that there is adequate consultant advice available to the news structures and boards. One third of PCTs are currently without access to consultant advice in Dental Public Health, and around one fifth have no input from a Dental Practice Adviser, meaning that Dental Public Health is already considerably under-resourced. The average whole time equivalent in PCTs that have access to a Consultant in Dental Public Health is two days per week, with average Dental Practice Adviser input of only one day per week.

29. We recommend that all Dental Public Health posts that were in existence in 2010 be retrospectively protected to ensure that dental public health expertise is preserved, which should include recruiting to any posts that were vacant during that year. The budget for Consultants in Dental Public Health and Dental Practice Advisers who retire or move on during the transition period must be protected, and not diverted elsewhere. Dental public health is already underfunded, and the loss of any of its budget or roles will have a negative impact on the oral health and health services of local populations.

30. Consultants in Dental Public Health are and must remain NHS employees. That some are already being transferred into the local authority structure and are losing touch with dental commissioning is a worrying development. We support the BMA's proposal that public health staff should sit within a single public health organisation that would be part of the NHS. The development of guidance on where Consultants in Dental Public Health will sit and their accountability and reporting structure is required. This should be led by the Department of Health with input from the NHS Commissioning Board when it takes up its shadow responsibility.

31. We welcome the Government's commitment to develop a detailed strategy document to be published in autumn 2011, but caution against the duplication of existing work. The Department of Health's *Improving oral health and dental outcomes: Developing the public health workforce in England*³⁵⁸ provides a comprehensive analysis of the requirements of the Dental Public Health workforce, and should be used as the starting point for the forthcoming strategy. It is essential to recognise that the Dental Public Health workforce does not simply mirror the medical model. Consultants in Dental Public Health cover a much wider range of functions than their medical counterparts, with no separate workforce dedicated to dental epidemiological surveys or oral health promotion and in addition we have a particular focus on commissioning, service redesign and service evaluations across all areas of dentistry.

32. *Healthy Lives, Healthy People* outlines a budget of £4 billion for public health spending, and the BDA would be interested to see how that figure has been calculated. We support the idea of a ring-fenced budget in principle, but we have concerns about the lack of clarity on how this budget will be divided across the healthcare professions. Given that the Dental Public Health workforce is currently insufficient to deliver a nationwide strategy effectively, we are concerned that a reduction in funding will heighten this challenge, resulting in a detrimental impact on oral health. We understand the current financial challenges facing the NHS, but advise that, if there is a commitment to improving the public health of the nation, appropriate investment must be made to support this aim. The 2008 workforce summary for Dental Public Health estimated a target of one whole-time Consultant in Dental Public Health per 600,000 population and Dental Public Health teams should be developed to meet this target.

33. Alongside the commitment to improve the oral health of five-year-old children, we urge the Government to consider a similar target for the "heavy metal"³⁵⁹ generation, who will have significant restorative needs as they approach older age. As set out in our response to the public health Outcomes Framework consultation, we believe that an indicator is required for the maintenance of functional dentition into older age. In order to meet this increasing demand, it is vital that careful workforce planning is undertaken to ensure that we have sufficient staff numbers to carry out the volume of restorative work that will be required over the next 20 years.

34. The BDA responded to the Developing the healthcare workforce consultation, and we urge the Department to make use of all available data on the dental workforce and the future challenges it faces. We note that many members of the Dental Public Health workforce are approaching retirement, and clear succession planning is required. Dentistry also has a number of small specialties, including periodontics, endodontics and prosthodontics, with just under 30% of practising staff below the age of 55, and with limited training opportunities. Similarly, a lack of clinical academic places has the potential to destabilise training in these specialist areas, and this situation should be carefully monitored to ensure that the supply of specialist dentists meets the demand for their services.

35. Academic Dental Public Health must also be supported. Funding is required to promote excellence in research and teaching, in order to develop sound, evidence based practice.

36. We support the proposal in the Scally Report that the professional regulation for Consultants in Dental Public Health remain with the General Dental Council.

³⁵⁸ Ibid 2

³⁵⁹ Defined in Professor Jimmy Steele's Review of NHS dental services in England as "The younger generation of 1978 (16–34-year-olds) who had high levels of decay and many fillings, mostly of dental amalgam." As this cohort ages, they will require significant restorative work to maintain their oral health. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101180.pdf

HOW THE GOVERNMENT IS RESPONDING TO THE MARMOT REVIEW ON HEALTH INEQUALITIES

37. The BDA welcomes the focus on reducing health inequalities. Oral health is an area in which inequalities are rife, as set out in our recent paper *Oral health inequalities*.³⁶⁰ Vulnerable groups in society, including those with disabilities, prisoners, older people and children, are particularly affected and there is a strong correlation between oral health and socioeconomic status. We agree with the stated need to share responsibility across society for reducing these unacceptable disparities, with co-ordinated involvement of all sectors and health and social care agencies. Many of the factors underlying oral health inequalities, including diet, smoking and alcohol abuse, are common to poor general health. Close partnership working between all health and social care professionals is essential to deliver consistent and appropriately targeted messages across society.

38. People with disabilities must be considered specifically within local needs assessments, as their particular requirements can be overlooked in the absence of positive measures to include them. As recommended in the 2007 report *Valuing People's Oral Health*, oral health should be included in every care plan; co-ordination between all relevant health and social care professionals is required in planning, commissioning and delivering services. Robust local data must be the foundation of the needs assessment.

39. We welcome the emphasis on tackling the underlying social factors affecting inequalities in health and wellbeing, including environment, housing, education, as identified in the Marmot Review. Budgets for specific oral and general health interventions must be protected, and must not be subsumed into funding targeted to the underlying social determinants of health. This must be a statutory undertaking for local authorities.

June 2011

Annex A

DENTAL PUBLIC HEALTH FUTURES

1. We support the sound strategy for Dental Public Health which already exists³⁶¹. This should underpin the development of the Government's public health strategy, which we understand will be published in autumn 2011. This strategy was developed with broad professional input.

2. We recommend that a commitment be made to ensure that there is adequate consultant advice available to the new structures and boards. One third of PCTs are currently without access to consultant advice, and around one fifth have no input from a Dental Practice Adviser, meaning that Dental Public Health is already considerably under-resourced. The average whole-time equivalent (WTE) in PCTs that do have access to a consultant is two days per week, with average Dental Practice Adviser input of only one day per week.

3. The budget allocations must match the range of required activities to deliver the Dental Public Health strategy. Alongside this, we seek clarification of how the proposed public health budget of £4 billion³⁶² has been determined, and urge the Government to consider ring-fencing amounts for each area of healthcare, including Dental Public Health. A defined budget is the only way to ensure that each of the healthcare professions can effectively plan and deliver their services. We would welcome the opportunity to work with the Department of Health and the NHSCB to calculate the public health budget and numbers of staff required to achieve the Dental Public Health aims, including epidemiology, oral health promotion, health services and oral health strategy.

4. We recommend that all Dental Public Health posts that were in existence in 2010 be retrospectively protected to ensure that Dental Public Health expertise is preserved, which should include recruiting to any posts that were vacant at that time. The budget for Consultants in Dental Public Health and Dental Practice Advisers who retire or move on during the transition period must be protected, and not diverted elsewhere. Dental Public Health is already underfunded, and the loss of any of its budget or roles will have a negative impact on the oral health and health services of local populations.

5. Consultants in Dental Public Health are and must remain NHS employees. That some are already being transferred into the local authority structure and losing touch with dental commissioning is worrying. We support the BMA's proposal that public health staff should sit within a single public health organisation that would be part of the NHS. The development of guidance on where Dental Public Health consultants will sit and their accountability and reporting structure is required. This should be led by the Department of Health with input from the NHS Commissioning Board (NHSCB) when it takes up its shadow responsibilities.

6. In order to be in a position to give this advice, it was recommended in the Dental Public Health strategy that Consultants in Dental Public Health should work as part of a network. The model described by the BMA³⁶³—of a single public health agency with secondments to other organisations or with whatever sub-national arrangements of the NHS Commissioning Board—appear to be the favoured and most sensible models. High level input into these structures as they are developed is important. It will also ensure that Dental Public

³⁶⁰ http://www.bda.org/Images/oral_health_inequalities_policy.pdf

³⁶¹ Improving oral health and dental outcomes, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114488

³⁶² Healthy Lives, Health People: our strategy for public health in England

³⁶³ BMA response to Healthy Lives, Healthy People

Health continues to offer best value for money and contributes to the Department of Health's QIPP agenda by supporting service redesign and quality management.

7. As all dental services—primary, secondary and specialist—will be commissioned by the NHS Commissioning Board, it is essential that the commissioning of these services must be supported by a dentally qualified team, and not passed to any other healthcare specialty. These teams should be led by Consultants in Dental Public Health and would further support commissioning.

8. It is imperative that Consultants in Dental Public Health maintain their responsibilities regarding quality, access, probity and performance in the new NHS structures. They must also continue to be involved in the Joint Strategic Needs Assessment (JSNA) and health improvement programmes to ensure that identified needs are addressed at population level, and must have a role in quality oversight alongside the Care Quality Commission (CQC).

9. Although the oral health of the population continues to improve, there are still significant public health challenges to address, spanning the entire population. Issues such as access to quality, effective dental services, poor diet and nutrition, smoking and alcohol consumption, and the restorative needs of the “heavy metal” generation as described in the Steele Review³⁶⁴ will all play a part in ensuring that there will continue to be a significant long-term role for consultants in improving health and addressing inequalities.

10. During the transition period, a new dental contract will be piloted by the Department of Health, which is due to be implemented in 2014. To support general dental practitioners, commissioners and the Department of Health in piloting the new contract, it is vital that there is continuity in the provision and availability of dental public health services within the NHS, to ensure the process has expert clinical involvement.

11. The specialty of Dental Public Health must be safeguarded through the protection of academic careers, education and training, and the availability of sufficient consultant and training posts, thereby ensuring opportunities for career progression. Salaries and terms and conditions must continue to reflect the level of expertise currently provided by Consultants in Dental Public Health to ensure that the specialty can attract and retain the best people for the role. Terms and Conditions and Salaries must remain as core NHS. Clinical commissioning expertise must be safeguarded to ensure that Dental Public Health is not overlooked by non-clinical commissioners who are sometimes unaware of the importance of the specialty. We believe that this is best achieved by ensuring that public health, including dental public health remains the responsibility of the NHS.

12. The continuum of education and training in dental public health must be closely monitored and safeguarded. Trainees will continue to require both NHS and local authority-based experience to build the required competencies to become a Consultant in Dental Public Health. We must ensure that Consultants in Dental Public Health are able to work effectively across organisations and populations within new structures.

Written evidence from the National Institute for Health and Clinical Excellence (PH 139)

INTRODUCTION

1. The National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. NICE's public health guidance is the most systematic and thorough appraisal of the evidence of the effectiveness and cost effectiveness of public health actions and interventions in the world. Whatever the shape of the new public health system, it is paramount that it has access to and uses the best available evidence. This is something NICE can provide.

2. NICE's public health programme³⁶⁵ produces guidance and advice for the NHS, local government and other sectors, with recommendations about populations, communities, groups and individuals on actions, interventions, activities, policies and strategies that can help prevent disease or protect and improve health. All recommendations, standards and services are developed in consultation with independent advisory committees that include experts and members of the public, who examine the best available evidence of effectiveness (does it work?) and cost effectiveness (is it good value for money?).

3. NICE also provides access to a range of public health evidence, including NICE guidance, through NHS Evidence. This service incorporates the resources provided by the National Library of Public Health, and provides public health professionals with a comprehensive set of evidence to inform population planning and commissioning.

4. We welcome the opportunity to contribute to this inquiry, prompted by Government proposals for major changes to the organisation of public health services, as part of its wider plans for reform of the NHS. We have submitted evidence to Government consultations on the Health and Social Care Bill currently progressing through Parliament, and on the White Paper *Healthy Lives, Healthy People: Our Strategy For Public Health In England*.

³⁶⁴ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101180.pdf

³⁶⁵ <http://guidance.nice.org.uk/Type/PHG/Published>

5. The changes to the public health system announced in the White Paper mean that NICE will maintain the rigorous, evidence-based approach that enables it to provide authoritative, independent advice. In the proposed new system, it is vital that local government and NHS commissioners have easy access to evidence-based solutions. Existing NICE public health guidance (or derivatives of it) provides, or potentially provides such access. We are taking this opportunity to look at how we might adapt our products, communications, and range of engagement activities to meet the needs of the new circumstances.

6. The recently published Health and Social Care Bill also sets out a role for NICE in preparing Quality Standards for public health services and giving advice, guidance, information and recommendations on matters connected with public health services (clauses 218 and 221).

7. The White Paper states that NICE will work to specific commissions from Public Health England to add maximum value by providing authoritative, independent advice on the evidence of effectiveness and cost effectiveness of public health interventions (section 4.87). It also refers to NICE's work on the relative cost effectiveness of different interventions as the basis for Public Health England's function of developing intelligence to support directors of public health in commissioning local services. The White Paper also refers to the work NICE has undertaken on the return on investment of public health interventions.³⁶⁶

8. The proposals outlined in both the Bill and the White Paper present an unprecedented opportunity to refocus public health efforts, with local government at the heart of these new arrangements.

PUBLIC HEALTH AND THE ROLE OF NICE GUIDANCE AND ADVICE

9. There are three broad domains of public health: health improvement, health protection and health services. NICE has expertise and guidance covering all three domains, from recommendations on increasing physical activity in populations to work in development on identifying and managing tuberculosis among hard-to-reach groups. Rather than a summary of high-level messages on public health topics, our guidance is focused on using the evidence base to tease out the intricacies within each topic, identifying issues such as groups to target, inequalities to address, and providing methods for costing the impact of interventions so that they can be adapted and used at a local level.

10. The White Paper outlines how the new public health system will involve Public Health England, local government and NHS commissioning supporting a proposed public health outcomes framework and a "health premium", which will incentivise local government and communities to improve health and reduce inequalities, while leaving them free to decide how best to do this, in line with local needs (section 2.8).

11. For local authorities, being able to demonstrate improved outcomes will be critical, not just in improving people's lives, but in attracting the health premium incentive. Public health advice and guidance from NICE will therefore play a key role in enabling these organisations to deliver improvements in public health. NICE's expertise lies in examining and synthesising the current evidence base, and we have developed unrivalled expertise in the challenges associated with constructing the evidence base.³⁶⁷

12. NICE public health guidance covers all the topic areas identified in the White Paper, apart from emergency preparedness, pandemic flu and excess winter deaths—topics on which NICE would be willing and able to develop guidance and advice. There are now 35 published pieces of guidance, much of which relates to fundamental public health topics such as tobacco, alcohol, diet and obesity, physical activity, mental health and child health.

13. The model used in public health in NICE has taken a life-course approach, which is also central to the White Paper. We provided support for the WHO Commission on the Social Determinants of Health, as one of the supporting evidence hubs concerned with Measurement, Evidence and Knowledge which has been influential (through the work of Sir Michael Marmot) in the White Paper's focus on the wider determinants. Our existing product range therefore aligns with this White Paper priority.

14. We are taking the opportunity to review the guidance and support for putting guidance into practice so that we can ensure that, at the point when local government takes the lead in public health, our guidance provides practical assistance to local authorities as they seek to make progress against elements of the outcomes framework; helps Directors of Public Health in their duties of promoting health and well-being; and supports health service commissioning.

NICE QUALITY STANDARDS

15. The Health and Social Care Bill refers to quality standards for public health. NICE has already started to consider how quality standards could be used in the public health arena. Public health quality standards would be able to:

- (a) support the public health outcomes framework by defining high standards for public health interventions and processes;

³⁶⁶ Endnote 106, page 96, *Healthy Lives, Healthy People: Our Strategy For Public Health In England*.

³⁶⁷ Kelly, M.P., Morgan, A., Ellis, S., Younger, T., Huntley, J., Swann, C. (2010) Evidence based public health: A review of the experience of the National Institute of Health and Clinical Excellence (NICE) of developing public health guidance in England, *Social Science and Medicine*, 71 :1056—1062 <http://dx.doi.org/10.1016/j.socscimed.2010.06.032>

- (b) support progress on outcomes by providing a package of information, including indicators, which can be a tool for national and local commissioners and the range of public health service providers;
- (c) offer benchmarks against which local authorities, NHS commissioners, other local agencies and the public can assess progress on priorities—particularly priorities related to the premium;
- (d) align with the GP Quality and Outcomes Framework by supporting primary and secondary prevention indicators;
- (e) highlight the contribution of public health interventions to NHS and adult social care outcomes, support service integration where appropriate, and clarify the role of public health on care pathways that cross the boundaries of clinical care, social care, and prevention and health improvement and;
- (f) Fit with the White Paper’s aims of devolving responsibility, including responsibility for prioritisation based on local need. In the case of local government, they would be sensitive to the local democratic mandate and the idea of localism.

16. In the same way that our quality standards on clinical topics are produced, public health quality standards would be based on evidence, building on the platform of existing or future NICE guidance and/or NICE advice products, but also taking account of other good quality evidence, including resources available through NHS Evidence. They could take three main forms:

- (a) As a preventative dimension to any clinical pathway and relevant NICE clinical quality standards. COPD and diabetes are two good examples of where a preventative aspect to the clinical pathway would fit well.
- (b) On key public health topics for the NHS on tobacco, alcohol, obesity and physical activity. This would ensure that those areas currently the responsibility of the NHS (eg alcohol nurses working in A&E Departments) remain an NHS priority when public health responsibilities transfer to local authorities. There is an opportunity to develop integrated packages around each of these areas, something which NICE is already trialling with *NICE Pathways* (see below).
- (c) On topics that apply to local government where standards would be helpful, eg contraceptive services, smoking cessation, early years services, and the wellbeing of looked after children.

PUBLIC HEALTH AND THE EVIDENCE BASE

17. With the changes in public health structures there is also an opportunity to take a fresh look at the opportunities presented by new ways of using the evidence base, particularly with respect to how evidence can be collated and accessed digitally. Evidence-based medicine has made a major impact in the clinical arena over the last three decades, and there is an opportunity to further develop evidence-based public health. However, this will need to move beyond systematic reviews to harvesting the potential benefits of digital, rather than paper-based ways of cutting into and extracting information. If the evidence base is conceived of as an evolving digital pool rather than an electronic way of representing paper documents, potentially it provides a more powerful and smarter way of doing things, which can be better tailored to different audiences, whether local government officer or members, public health expert or clinician. As part of a wider digital transformation strategy, NICE has been pioneering the following:

- (a) NHS Evidence,³⁶⁸ managed by NICE, a service that enables access to authoritative clinical and non-clinical evidence and best practice through a web-based portal. It helps people from across the NHS, public health and social care sectors to make better decisions as a result. An enhanced service was launched in May 2011 and includes access to the former National Library for Public Health.
- (b) NICE Pathways³⁶⁹ is a new interactive tool which provides online access to NICE recommendations, including public health topics such as smoking³⁷⁰, diet³⁷¹ and physical activity.³⁷² NICE Pathways allows links to be created between these different public health topics, and is the first time access to public health evidence has been made available in this way. The aim is to make information available based on “setting” (school, workplace, etc.) or “topic” (smoking, diet, etc).
- (c) Opportunities to use the latest technology to provide access to the public health evidence base alongside relevant data and intelligence. Effective syndication of public health evidence to third party providers of data and statistics will provide an efficient resource for Public Health England, to inform population planning and resource allocation. The development of this work is being informed by an external Public Health Information Reference Group, which is providing advice on the information requirements that should sit alongside NICE Pathways, including cost information and support for prioritising public health interventions.

³⁶⁸ www.evidence.nhs.uk

³⁶⁹ <http://pathways.nice.org.uk/>

³⁷⁰ <http://pathways.nice.org.uk/pathways/smoking>

³⁷¹ <http://pathways.nice.org.uk/pathways/diet>

³⁷² <http://pathways.nice.org.uk/pathways/physical-activity>

PUBLIC HEALTH CONCEPTS

18. It is our view that there has been an overemphasis on structures for public health in much of the discussion about the White Paper and the Bill, with perhaps not as much focus on the concepts behind the proposals, which themselves deserve further analysis.

19. The simple view of public health is that is composed of two broad approaches:

- (a) *individualistic* focusing on educating /informing /counselling people to change their behaviour;
- (b) *population* focussing on the legislative/regulatory route (for example through laws on seatbelt use or banning smoking in public places and clean air).

20. Both methods have had some successes, but have their drawbacks. In a), this process appeals to people's rational behaviour (by demonstrating the consequences of smoking/lack of exercise/unhealthy diets, people will change) but fails to take into account the non-rational side of human nature. For b), there are clearly limits to how much of human life can be regulated. In free societies such as ours, it becomes difficult to avoid the "nanny state" labelling of such activities.

21. The alternative approach to these two positions at opposite ends of the spectrum is one that involves an understanding of how human health evolves from a combination of behaviour and habits, and the interaction between human agency and social structures. It is this approach that NICE has taken in producing public health guidance. The White Paper embraces the NICE approach by speaking a new public health language, advocating an approach that also draws on a tradition of community development/empowerment approaches. Instead of individual behaviour change versus population approaches as polar opposites, a self-governing and self-regulating society is envisaged in which local action by individuals, communities, associations and businesses generate and protect good health.

22. These approaches are ones that NICE has adopted, for example through its work on services and environmental changes (by providing convenient and safe ways for people to be physically active) and providing better access to a range of health and community services, particularly for disadvantaged groups. We have advocated population-based approaches which are not legislative but about identifying those who are most at risk and delivering tailored support. We have also produced work that is concerned with reducing the risks of ill health that arise from the actions of others, such as drink driving.

23. Health in this view is the outcome of social processes which flow naturally out of the activities of institutions and individuals. To help steer or nudge these processes, evidence-based public health activities focus on social norms and community networks. Local action leads to the establishment and diffusion of health-beneficial good practice and social integration. Resilience develops and flourishes in these circumstances, in the same way as the opposites—vulnerability and exposure to excess risk—are endemic in the absence of a well integrated local social system. NICE's public health activities have been structured around these ideas and we look forward to continuing to develop and refine our guidance and processes to best support the new system.

June 2011

Written evidence from Help the Hospices (PH 140)

1. ABOUT HELP THE HOSPICES

1.1 Help the Hospices is the leading charity supporting hospice care throughout the UK. We want the very best care for everyone facing the end of life.

1.2 The majority of hospice care in the UK is provided by our member hospices—local charities rooted in the communities they serve. Care is given free of charge to the patient and their friends and family. It can be at home, in the hospice and in the community and can be for days, months or years. We are here to represent and support our members. We work with our members and other organisations as they strive to grow and improve hospice and palliative care throughout the UK and across the world.

1.3 Our services are here to support hospice people and champion the voice of hospice care. They include a wide range of training and education programmes, informative and practical resources for hospice staff, work to influence government policy and support for quality care and good practice.

2. ABOUT MEMORANDUM

2.1 This memorandum draws on the experience of independent charitable hospices around England, and is supplemented by references to research conducted by Help the Hospices and others.

2.2 We have limited our comments to the following areas:

- the creation of Health England within the Department of Health;
- the future role of local government in public health;
- arrangements for public health involvement in the commissioning of NHS services;
- arrangements for funding public health services; and

- the future of the public health workforce.

3. SUMMARY OF KEY POINTS

- There is a need to develop standards to benchmark local authority and GP commissioning consortia performance and progress (4.6).
- Hospice care should be used as a model for the integration of health and social care (5.3).
- The Government should provide incentives to partnership working, and encourage local authorities and commissioning consortia to engage other key local government departments regarding areas such as housing, transport and planning (5.4).
- The Department of Health should consider how to support open, appropriate sharing of information for joint strategic needs assessments in a market place where such information may become increasingly commercially sensitive' (5.6).
- The Government should monitor local authorities to make sure they do not simply redesignate many of their existing activities as public health, because of existing pressure on their budgets (7.1).

4. THE CREATION OF PUBLIC HEALTH ENGLAND WITHIN THE DEPARTMENT OF HEALTH

4.1 Getting end of life and bereavement care right can not only vastly improve people's individual experience of care, but also the experience of carers, friends and family. As Dame Cicely Saunders, founder of the modern hospice movement, noted: "How people die remains in the memory of those who live on".

4.2 The number of people who will die each year is expected to rise over the next decade. While people may have an increased life expectancy, there are growing numbers of people living with, and dying with, complex health and social care needs. However, alongside two-thirds of us being uncomfortable discussing dying,³⁷³ there is also currently a disconnect between where people say they want to die, and where they actually die. About 70% of people say they want to die at home, but at present most deaths in England occur in NHS hospitals.³⁷⁴

4.3 We welcome the creation of Public Health England, as public health has a vital role to play in improving people's experience of care at the end of life, both individually and collectively, and in increasing their confidence and ability in discussing dying, death and bereavement. We support the Government's commitment in the public health white paper to continue to promote the implementation of the End of Life Care Strategy, and the reference to the Dying Matters national coalition.

4.4 Currently more than 200 independent charitable hospices across the UK provide expert advice, support and health and social care to about 360,000 patients, carers and family members. They are rooted in the communities they serve and as well as direct care, hospices offer public health benefits through education, advice and support for health and social care professionals. They also offer employment and volunteering opportunities within their local communities.

4.5 A recent study by the Economist Intelligence Unit identified the UK as having the best-developed end of life care among 40 countries surveyed. The ranking was attributed, in part, to the "well-established hospice movement".³⁷⁵ It is vital to make sure that the progress in end of life care enabled by the 2008 End of Life Care Strategy is sustained and that the future public health system enables hospices to continue their valuable work in partnership with GPs, GP consortia and local authorities, alongside the new Public Health England—contributing to the improvement of health outcomes and the public health both nationally and locally.

4.6 The transition period for reform will only work if new and existing structures within the system are supported by strong accountability mechanisms. To ensure the quality of services, *we recommend standards should be set to benchmark local authority and GP commissioning consortia performance and progress.* Without a formal performance management mechanism, it may be difficult for local communities and Public Health England to monitor progress. Transition and benchmarking will be helped by making sure local authorities and GP consortia have access to timely and appropriate data and analysis to make informed decisions.

5. THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

5.1 We welcome the direction towards the integration of health and social care through the enhanced role for local government proposed in "Healthy lives, healthy people". To make sure that health and wellbeing boards are able to engage effectively with local people and neighbourhoods, we have welcomed the suggestion that local authorities may also choose to invite local representatives of the voluntary sector and other relevant public service officials to participate in the board.

³⁷³ Dying Matters. NatCen Survey, 2009. <http://www.dyingmatters.org/site/why-talk-about-it/key-facts> (accessed 9 June 2011)

³⁷⁴ Department of Health. *End of Life Care Strategy—promoting high quality care for all adults at the end of life*. London: Department of Health, 2008.

³⁷⁵ The Economist. *Grim reapings—An attempt to rank end of life care in different countries*. www.economist.com/node/16591106 (accessed 10 March 2011).

5.2 We are working to support hospices to strengthen their relationship with local authorities and to develop their skills in engaging with local authorities.

5.3 Hospices are unique among providers of health and social care because they contribute so significantly to the funding and provision of palliative and end of life care. In 2009, hospices spent £686.9 million. In short, for every £1 the state invests in local charitable hospices, hospices deliver £3 worth of care. We are anxious to make sure that this “co-commissioning” role played by the voluntary sector is not lost in the proposed new public health system. *We recommend that hospice care be used as a model for the integration of health and social care.*

5.4 We support the white paper’s recognition that the “embedding of public health within local government... will enable joint approaches to be taken with other areas of local government’s work”. There is strong evidence to suggest that there should be emphasis on collaboration and integration between public health and areas such as housing, transport and planning, as well as health providers, when making commissioning decisions, redesigning care pathways and integrating services. *We recommend that the Government provides incentives to partnership working, and that local authorities and commissioning consortia engage other key local government departments regarding areas such as housing, transport and planning.*

5.5 Hospices can contribute valuable local intelligence to help shape local authorities’ and commissioning consortia’s understanding of need, gaps in service and the quality of services, and we believe must they be supported to do so. Data and intelligence can also be used by commissioners and providers such as hospices to support care, for example with regards to epidemiology—deaths, causes, ages and gender.

5.6 To be truly effective, it is essential that joint strategic needs assessments are supported by a systematic collection and analysis of information and proper engagement with hospices, alongside local people, businesses and other charities, to become genuinely cross-sector exercises which effectively inform commissioning. *We recommend that the Department of Health should consider how to support open, appropriate sharing of information for joint strategic needs assessments in a market place where such information may become increasingly “commercially sensitive”.*

6. ARRANGEMENTS FOR PUBLIC HEALTH INVOLVEMENT IN THE COMMISSIONING OF NHS SERVICES

6.1 We welcome the recognition of the need for close partnership working between the NHS and Public Health England.

6.2 Significant engagement from commissioning consortia leadership with the health and wellbeing boards will be essential to joining up public health and healthcare. In some areas, commissioning consortia will have a different geographical area to the health and wellbeing board. This will make it difficult for the consortia to commission on a population-wide basis in collaboration with local authority colleagues.

6.3 Help the Hospices supports the application of the principle of subsidiarity in NHS commissioning, but we are concerned about some of the practical considerations in the move towards clinical commissioning. We support the proposals to strengthen the public health role of GPs; these proposals must support and strengthen the role of GPs in end of life care.

6.4 Good primary care is critical to public health and tackling inequalities, and GPs have a valuable role in both the provision and signposting of palliative and end of life care. However, a recent survey by Help the Hospices revealed that one in four GPs are not confident in their ability to provide information to a patient with less than six months to live. This is despite GPs seeing on average more than four patients a month with a terminal illness³⁷⁶. For clinical commissioning to work, there is an urgent need for GPs to work closely with local hospices to build expertise around the delivery of hospice and palliative care in their communities. Consortia will need support to develop capacity and capability and to make sure they have access to the management and strategic skills required of effective commissioning. Individual GPs will need support and incentives to deliver quality outcomes for their patients. One way to achieve this would be to introduce penalties for GPs that fail to make referrals to appropriate services.

6.5 Many hospices have already begun to cultivate relationships with local GP leaders. However, a structural change to the mechanics of commissioning is not enough, on its own, to ensure better outcomes for patients.

7. ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES

7.1 We welcome the Government’s commitment to improving the health of the population and are pleased that funding for public health will be ring fenced. However, *we recommend that the Government should monitor local authorities and make sure that they do not simply redesignate many of their existing activities as public health, because of existing pressure on their budgets.*

³⁷⁶ nfpSynergy (2010) Primary Healthcare Professionals Monitor, nfpSynergy

8. THE FUTURE OF THE PUBLIC HEALTH WORKFORCE

8.1 We support the vision for an expert, professional, committed and flexible public health workforce outlined in “Healthy lives, healthy people” and welcome the commitment to developing a more detailed workforce strategy for public health.

8.2 The reforms must enable the current and future workforce to respond to patient need, changing service models and the complex challenges of 21st century healthcare. To achieve this, palliative and end of life care must be integrated and embedded in the workforce, including public health professionals, to make sure all agencies and staff appreciate the importance and principles of end of life care and are better equipped to meet people’s needs.

June 2011

Written evidence from ADCS and ADASS (PH 141)

1. INTRODUCTION

1.1 ADCS and ADASS members are jointly responsible through the activities of their departments for the wellbeing, protection and care of their local communities and for the promotion of their wellbeing and protection through the use of direct services and the co-ordination of, and liaison with the NHS and other statutory agencies, voluntary agencies, and private companies.

1.2 ADCS and ADASS members have leadership responsibilities in local authorities to promote community engagement, local access to services and to drive partnership working to deliver better outcomes for local populations, based on a full understanding of local need. They participate in the planning, delivery and commissioning of the full range of council services and influence the direction of planning through formal and informal partnership arrangements with a range of partners which include the NHS and allied health professionals. We have particularly strong experience in working in partnership to design and deliver effective early intervention and prevention programmes.

1.3 We welcome the Select Committee’s inquiry and the opportunity it presents to further scrutinise public health proposals. We believe that Government has set a broadly positive direction for public health. However, notwithstanding the current “pause” in the passage of the Health and Social Care Bill, we are concerned that our ability to understand fully the proposed public health landscape is limited by the passages of both the Health and Social Care Bill and Localism Bill concurrently with consultations on the Public Health White Paper, and by the lack of detail on funding and accountability arrangements in the new proposals.

1.4 Local authorities remain committed to working with our partners to absorb, navigate and develop the new arrangements to the benefit of our local communities. We believe that local authorities are in a good position to provide a degree of stability in a time of turbulence resulting from the pace of change and immaturity of the emerging structures. We are keen that local authorities are able to share their expertise in managing transition with the new structures. There are over 130 shadow Health and Wellbeing Boards in operation, developing early local approaches to ensuring focus and accountability on improved outcomes, including addressing health inequalities, in the proposed system. Our evidence is based on these experiences and our experience working collaboratively in recent years.

2. SUMMARY

- Local authorities have significant experience working collaboratively with a range of partners to plan and deliver public health initiatives to improve the lives of local people. We welcome government’s intention to return to local authorities a leading role in improving, promoting and protecting the health of their communities.
- We are concerned by a lack of clarity on responsibility, accountability and scrutiny in proposed new elements of the public health system.
- We recognise the important role of GPs in the design and delivery of local public health services but public health and wellbeing provision cannot be solely rooted in a medical model. A wide range of partners must be involved from design, through delivery and to review.
- Schools make a crucial contribution to achieving improved public health outcomes, but we are concerned that limited reference to this in the proposals alongside both increased autonomy of schools and a requirement only to “have regard to” public health priorities may risk the contribution they make in future.
- We welcome the move of directors of public health to local authorities and we note a range of approaches emerging to the integration of this role into local authorities. We would welcome further discussion to determine an approach that ensures a coherent system, service continuity and transparency whilst allowing for necessary local flexibility.

- Health and Wellbeing Boards should be given statutory powers both to sign-off local commissioning plans from all partners and to hold these commissioners to account against their plans. The status of Joint Strategic Needs Assessments (JSNAs) should be strengthened with clear duties on commissioners to take account of Health and Wellbeing strategies in their commissioning plans.
- We are concerned that the prioritisation of the needs of vulnerable children, young people and adults, who are at risk of being out of the reach of public health initiatives, has yet to be embedded in the new arrangements. Reflection of their stories in the JSNA alongside sufficient representation of the needs of these groups on planning and commissioning bodies is crucial.
- A match between the level of ambition of reform of the system and resources available must be made.
- The health premium appears to incentivise short-term approaches and, to successfully contribute to addressing health inequalities should be restructured to incentivise long-term solutions, and be weighted towards areas facing high levels of deprivation.

3. *Public health architecture and the role of the local authority*

3.1 We welcome Government's intention set out in *Healthy Lives, Health People* to return to local authorities a leading role in improving, promoting and protecting the health of their communities.

3.2 The proposed structures outlined in the White Paper appear to build on established and successful collaborative working and integrated approaches between the NHS, local authorities and a number of other partners in recent years. We welcome the extension of collaborative arrangements intended to create services that collectively address the health and wellbeing needs of local people and populations.

3.3 We remain concerned that the White Paper and the Health and Social Care Bill provide little detail on the structure intended to deliver these reforms, or the extent to which local areas will be able to determine and build their own structures reflective of their own individual needs. The Consultation on Funding and Commissioning Routes for Public Health begins to set out the different responsibilities of the various organisations in the proposed new public health system, the intended relationship between Public Health England, the NHS Commissioning Boards, Monitor, HealthWatch, the Health and Wellbeing Boards and, ultimately, GP Consortia, remains unclear.

3.4 We are also concerned that the proposed governance structure remains ambiguous, with a confusing mixture of national and local direction. Proposals offer no clear detail on lines of accountability and scrutiny in the system.

3.5 We accept the crucial role GPs play in the design and delivery of local public health services, but we firmly believe that health and wellbeing cannot be solely rooted in a medical model. Public health must involve a wide range of partners from design through to delivery and review. We note that proposals for GP Consortia do not place any limitations on the formation of Consortia in terms of geography. Although we recognise the advantages of GP Consortia forming in such a way that reflects best the local communities which they serve, we are concerned that the potential lack of alignment between different structures and layers within the new local public health system may present significant challenges to integrated approaches.

3.6 We are also concerned about the limited reference to the critical role of schools in the public health agenda, particularly in the health promotion and early intervention initiatives that are undertaken within school settings, such as healthy eating, exercise and efforts to reduce teenage pregnancies and improve the sexual health of young people. We are concerned that the important role of schools in delivering local public health agendas may be further diluted by the requirement on academies and free schools only to "have regard to" public health priorities, potentially limiting local capacity to develop cohesive and strategic local public health agendas.

4. *Directors of Public Health*

4.1 The role of the Director of Public Health (DPH) in each local authority will be key to supporting individual GPs and GP Consortia to address their public health responsibilities. We welcome the movement of the DPH to local authorities. We believe this reinforces a broader approach to health and wellbeing both within wider local authority activities, such as housing, transport and planning, as well as in the core business of addressing health inequalities. We believe DPHs will provide a critical role in straddling and brokering the professional relationships between health (GP Consortia, NHS) and local authorities to draw out the full advantages that each stakeholder can bring to improving health outcomes and tackling health inequalities.

4.2 We have already noticed a range of approaches emerging to the assimilation of DPHs into local authority structures. Some DPHs report directly to local authority chief executives and others to the director of adult services/ community services. Similarly, there is divergence on the definition of the role of DPHs, with some defined as clinical specialists and others as knowledge leaders. We also note confusion on the accountability and division of responsibility for this role between Public Health England and local authorities. Given the critical role of DPHs in the new system, we would welcome further discussion to determine an approach which

ensures a coherent system, service continuity, and transparency for this role whilst allowing for flexibility to respond to local contexts.

4.3 ADCS and ADASS agree that voluntary registration for Directors of Public Health is insufficient. We believe that there should either be compulsory registration or none at all.

5. *Planning and commissioning*

5.1 We believe the proposed Health and Wellbeing Boards will be critical to the dynamics of local commissioning and we have strongly urged that the Boards are given statutory powers to both sign-off local commissioning plans from all partners and to hold these commissioners from across GP Consortia, Public Health England, the NHS and local authorities to account against their commissioning plans. To complement the enhanced role of the Health and Wellbeing Boards, we also urge that the status of the Health and Wellbeing Strategies and the Joint Strategic Needs Assessments (JSNA) be strengthened, with clear duties on commissioners to take account of Health and Wellbeing Strategies within their commissioning plans.

5.2 We remain concerned that, at times, the needs and stories of children and young people and marginalised adults, such as adults with learning disabilities can be lost in the accumulation of information and evidence as part of the JSNA. We strongly suggest that in any efforts to build a local evidence base through the JSNA, and in the efforts of Public Health England to build a national evidence base, full attention is given to the lives and needs of children and young people and marginalised adults in order to ensure both general needs and the specific needs and wishes of the most vulnerable in our local communities are met.

5.3 We are particularly concerned that there appears to be potentially inadequate representation of the needs of children and young people in the planning and commissioning arrangements in the proposed system. ADCS remains concerned that there is only one “Children Services” representative on the Health and Wellbeing Boards (Director of Children Services). We would expect that in any new arrangements, all partners are cognisant of their wider roles to improve the outcomes for children and young people and see this as part of their core responsibilities; this is particularly pertinent for the shared responsibility to safeguarding arrangements. While accepting that there are proposals to transfer safeguarding responsibilities currently held by PCTs and SHAs to the new health infrastructure, we are concerned that these responsibilities may become diluted and/or fragmented across the range of new structures and systems delivering health care.

5.4 ADCS is concerned that the lack of children’s services representation at planning and commissioning stages in conjunction with lack of clarity over relationships between components of the new system may lead to further fragmentation across an increasingly divergent set of arrangements, for example responsibility for health care of pregnant women or the exact accountability and reporting arrangements for directors of public health. We are concerned about the lack of clarity over positioning of child and family poverty strategy in the new system. We believe this will be compounded by a fragmented approach in national policy, particularly between government departments towards responsibility for children and family services and resulting differences in approach, for example “individualism” in the Department of Health and “families” in the Department for Education.

5.5 We are particularly concerned that the detail on how the specific needs of looked after children and vulnerable children and adults will be prioritised in revised arrangements is yet to be developed. It is these groups of children, young people and adults who need support and care the most and who often suffer from a lack of public health initiatives. It is vital that these particular groups are considered within the roles and responsibilities between Public Health England, GP Consortia, and the NHS Commissioning Board. We particularly note the lack of a joined up approach to the planning, development and delivery of services for children and adults with mental health needs. We have urged Government to provide further detail on its expectations in this regard and suggest consideration of work by the Joint Commissioning Panel for Mental Health (JCP-MH), a collaborative approach by 13 organisations, including ADASS, to develop practical guidance for commissioners of mental health and wellbeing services.

6. *Arrangements for the funding of public health*

6.1 Clearly, the allocation of sufficient resources is crucial to effective implementation of the measures set out in the White Paper. Although we acknowledge the limitations of the current economic climate, there must be a match between the level of ambition and the resources made available to meet that ambition. We have sought urgent clarification on the level of allocation provided to local authorities to:

- meet the expectations detailed in the White Paper;
- match the level of deprivation (aligned to evidence detailed in the JSNAs), with clear reference to accommodating the compounded impacts of high density deprivation and health inequalities in particular areas, reducing their ability to qualify for the health premium—these areas must be supported rather than penalised; and
- make adequate provision for a minimum floor to ensure smaller councils are not disproportionately disadvantaged.

6.2 We note confusion regarding the status of the ring-fence proposed for the public health budget and are concerned that this may create tensions between localism and national direction. We would welcome further

debate on how to balance local and national tensions based on greater clarity on the structure of the new arrangements, including the relationship between different government departments and their demands on the public health ring-fence. We are keen to explore further how community budgets can fit within the proposed reforms, with a emphasis on closer integration, shared priorities and a consistent and coherent governance framework operated at the local level through the Health and Wellbeing Boards.

6.3 We know that the causes of health inequalities are complex, deeply rooted and are often compounded in areas experiencing both high levels of multiple deprivation alongside very transient populations. It is these areas which particularly require long-term sustained solutions. We are concerned that proposals for a health premium as set out in the White Paper appear to incentivise a more short-term approach and that the extent of local discretion afforded to commissioners is very likely to exacerbate this tension. To mitigate this, we have urged Government to consider:

- restructuring the health premium to incentivise long-term solutions to health inequalities, weighted towards areas facing high levels of deprivation;
- strengthening the role of Health and Wellbeing Boards to hold all partners with commissioning responsibilities to account against the local Health and Wellbeing Strategies focussed on addressing long term health inequalities; and
- weighting the funding allocation towards areas with high levels of deprivation, multiple deprivations and/or high health and wellbeing needs.

6.4 We also suggest that the Health and Wellbeing Strategies be consistently aligned to the six health inequalities priorities identified in the Marmot Review. This will provide cohesion and focus, as well as a more long-term and sustainable approach to reducing health inequalities. We appreciate the need to accommodate local accountability to meet specific needs of local communities alongside broader strategic objectives.

6.5 It is widely acknowledged that there is a strong correlation between prevention and early intervention and up-stream benefits (improved outcomes and reduced costs). The White Paper clearly aligns to this philosophy but there is limited evidence as to how this can be taken forward in a consistent, cohesive and strategic way. We are concerned that the extent of local discretion, limitations on commissioning accountability and oversight, and the construct of the health premiums do not encourage a more structured approach. There are continued risks that more long-term and seemingly more intractable health inequalities are avoided for more short term “easy wins”. This will significantly disadvantage those areas with the greatest level of health inequality.

6.6 We are keen to address the relationship between prevention and early intervention with partners and we welcome further discussion regarding how best to address this inter-dependency. We strongly believe that the solutions are held locally but that to realize mutual benefit, the whole approach must be localised with appropriate and equitable funding allocations. We are concerned that important local public health opportunities may be missed as Government continues to encourage local authorities to allocate resources from depleted early intervention and prevention funds in the now amalgamated Early Intervention Grant to specific ministerial priorities, reducing scope for local decision making to meet the needs of local populations.

6.7 We believe a key issue remains the challenges of information sharing. Information sharing protocols are developed but these remain unwieldy. Any efforts in easing these barriers to sharing information while maintaining the confidentiality of the person would be of huge benefit.

June 2011

Written evidence from NHS North Lincolnshire Directorate of Public Health (PH 142)

1.0 Thank you for inviting responses to the Health Committee on Public Health. Please find enclosed a summary of NHS North Lincolnshire’s Public Health Directorate concerns about the proposed changes to Public Health.

2.0 SUMMARY

2.1 We agree with the Public Health white paper and the Faculty of Public Health that there are three domains of public health:

- Health protection (infectious diseases, environmental hazards and emergency planning).
- Health improvement (lifestyles, inequalities and the wider social, economic and environmental influences on health).
- Health services (service planning, commissioning, audit, efficiency and evaluation).

2.2 We share the same concerns as the Faculty of Public Health, Royal Society for Public Health, and Association of Directors of Public Health (<http://www.fph.org.uk/uploads/Letter%20to%20David%20Cameron.doc>) with regards to the proposed changes to Public Health in England and that these concerns have been overshadowed the other changes to the NHS.

2.3 We have particular concerns about the proposed reforms in the following areas:

- Lack of standard setting and professional regulation of public health specialists if employed by local authorities.
- Fragmentation of the public health system. One of the three domains of public health—health services (service planning, commissioning, audit, efficiency and evaluation), is integral to commissioning of health services. It will be very challenging for this aspect of the public health function to be delivered from a local authority setting yet to separate this from the rest of the Public Health workforce may lead to fragmentation of the public health system.
- The “health premium” proposal is flawed and unworkable.

3.0 LACK OF STANDARD SETTING AND PROFESSIONAL REGULATION

3.1 Public health specialists are generally members or fellows of the Faculty of Public Health, all are required to be on the Specialist Register. This gives the public reassurance in their professional standing, Continuous Professional Development, qualifications and training and sets the rigorous standards which all members of the profession are required to meet.

- 3.2.1 We are concerned that, as plans currently stand, public health specialists employed by the Local Authority will not be mandated to be above this quality line. Public health is a professional undertaking with defined competencies and standards in order to protect the public’s health. Not mandating that public health specialists require this status puts the health of the population at risk.
- 3.2.2 There is also a significant risk that failure to require that Directors of Public Health in particular, but also other Public Health specialists are properly trained and registered, will result in significant inequity across the country, as some Local Authorities will wish and be able to recruit properly trained experts, whereas others may not.

4.0 HEALTH SERVICES PUBLIC HEALTH SPECIALISTS

4.1 Health services public health is a vital domain of Public Health and makes a major contribution both to improving the health of the population, and reducing health inequalities. Many Public Health consultants who undertake this work are first: qualified doctors, undertaking junior medical jobs before higher specialist training in public health; nurse consultants or from other areas of clinical practice with substantial clinical experience. This together with an additional five years training with associated additional professional qualifications and study, gives them a broad and deep understanding of the NHS and the health needs of the population.

4.2 Public health specialists’ input into commissioning of health care is integral to daily working. No-one else has the academic rigour and practical experience of commissioning nor the understanding of the health needs of the population, the evidence base, and is able to balance complex interrelated disease pathways with health economics within the context of finite monies to pay for services.

4.3 A population perspective to health service planning has been integral to the NHS for decades now and has ensured rationing of finite resources in a fair and equitable manner. Public Health specialists have worked alongside GPs, hospital specialists, nurses, other clinicians, social care and NHS managers for years to ensure a multiprofessional clinical input into commissioning.

4.4 It has been suggested that GP commissioners would be able to buy health needs assessments from local universities in order to make commissioning decisions. The reality is that commissioning is a hugely complex juggling act. Public health specialists provide leadership and strategic direction as well as managing health service quality improvement projects and programmes. Universities may be able to complete one off needs assessments—but they won’t be in a position to ask the right questions of providers at contract meetings about PH issues or to interrogate the evidence routinely to check that change is heading in the right direction. Commissioning support units will be expected to provide this monitoring support to GPs—but without PH expertise within those units we are not convinced this will happen. The process needs to be local enough and responsive enough to allow commissioners to report on potential PH performance issues as they arise.

4.5 The developing GP commissioning consortium in North Lincolnshire recognise that they do not have the time nor the skills of balancing the needs of a whole population with the evidence base, reducing inequalities, and commissioning services which offer value for money. They like all other GP commissioners in the country are keen to have public health support in the future. It will be extremely challenging to directly influence NHS commissioning from within the Local Authority, as is currently planned

5.0 THE “HEALTH PREMIUM”

5.1 In our view the “Health Premium”, as described in the Public Health White Paper and associated consultation document, is not workable for the following reasons.

5.2 There are no outcome measures that are sufficiently robust as overall measures of population health (and hence health inequality, and reduction in health inequality) that are sufficiently responsive at local level in a relatively short space of time, to be a valid tool for this purpose.

5.3 Even if there were, the mechanism would need to take into account other factors on health and health inequalities at population level. For example, economic changes in an area which health services cannot influence. Another example would be the impact of population change, in particular immigration and emigration, both in and out of a district as well as internally, within a district. If these sort of factors are not taken into account, local areas will end up being penalised, or rewarded, simply because of the impact of population change on local health indicators. At present, the impact of immigration and emigration is completely undefined, though real.

5.4 Even if the above problems were overcome, we cannot conceive of any additional incentive that this proposed mechanism would deliver. However there is a real danger that if implemented, the “health premium” would end up further disadvantaging already disadvantaged districts, since they are the ones least likely to be able to attract it, through no fault of their own.

June 2011

Written evidence from Dr Fay Haffenden (PH 143)

- There is a wealth of evidence from the Marmot Review and other research that the early years are crucial to children’s long term outcomes.
- Children, young people and families want integrated, family-centred services.
- The current proposals will fragment the commissioning of children’s services, making further integration much more difficult, if not impossible.
- This will be a disaster for children and the future health and wellbeing of the population.

1. The commissioning of children’s services seems to me to be completely fragmented with (as I understand it!):

- NHSCB responsible for primary care (so GPs +/- practice nurses for six–eight week check and GP visits +/- follow up from A&E) and Health Visitors and specialist commissioning
- PHE responsible for the Healthy Child Programme (HCP) 0–five, child public health +/- screening and immms and vacs +/- child health records (or do these go with the GP commissioners or NHSCB?)
- LAs responsible for HCP five–19, children’s centres, schools, LA children’s info systems—and school nursing, I think
- GP commissioners responsible for maternity services and most secondary care

2. We already know how difficult it is to get responsibility and accountability clear across complex pathways such as for children with disabilities or screening, Eg where will responsibility sit for say a child not getting a bloodspot? Who would pick it up? Who would be sued for a missed child who had one of the conditions they should have been screened for?

3. We have been struggling to make joint commissioning for children a reality between LA and the NHS which we know is essential to getting more integrated services focused on the child and family and getting services working out of their silos—but to try and get joint commissioning between all the new players functioning at different levels and geographies commissioning different bits of the pathway from different providers

June 2011

Written evidence from Lundbeck (PH 144)

SUMMARY

- Lundbeck broadly supports the Government’s public health proposals and welcomes the recognition that alcohol misuse is a key public health priority. The challenge posed by alcohol misuse is significant and growing. It affects 4% of the population and over 10 million people drink over the recommended limits.
- The Government has stated that Public Health England will give local authorities the responsibilities to commission “treatment, harm and prevention services for alcohol misuse in their local population.” However, there is a lack of additional detail about how the full range of NICE recommended services and treatments, from primary prevention through to NHS delivered secondary prevention, will be commissioned. Greater clarity is needed in a number of areas.

- In particular, it would be helpful to understand exactly who will have responsibility for commissioning alcohol services. In other areas, such as mental health, a clearer distinction has been made between primary prevention which will be funded by the local authority and secondary prevention which will be funded by the NHS. It would also be useful to know what priority (if any) secondary prevention will be given in the ring-fenced public health budget.
- Tackling alcohol misuse must be a priority within local government. This will need coordinated action across public health, the NHS and social care led by Directors of Public Health. In addition, where the outcomes for these areas overlap, as for alcohol, Joint Strategic Needs Assessments will be key in ensuring that appropriate services are commissioned.
- Given that alcohol is a major contributor to health inequalities and has a causal relationship in almost 60 diseases and injuries, we would welcome an indication of how root public health problems such as alcohol misuse, will be addressed in patients presenting with illnesses such as diabetes, cancer and heart disease.

RESPONSE

1. We are an ethical, research-based pharmaceutical company and specialists in psychiatry and central nervous system (CNS) disorders, with an interest in alcohol policy.

2. We broadly support the reforms to the NHS as set out in the Health and Social Care Bill, including the creation of a public health service both nationally and locally with a ring-fenced £4 billion budget.

3. We welcome the recognition within the Government proposals that alcohol misuse is a significant and growing public health challenge. Alcohol misuse affects 4% of the population and over 10 million people drink over the recommended limits, compared to the 0.5% of people who use drugs. The harm to health and society caused by alcohol is also well documented; the prevalence of liver disease, of which alcohol is the major contributor, is growing and it is set to overtake stroke and coronary heart disease as a cause of death within the next 10 to 15 years.³⁷⁷ There were 1.1 million hospital admissions due to alcohol misuse in 2009–10, an increase of 100% since 2002–03 and it is estimated that the cost of alcohol related harm to the NHS in England is £2.7 billion in 2006/07 prices.^{378,379}

4. The Department of Health paper “Health Lives: Healthy People: Consultation on the funding and commissioning of public health routes” states that Public Health England will give local authorities the responsibilities to commission treatment, harm and prevention services for alcohol misuse in their local population.³⁸⁰

5. Lundbeck supports local authority commissioning of alcohol services, as they will often be best placed to understand, plan and deliver services to meet the unique local needs of their communities. However, greater clarity is needed on how local authorities will commission the full range of interventions across the three domains of public health: health protection, health promotion and healthcare.

6. Services for alcohol misuse can vary, as set out in the NICE guidelines for alcohol use disorder, including the provision of advice and information to the wider population, screening & identification and treatment such as brief interventions and assisted withdrawal in a community or residential setting.³⁸¹ These services straddle both public health for primary prevention and the NHS for treatment including secondary prevention in primary care.

7. In other areas, such as sexual health and mental health, the consultation document on commissioning and funding routes for public health outlines how different prevention and treatment services would be funded and commissioned. For example, in sexual health local authorities are to commission sexual health services, except for contraceptive services which will be the responsibility of the National Commissioning Board via GPs. In public mental health, there is also a clearer split between how primary prevention measures are funded and commissioned by local authorities and treatment is commissioned and funded by the NHS.

8. The consultation on public health commissioning routes also states that the NHS will fund some alcohol services. The example given is that Alcohol Health Workers would be commissioned in all healthcare settings, but no additional activities are mentioned. NHS funding of Alcohol Health Workers is to be welcomed, but we would not suggest that NHS funding for alcohol misuse services be confined solely to Alcohol Health Workers. Whilst we accept this is just an example more detail would be useful.

9. The public health budget is to be significant, up to £4 billion. An indication of priorities for spending the public health budget would be also useful, for instance which public health priorities will be invested in.

³⁷⁷ Department of Health (2010) Press Release “Department of Health to develop National Liver Strategy” http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PolicyAndGuidance/DH_107304?PageOperation=email

³⁷⁸ The Health and Social Care Information Centre (2011), Statistics on Alcohol: England, 2011. http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/Alcohol_2011/NHSIC_Statistics_on_Alcohol_England_2011.pdf

³⁷⁹ The Health and Social Care Information Centre (2011), Statistics on Alcohol: England, 2011. http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/Alcohol_2011/NHSIC_Statistics_on_Alcohol_England_2011.pdf

³⁸⁰ Department of Health (2010) Healthy lives, healthy people: consultation on the funding and commissioning routes for public health http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_123114.pdf

³⁸¹ NICE (2010) public health guidance 24: Alcohol-use disorders: preventing the development of hazardous and harmful drinking.

Additionally, will the focus of the budget be on primary prevention or will secondary prevention services, such as brief interventions, be included. In the consultation document, it is stated that for drugs services, brief interventions will be funded by the NHS, but this is not indicated for alcohol services. For alcohol misuse, brief interventions are recommended by NICE guidance and should be included as an example of NHS funded activities, to ensure consistency and appropriate funding is made available.³⁸²

10. Given the scale of the challenge of alcohol misuse outlined above, it is clear that the issue will need to be a high priority for local government, with coordinated partnership working between all organisational levels involved in delivering public health care.

11. The proposed creation of Directors of Public Health and Health and Wellbeing Boards at a local authority level will be important in helping to ensure that people who misuse alcohol, do not fall through the gaps between the public health service, NHS and social care, and that the full range of NICE recommended treatments are available to them.

12. The Joint Strategic Needs Assessment will be an important tool in enabling local partnerships to work together on health and well-being priorities. The Health and Social Care Bill must ensure that effective structures and incentives are in place to ensure consortia and local authorities coordinate activity across the boundaries of public health and health. The consultation on commissioning and funding routes indicates that where a health, public health and social care outcome overlap, as set out in Department of Health outcome framework documents, this should be a “focus of Joint Strategic Needs Assessment” for joint working. Alcohol misuse is included as an outcome in the frameworks for health, public health and social care and should therefore be a priority for the Joint Strategic Needs Assessment.

13. If this collaborative working is not taken into account, the danger is that this issue will fall even further behind other health problems in the change to the commissioning structure. In England, 26% of the adult population, including 38% of men and 16% of women, consumes alcohol in a way that is potentially or actually harmful to their health, and 4% of adults in England are alcohol dependent.³⁸³ Under the current system only a small minority of dependent drinkers currently receive treatment, estimated at one in 18 which is less than 6%.³⁸⁴ If this were to fall any further it would have a devastating impact on individuals’ health, society and the NHS, as treating alcohol-related conditions already cost the NHS approximately £2.7 billion a year.³⁸⁵

14. We welcome the development of the Public Health Outcomes Framework to sit alongside the NHS Outcomes Framework and Adult Social Care Framework. As alcohol misuse is recognised across the three Outcomes Frameworks, it is vital that there is clear accountability for achieving improved health outcomes between the three services.

15. As argued above, the Government has stated that if an outcome measure is identified across the three domains then it should be a priority for the Joint Strategic Needs Assessment. However, it is unclear how health priorities that overlap in two frameworks should be dealt with. We would propose that these issues are also recognised in the JSNA.

16. Alcohol misuse is a major contributor to health inequality, ill-health and societal harm. The World Health Organisation states that alcohol consumption is the third largest risk factor for disease burden in developed countries, and has a causal relationship with more than 60 types of disease and injury, including diabetes, heart disease, and cancer.

17. We would welcome an indication of what the public health approach will be to co-morbidities related to public health problems, such the relationship between alcohol and diabetes. How will the reforms ensure that underlying public health problems such as alcohol misuse are detected and tackled in patients presenting with illnesses such as diabetes, cancer and heart disease.

18. We support the proposed Health Premiums, aimed at incentivising action to reduce health inequalities. In order to utilise the health premium most effectively, it should concentrate on health issues that overlap across the outcomes frameworks and the domains within Public Health Outcomes Framework. The Government proposals state that the Health Premium will depend on progress made in improving the health of the local population and reducing health inequalities. Rates of admission for alcohol misuse are one of the proposed indicators for health improvement. Given the scale of alcohol misuse, we believe that local authorities will need to have a clear focus on indicators relating to alcohol when they are formulating health.

19. A focus on secondary prevention in primary care will be necessary to effectively address health inequalities. The Department of Health paper *Tackling health inequalities: 2006–08 policy and data update for the 2010 national target* makes clear that one of the quickest ways to tackle inequalities in health is through proactive secondary prevention in primary care.³⁸⁶

³⁸² NICE (2010) public health guidance 24: Alcohol-use disorders: preventing the development of hazardous and harmful drinking

³⁸³ NICE (2011) *Alcohol-Use Disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence CG115*

³⁸⁴ House of Commons Health Select Committee (2009) *Alcohol: First Report Session of 2009–10*

³⁸⁵ NHS Confederation (2010) *Briefing No 193: Too much of the hard stuff?*

³⁸⁶ DH (2009) *Tackling health inequalities: 2006–08 policy and data update for the 2010 national target*

20. We would welcome more information about how the important work of Public Health Observatories will be maintained and strengthened in the reformed public health services. PHOs have a vital role in providing high-quality intelligence on alcohol related harm, which can be used to support effective evidence-based public health interventions. Particularly important has been the work of North West Public Health Observatory in association with Liverpool John Moores University to create local profiles of alcohol related harms for every Local Authority in England.

June 2011

Written evidence from Rutuja Kulkarni (PH 145)

- **the creation of Public Health England within the Department of Health;** It may be an opportunity to have local PH structures as a vital part of PHE along with Health Protection and Substance Misuse to ensure the integrity of the profession;
- **the public health role of the Secretary of State;** can the role be without an ongoing responsibility given the proposed changes were introduced by the Sec of State? “Politics” will certainly play a part of the local PH set up and without the matching central perspective would this lead to a lack of governance?;
- **the future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies);** considerable work needs to be in place prior to this being implemented in terms of the perception in Local Authorities about the HR Framework for the transfer and the ring fencing of the PH function. Local Authorities need to develop their own culture to be able to “assimilate” PH teams into their structure. Clear guidance needs to be outlined to ensure that the DPH is NOT reporting into a Director of Social Services as this would limit the PH functionality and outcomes for the local population;
- **arrangements for public health involvement in the commissioning of NHS services;** PH needs to be central to the commissioning of NHS services to ensure that upstream/Prevention is integral to secondary care and primary care commissioning;
- **arrangements for commissioning public health services;** the proposals for commissioning PH services via four different bodies (GPC, Local Authorities, NHS Commissioning Boards and PHE) could result in fractured services and poorer outcomes for the health on the population. A preferred option would be to locate all of the PH commissioning in one body and have scrutiny located elsewhere;
- **the future of the Public Health Observatories;** PHO need to work at a national level but must also provide a local picture;
- **the structure and purpose of the Public Health Outcomes Framework;** Similar to the dispersal of commissioning in four different bodies, having four different organisations responsible for delivering the outcomes could create duplication. At present there is no link with the Integrated Performance Measures and this needs to be firmly established to drive down inefficiencies;
- **arrangements for funding public health services (including the Health Premium);** It will be important to have accountability for the arrangements of funding for PH services including the health premium to ensure the Prevention aspect of QIPP is supported fully and funding is not diverted to downstream interventions at the expense of upstream interventions;
- **the future of the public health workforce (including the regulation of public health professionals);** and PH workforce has been developed in the recent years for example through the UKPHVR and it is vital that such developments are not lost in this shuffle and processes are reinvented; and
- **how the Government is responding to the Marmot Review on health inequalities.** It is essential for GPCs and Local Authorities to keep the JSNA in central focus when they commission services as the JSNA will highlight local inequalities and local progress. Governance and accountability should be built into any arrangements.

June 2011

Written evidence from Public Health Manchester (PH 146)

This memorandum relates to the following terms of reference:

- Arrangements for funding public health services (including the Health Premium).
- How the Government is responding to the Marmot Review on health inequalities.

SUMMARY

- (i) The weighting for health inequalities in the PCT allocation formulae for 2011–12 has been reduced from 15%, the value for 2009–10 and 2010–11 allocations, to 10%.
- (ii) This results, other things being equal, in a shift in both target and actual allocations from poor health

PCTs to good health PCTs. The effect on target allocations ranges from a 4.1% reduction for Tower Hamlets PCT to a 4.2% increase for Surrey PCT.

- (iii) The very slow pace of change greatly reduces the effect on actual allocations for 2011–12. However the change implies a long term shift of resources from deprived areas to prosperous areas, compared with retention of the 15% weighting.
- (iv) The reduction of the health inequalities weighting is a ministerial judgment rather than an evidence based recommendation from the Advisory Committee on Resource Allocation. In fact the decision seems to contradict evidence from the recent DH-commissioned research on the subject.
- (v) This change could be interpreted as a reduction in the priority of tackling health inequalities and could be seen as contradicting the aspirations described in the recent White Papers, particularly in view of currently worsening health inequalities.
- (vi) This change in allocation policy will be of concern to future GP consortia in areas of poor health, and to all who work in the field of health inequalities.
- (vii) Currently PCT spend on public health comes out of general allocations; this change in health inequalities weight will therefore reduce the ability of poorer health PCTs to spend on public health and conversely improve that for better health PCTs. The implications for future public health budgets are unclear.
- (viii) It would be helpful to know the reasoning behind this reduction in health inequalities weight in view of the stated commitment to tackle health inequalities.
- (ix) It is important to clarify whether or not this change is a signal of an intention to move resources from poor health areas to better health areas.

1. The health inequalities formula is part of the set of formulae used to calculate theoretical target allocations for PCTs which themselves are used to inform actual allocations via a damping process named “pace of change”. It is a very simple formula consisting of the disability-free life expectancy (DFLE) of a PCT subtracted from 70 which acts as a sort of ideal upper limit not quite achieved by the PCT with the best health. It is a very strongly discriminating formula with a very wide range—from Liverpool with $70 - 55.8 = 14.2$ to Surrey with $70 - 68.5 = 1.5$ giving a range ratio of 9.5. When it first came out the Advisory Committee on Resource Allocation (ACRA) recommended that it be given a weight in the range 10% to 20%, and for 2009–10 and 2010–11 allocations the central figure of 15% was chosen by the previous administration.

2. The PCT allocations for 2011–12, announced on 15 December 2010,³⁸⁷ include a reduced weighting of 10% for the health inequalities formula (also known as the Disability Free Life Expectancy or DFLE adjustment), down from 15%.

3. A reduction in the weighting of the DFLE adjustment entails a commensurate increase in the weighting of the other formulae. The DFLE adjustment distributes to poor health areas in a stronger way than the average of the other formulae. Consequently any reduction in its weight entails a reduced distribution to poor health areas.

4. A quantitative assessment of this reduced target distribution to poor health areas can be made from a sensitivity analysis of the 2011–12 formulae using the Dept of Health exposition book released on 8 March 2011. For 2011–12 the reduction in DFLE weighting from 15% to 10% gives a range of changes in target allocation from -4.1% (Tower Hamlets PCT) and -4.0% (Manchester) to +4.2% (Surrey PCT) and +3.9% (Kensington & Chelsea). The negative changes are generally for poorer health areas and vice versa. Poor health PCTs (the half of PCTs with worst DFLE) lose on average 1.7% (£8.3 million) of target allocation while better health PCTs (the half of PCTs with the best DFLE) gain 1.7%, a 3.4% relative movement. 94% of Spearhead PCTs lose out. The north to south relative movement (five northernmost SHAs vs. five southernmost SHAs) is 2.2%. Manchester’s reduction translates into a reduction of £41.7 million. The effect on Greater Manchester PCTs is given in table 1 showing a reduction of 2.0% or £98.4 million for Greater Manchester. Results for all 151 PCTs and ten SHAs are in Appendix 1.

5. The health inequalities or DFLE formula is a measure of both mortality and morbidity so one would expect those PCTs which lose from the weight reduction to have higher mortality in general. This is borne out in the scattergraph of the change in target allocation versus under 65 SMR—a measure of premature mortality—in Figure 1.

³⁸⁷ Dept of Health. NHS Allocations 8 March 2011
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124949

Table 1

EFFECT ON 2011-12 GREATER MANCHESTER PCT CLOSING TARGET ALLOCATIONS OF CHANGING THE HEALTH INEQUALITIES WEIGHT FROM 15% TO 10%

PCT	2011-12 closing target DFLE at 15%	2011-12 closing target DFLE at 10%	change £ 000's	change %	Spearhead = S
Ashton, Leigh and Wigan PCT	574,171	560,130	-14,040	-2.4	S
Bolton PCT	489,187	480,663	-8,524	-1.7	S
Bury PCT	313,930	311,068	-2,862	-0.9	S
Heywood, Middleton and Rochdale PCT	390,103	382,574	-7,529	-1.9	S
Manchester PCT	1,032,222	990,556	-41,666	-4.0	S
Oldham PCT	409,068	400,865	-8,203	-2.0	S
Salford PCT	470,780	458,809	-11,971	-2.5	S
Stockport PCT	452,132	454,813	2,682	0.6	
Tameside and Glossop PCT	420,446	413,495	-6,951	-1.7	S
Trafford PCT	333,460	334,374	914	0.3	
Greater Manchester	4,885,498	4,787,348	-98,151	-2.0	

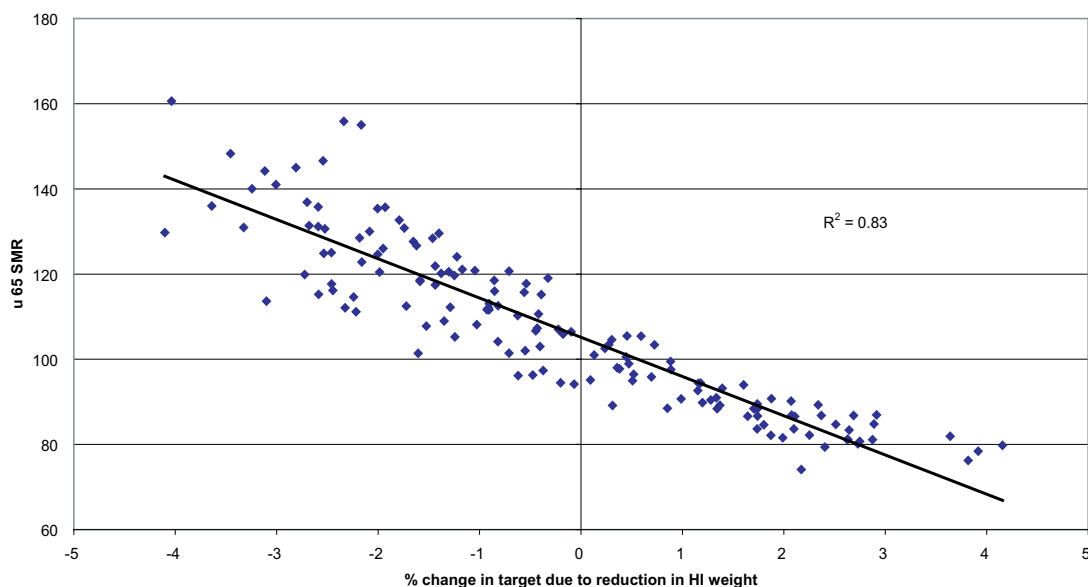
Source: Public Health Manchester analysis of DH exposition book

6. All the points above relate to target allocations. The rate at which PCTs move towards these targets is determined by ministers under “pace of change” rules. The current pace of change is very slow leading to a timescale to achievement of target of the order of 20 years. The above comments therefore concern the longer term effect. In the short term the damping is such that the reduction in health inequalities weight has an effect on actual allocations for only a few PCTs and these effects are relatively small. The second of two articles^{388, 389} on the issue in the Health Service Journal attempted to highlight such limited effects.

7. The effect on actual allocations for Greater Manchester is small. The calculation has to make the assumption that the pace of change algorithm remains unchanged in going from 15% to 10% health inequalities weight. Only two PCTs are affected. Ashton, Leigh and Wigan PCT loses £0.9 million (0.17%) and Trafford PCT gains £0.35 million (0.08%), giving a net loss for Greater Manchester of £0.55 million (0.011%). This very modest level of change will be replicated in a small number of other PCTs. Thus it can be seen that the concern is not so much with the effect on 2011-12 allocations, though these will be of concern to a small number of PCTs, but with the longer term and the implications for future policy in both public health and consortia allocations.

Figure 1

Change in target allocations due to reduction in Health Inequalities Weight versus Standardised Mortality Ratio for people under 65 years (u65 SMR)



³⁸⁸ Gainsbury S Fair funding change “threatens” poorer areas. Health Serv. J. 10 February 2011

³⁸⁹ Dowler C Funding formula change boosts South. Health Serv. J. 24 March 2011

8. There are new, improved formulae for prescribing and mental health as recommended by ACRA. The new prescribing formula has little redistributive effect but the new mental health formula distributes more strongly to poor health areas than the formula it replaces. In fact it redistributes by a relative amount of 1.6% which is about half of and in the opposite direction to the effect of the reduction in HI weight, though for Greater Manchester the effect is greater and roughly equal and opposite to the HI weight effect.

However this effect has no relevance to the ministerial judgment to reduce the HI weight. The new mental health formula forms part of normal data and formula improvements commissioned and recommended by ACRA, whereas the HI change is purely a ministerial judgment. It is simply fortuitous that the new formula happens to work to some extent in the opposite direction.

9. The reduction in HI weight seems at odds with the conclusions of recent research³⁹⁰ on the HI weight commissioned by ACRA. The recommendations of this report included an option as follows: “Allocating 85% of the budget according to the original CARAN models, or variants.....and the remaining 15% using eg distance from best DFLE or some derivative of this. This approach is similar to the current (2009–10 and 2010–11) health inequalities formula.” (p154).

The conclusion of the report also included the following paragraph “We have found some evidence to suggest that the positive effect of funding on health is higher in more deprived PCTs compared with less deprived PCTs . This would suggest that if the same incremental allocation were made to every PCT we would expect Health inequalities to be reduced. It also suggests that if a given amount of resources were redistributed from less deprived to more deprived areas there would be a net health benefit.” (p147)

In view of these quotes the reduction in HI weight seems strange.

10. The DH paper entitled “Summary of Target Formula Changes for 2011–12 Primary Care Trusts recurrent allocations”³⁹¹ makes no reference to the fact that 10% is a reduction from the last two years and therefore makes no justification of such a reduction. The relevant paragraphs are:

The DFLE (Disability free life expectancy) adjustment (Public Health Manchester comment—also known as the health inequalities formula) is retained as part of our commitment to reducing health inequalities. The size of the adjustment determines the weighting of the main formula, which aims to fund equal access for equal need, and funding to support work to reduce health inequalities. The main formula already includes weighting for the additional need for access to healthcare in elderly and/or deprived populations.

As in the last allocation round, ACRA could find no technical basis for the weighting of the DFLE adjustment and left it to ministerial decision. Until further work on allocations to GP consortia and the Public Health Service has been completed, this is being set at 10% (Public Health Manchester comment—reduced from 15% in previous years) to ensure that funding for work on health inequalities, including public health, continues and that funding to support access to healthcare and to respond to need for healthcare is sufficient. This is within the range first discussed by ACRA.

It is not clear what evidence the DH and ministers have to calculate that the reduction of allocations to poor health areas implicit in the DFLE reduction provides them with resources “sufficient to respond to need for healthcare” especially as health inequalities continue to worsen.

11. The Secretary of State attempted to explain the reason for the reduction in DFLE adjustment in the following conversation in the 15 December Health Select Committee meeting:³⁹²

Q559 Andrew George: The advisory committee has been doing that, and it has been looking at disease prevalence, demographic issues and deprivation.

Mr Lansley: Yes, and we are going to help it to go further in that direction. In the overall allocation today, we are devoting more weight to what is, through age and deprivation, reflective of need for health care services. You have asked what is being derated. At the end of the process, the ACRA told Ministers that they could allocate an amount of money, which might be 10, 15 or 20%, on the basis of inequalities in health outcomes. We are very clear that we are moving in due course towards separate allocations for NHS services and for public health. It is clear that the public health allocation will not exceed 10%, although we have not determined what it will be. So we as Ministers have said to the ACRA that we will set the allocation for relative health outcomes at 10% and allow, consequently, additional weight to be given to the factors, such as age and deprivation, that directly relate to health care need. That will impact on the balance of allocations in 2011–12.

The reason given for the reduction in health inequalities weighting seems to rest on the assumption that most or all of that weighting relates to public health. However when the weighting was developed it was seen as relating to the equal access principle in areas where there is unmet need i.e. to the provision of appropriate health care in deprived areas as a means to tackle health inequalities. It was not seen or developed merely as

³⁹⁰ Morris S et al. Research on the health inequalities element of the NHS weighted capitation formula: final report October 2010. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_122620.pdf

³⁹¹ Dept of Health Summary of target formula changes for 2011–12 Primary Care Trust recurrent allocations. 15 December 2010. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_122677.pdf

³⁹² House of Commons Health Select Committee. Q 559. Minutes of Evidence. 15 December 2010 <http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/513/10121502.htm>

a weighting to pay for more public health in deprived areas. The body responsible for developing the formulae (the Advisory Committee on Resource Allocation—ACRA) is aware of the issue and its Chair’s letter³⁹³ to the Secretary of State for Health containing their recommendations for the 2011–12 allocation formulae contains the following relevant section:

I would like to draw your attention to ACRA’s position in relation to the health inequalities adjustment. Despite intensive investigation, and because of the lack of previous NHS research on the issue, ACRA has been unable to find sufficient evidence to use to determine the size of the adjustment. We recommend that the current form of the adjustment is retained, however the scale of the adjustment is a matter for your judgment in the context of the persistent gap in health inequalities.

The White paper sets out that your future approach to health inequalities will be based more clearly on public health interventions, funded through a separate allocation. It is worth considering that the current adjustment is intended to allow for unmet health care need as well as health improvement activities. We would be happy to explore estimating the size of any unmet health care need alongside any advice you may seek from us on developing a public health allocation.

It appears that the Secretary of State’s assumption is at odds with ACRA’s implication that there is no evidence yet on the proportion, if any, of the DFLE weighting which covers public health expenditure. Therefore a judgment on the DFLE weighting should be based on criteria other than any assumed reference for the weighting. The decision also cannot be related to the future possibility that the Public Health budget may be more strongly distributed to poor health areas than the main commissioning budget, because both budgets are included in the latest allocation.

ACRA’s recommendation that the decision on the DFLE weighting should be taken “*in the context of the persistent gap in health inequalities*” taken together with the fact that health inequalities are worsening, make this reduction in DFLE weighting even more puzzling.

June 2011

APPENDIX 1

EFFECT ON 2011/12 PCT AND SHA CLOSING TARGET ALLOCATIONS OF CHANGING THE HEALTH INEQUALITIES WEIGHT FROM 15% TO 10% IN ORDER OF SIZE AND DIRECTION OF EFFECT

PCT	2011–12 closing target DFLE at 15%	2011–12 closing target DFLE at 10%	change £ 000's	change %	Spearhead= S
Tower Hamlets PCT	455,390	436,705	-18,686	-4.1	S
Manchester PCT	1,032,222	990,556	-41,666	-4.0	S
Newham PCT	494,707	476,702	-18,005	-3.6	S
Liverpool PCT	964,224	930,913	-33,311	-3.5	S
City and Hackney Teaching PCT	477,582	461,698	-15,884	-3.3	S
Nottingham City PCT	566,335	547,970	-18,365	-3.2	S
Knowsley PCT	326,808	316,621	-10,187	-3.1	S
Barnsley PCT	473,915	459,219	-14,696	-3.1	S
Hartlepool PCT	181,862	176,393	-5,469	-3.0	S
Middlesbrough PCT	283,946	275,970	-7,976	-2.8	S
Sunderland Teaching PCT	550,752	535,753	-14,999	-2.7	S
Islington PCT	391,822	381,239	-10,583	-2.7	S
Stoke On Trent PCT	528,026	513,873	-14,153	-2.7	S
Hull Teaching PCT	511,249	498,006	-13,243	-2.6	S
Blackburn with Darwen Teaching Care					
Trust Plus	283,680	276,333	-7,347	-2.6	S
County Durham PCT	1,008,739	982,640	-26,100	-2.6	S
Salford PCT	470,780	458,809	-11,971	-2.5	S
Halton and St Helens PCT	596,778	581,645	-15,133	-2.5	S
Newcastle PCT	490,132	477,756	-12,375	-2.5	S
Leicester City PCT	559,216	545,454	-13,762	-2.5	S
Barking and Dagenham PCT	325,038	317,045	-7,993	-2.5	S
Ashton, Leigh and Wigan PCT	574,171	560,130	-14,040	-2.4	S
Heart of Birmingham Teaching PCT	506,630	494,779	-11,850	-2.3	S
Wakefield District PCT	637,533	622,711	-14,822	-2.3	S
Doncaster PCT	559,051	546,522	-12,529	-2.2	S
Rotherham PCT	457,606	447,457	-10,149	-2.2	S
Gateshead PCT	379,262	370,983	-8,279	-2.2	S

³⁹³ ACRA chair’s letter to Secretary of State on NHS Resource Allocation Formula 27 September 2010.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_122685.pdf

<i>PCT</i>	<i>2011-12 closing target DFLE at 15%</i>	<i>2011-12 closing target DFLE at 10%</i>	<i>change £ 000's</i>	<i>change %</i>	<i>Spearhead= S</i>
Blackpool PCT	289,123	282,861	-6,262	-2.2	S
South Birmingham PCT	624,444	610,953	-13,491	-2.2	S
Sandwell PCT	582,831	570,683	-12,147	-2.1	S
Oldham PCT	409,068	400,865	-8,203	-2.0	S
Birmingham East and North PCT	729,973	715,352	-14,620	-2.0	S
Redcar and Cleveland PCT	248,879	243,936	-4,943	-2.0	S
South Tyneside PCT	297,044	291,253	-5,792	-1.9	S
Heywood, Middleton and Rochdale PCT ¹	390,103	382,574	-7,529	-1.9	S
Lambeth PCT	578,489	568,128	-10,361	-1.8	S
Bolton PCT	489,187	480,663	-8,524	-1.7	S
Stockton-on-Tees Teaching PCT	324,506	318,915	-5,591	-1.7	S
Tameside and Glossop PCT	420,446	413,495	-6,951	-1.7	S
Wolverhampton City PCT	445,995	438,759	-7,236	-1.6	S
Bassetlaw PCT	196,134	192,986	-3,148	-1.6	S
East Lancashire Teaching PCT	670,273	659,640	-10,633	-1.6	S
Waltham Forest PCT	413,219	406,665	-6,554	-1.6	
Sheffield PCT	934,232	919,990	-14,241	-1.5	
Bradford and Airedale Teaching PCT	875,399	862,603	-12,796	-1.5	S
Camden PCT	419,825	413,793	-6,033	-1.4	
Greenwich Teaching PCT	435,325	429,071	-6,254	-1.4	S
Southwark PCT	531,501	524,054	-7,447	-1.4	S
Haringey Teaching PCT	451,588	445,361	-6,226	-1.4	S
Plymouth Teaching PCT	445,730	439,716	-6,014	-1.3	
Coventry Teaching PCT	557,505	550,240	-7,265	-1.3	S
North Tyneside PCT	368,504	363,754	-4,750	-1.3	S
Walsall Teaching PCT	455,761	450,067	-5,694	-1.2	S
Telford and Wrekin PCT	263,903	260,620	-3,283	-1.2	
Wirral PCT	584,865	577,710	-7,156	-1.2	S
Lewisham PCT	485,923	480,240	-5,684	-1.2	S
Darlington PCT	177,558	175,700	-1,858	-1.0	
Derby City PCT	463,818	459,056	-4,761	-1.0	
Southampton City PCT	402,651	398,917	-3,734	-0.9	
Bury PCT	313,930	311,068	-2,862	-0.9	S
Central Lancashire PCT	747,786	741,012	-6,774	-0.9	S
Bristol PCT	734,214	727,571	-6,643	-0.9	
Sefton PCT	494,331	490,102	-4,229	-0.9	
Leeds PCT	1,268,038	1,257,231	-10,807	-0.9	
Wandsworth PCT	475,586	471,694	-3,893	-0.8	
Kirklees PCT	654,232	648,880	-5,351	-0.8	
Warrington PCT	317,241	314,988	-2,252	-0.7	S
Luton PCT	313,044	310,825	-2,220	-0.7	
Hounslow PCT	379,225	376,860	-2,365	-0.6	
Derbyshire County PCT	1,180,387	1,173,064	-7,323	-0.6	S
North East Lincolnshire Care Trust Plus	273,456	271,926	-1,530	-0.6	S
North Staffordshire PCT	349,456	347,532	-1,924	-0.6	
Portsmouth City Teaching PCT	334,602	332,800	-1,802	-0.5	
Northumberland Care Trust	546,206	543,612	-2,594	-0.5	S
Calderdale PCT	328,324	326,858	-1,466	-0.4	
Ealing PCT	541,063	538,726	-2,337	-0.4	
Hammersmith and Fulham PCT	283,611	282,424	-1,187	-0.4	S
North Lincolnshire PCT	265,585	264,510	-1,075	-0.4	
Peterborough PCT	256,304	255,300	-1,005	-0.4	
Nottinghamshire County Teaching PCT	1,061,627	1,057,660	-3,967	-0.4	
Brighton and Hove City PCT	434,846	433,431	-1,415	-0.3	
Dudley PCT	505,092	503,967	-1,125	-0.2	
Milton Keynes PCT	356,110	355,396	-714	-0.2	
Brent Teaching PCT	461,756	460,931	-824	-0.2	
Medway PCT	420,430	419,699	-731	-0.2	
North Lancashire Teaching PCT	558,876	558,331	-544	-0.1	
Redbridge PCT	403,086	402,814	-272	-0.1	
South Staffordshire PCT	937,099	937,972	873	0.1	S
Cumbria Teaching PCT	848,757	849,863	1,106	0.1	S
Eastern and Coastal Kent PCT	1,220,609	1,223,486	2,877	0.2	

<i>PCT</i>	<i>2011-12 closing target DFLE at 15%</i>	<i>2011-12 closing target DFLE at 10%</i>	<i>change £ 000's</i>	<i>change %</i>	<i>Spearhead= S</i>
Trafford PCT	333,460	334,374	914	0.3	
Torbay Care Trust	254,069	254,842	773	0.3	
Cornwall and Isles of Scilly PCT	890,382	893,157	2,774	0.3	
Enfield PCT	465,462	467,119	1,657	0.4	
Western Cheshire PCT	383,477	384,935	1,458	0.4	
Great Yarmouth and Waveney PCT	395,295	397,056	1,761	0.4	
Hastings and Rother PCT	315,054	316,482	1,428	0.5	
Lincolnshire Teaching PCT	1,167,262	1,172,760	5,498	0.5	S
South West Essex PCT	651,924	655,234	3,310	0.5	
Swindon PCT	306,200	307,790	1,589	0.5	
Stockport PCT	452,132	454,813	2,682	0.6	
North East Essex PCT	545,308	549,092	3,785	0.7	
Croydon PCT	550,110	554,098	3,987	0.7	
Isle of Wight NHS PCT	249,794	251,924	2,130	0.9	
Hillingdon PCT	387,903	391,328	3,425	0.9	
Northamptonshire Teaching PCT	993,778	1,002,588	8,810	0.9	S
Warwickshire PCT	791,591	799,405	7,814	1.0	
Central and Eastern Cheshire PCT	678,375	686,186	7,811	1.2	
Bournemouth and Poole Teaching PCT	540,122	546,382	6,261	1.2	
Westminster PCT	401,950	406,690	4,739	1.2	
East Riding of Yorkshire PCT	479,118	484,854	5,736	1.2	
Havering PCT	399,134	404,239	5,105	1.3	
Worcestershire PCT	825,802	836,819	11,017	1.3	
Norfolk PCT	1,183,973	1,199,868	15,895	1.3	
Shropshire County PCT	448,556	454,695	6,139	1.4	
South East Essex PCT	541,503	549,050	7,547	1.4	
Sutton and Merton PCT	542,089	550,775	8,687	1.6	
Herefordshire PCT	277,961	282,532	4,571	1.6	
Bexley Care Trust	337,933	343,694	5,760	1.7	
North Yorkshire and York PCT	1,148,405	1,168,061	19,656	1.7	
Somerset PCT	808,322	822,363	14,041	1.7	
Bedfordshire PCT	599,545	609,973	10,429	1.7	
North Somerset PCT	331,603	337,374	5,771	1.7	
Harrow PCT	318,404	323,946	5,542	1.7	
Devon PCT	1,143,276	1,163,880	20,604	1.8	
Leicestershire County and Rutland PCT	909,896	926,923	17,027	1.9	
Solihull Care Trust	308,340	314,131	5,791	1.9	
Barnet PCT	518,400	528,707	10,308	2.0	
Berkshire East PCT	552,695	564,146	11,451	2.1	
Gloucestershire PCT	858,348	876,170	17,822	2.1	
Cambridgeshire PCT	827,760	845,135	17,376	2.1	
West Essex PCT	401,746	410,215	8,469	2.1	
South Gloucestershire PCT	337,127	344,447	7,321	2.2	
Suffolk PCT	894,754	914,905	20,151	2.3	
East Sussex Downs and Weald PCT	523,146	535,373	12,228	2.3	
West Kent PCT	979,855	1,003,072	23,217	2.4	
Mid Essex PCT	504,893	517,027	12,134	2.4	
Hertfordshire PCT	1,580,966	1,620,676	39,710	2.5	
Bath and North East Somerset PCT	254,080	260,750	6,670	2.6	
Kingston PCT	238,715	244,995	6,280	2.6	
Oxfordshire PCT	834,186	856,236	22,050	2.6	
West Sussex PCT	1,202,872	1,235,203	32,331	2.7	
Dorset PCT	610,886	627,561	16,675	2.7	
Wiltshire PCT	641,699	659,332	17,633	2.7	
Hampshire PCT	1,811,303	1,863,354	52,050	2.9	
Bromley PCT	460,892	474,201	13,309	2.9	
Berkshire West PCT	616,447	634,407	17,960	2.9	
Buckinghamshire PCT	673,976	698,513	24,537	3.6	
Richmond and Twickenham PCT	234,717	243,677	8,960	3.8	
Kensington and Chelsea PCT	285,613	296,800	11,187	3.9	
Surrey PCT	1,477,334	1,538,711	61,377	4.2	
England	84,996,081	84,996,081	0	0.0	

<i>PCT</i>	<i>2011–12 closing target DFLE at 15%</i>	<i>2011–12 closing target DFLE at 10%</i>	<i>change £ 000's</i>	<i>change %</i>	<i>Spearhead= S</i>
SHA					
North East SHA	4,857,390	4,756,665	-100,725	-2.1	
North West SHA	12,630,092	12,438,489	-191,603	-1.5	
Yorkshire and the Humber SHA	8,866,143	8,778,827	-87,315	-1.0	
East Midlands SHA	7,098,452	7,078,462	-19,991	-0.3	
West Midlands SHA	9,138,964	9,082,381	-56,582	-0.6	
East of England SHA	8,697,015	8,834,356	137,342	1.6	
London SHA	13,146,060	13,104,418	-41,642	-0.3	
South East Coast SHA	6,574,146	6,705,458	131,312	2.0	
South Central SHA	5,831,764	5,955,692	123,928	2.1	
South West SHA	8,156,058	8,261,334	105,276	1.3	
North	42,591,040	42,134,824	-456,216	-1.1	
South	42,405,042	42,861,258	456,216	1.1	

Source: Public Health Manchester analysis of DH exposition book

Addendum to the written submission by Public Health Manchester (PH 146A)

1. This addendum to our memorandum seeks to clarify the relationship between the effect on target allocations (attained in the longer term) and that on actual 2011–12 allocations, both caused by the reduction in the health inequalities weighting from 15% to 10%.

2. The change in target allocations represents the maximum annual effect in the future, attained at a time determined by future ministerial decisions on the pace of change and historically within a band of about 7–20 years.

3. The final maximum change represents a movement of £718.0 million from poorer health PCTs to better health PCTs, a relative movement of about 3.4%.

4. The current year 2011–12 equivalent effect is estimated at £55.9 million, which is 7.8% of the maximum effect and a relative movement of about 0.3%.

5. From the current year the effect will increase annually up to the maximum, giving a total aggregate movement of allocation over the period of many times the maximum annual effect.

6. In our tables and in the context of current policy on allocations where all PCTs are given growth, at least nominal growth, “losing” PCTs are those whose growth and hence allocations are less than would otherwise be the case and vice versa for “gaining” PCTs.

7. The following tables compare losing and gaining PCTs for target allocations (maximum annual future effect) and for the 2011/12 actual effect. A measure of mortality, the under 75 standardised mortality ratio (u75 SMR), is also given to indicate the health of the population of the PCT relative to the England average of 100, which demonstrates that losing PCTs have higher mortality than average and gaining PCTs have lower mortality than average.

Table 1

TOP TEN LOSING PCTS FROM REDUCTION IN HEALTH INEQUALITIES WEIGHT IN TERMS OF MAXIMUM FUTURE ANNUAL EFFECT (TARGET ALLOCATIONS)

	<i>PCT</i>	<i>Change £m</i>	<i>Change %</i>	<i>u75 SMR</i>
1	Tower Hamlets	-18.7	-4.1	129.8
2	Manchester	-41.7	-4.0	158.2
3	Newham	-18.0	-3.6	133.4
4	Liverpool	-33.3	-3.5	147.3
5	City & Hackney	-15.9	-3.3	123.8
6	Nottingham City	-18.4	-3.2	132.9
7	Knowlsey	-10.1	-3.1	136.7
8	Barnsley	-14.7	-3.1	121.4
9	Hartlepool	-5.5	-3.0	131.7
10	Middlesbrough	-8.0	-2.8	131.4

Table 2

TOP TEN GAINING PCTS FROM REDUCTION IN HEALTH INEQUALITIES WEIGHT, IN TERMS OF MAXIMUM FUTURE ANNUAL EFFECT (TARGET ALLOCATIONS)

	<i>PCT</i>	<i>Change £m</i>	<i>Change %</i>	<i>u75 SMR</i>
1	Surrey	+61.4	+4.2	78.5
2	Kensington & Chelsea	+11.2	+3.9	69.3
3	Richmond & Twickenham	+9.0	+3.8	76.6
4	Buckinghamshire	+24.5	+3.6	79.9
5	Berkshire West	+18.0	+2.9	85.3
6	Bromley	+13.3	+2.9	80.5
7	Hampshire	+52.1	+2.9	80.4
8	Wiltshire	+17.3	+2.7	81.2
9	Dorset	+16.7	+2.7	75.7
10	West Sussex	+32.3	+2.7	85.6

Table 3

TOP TEN LOSING PCTS FROM REDUCTION IN HEALTH INEQUALITIES WEIGHT, IN TERMS OF 2011–12 ACTUAL ALLOCATIONS

	<i>PCT</i>	<i>Change £m</i>	<i>Change %</i>	<i>u75 SMR</i>
1	Leicester City	-7.7	-1.5	130.1
2	Nottingham City	-4.3	-0.8	132.9
3	Barnsley	-2.7	-0.6	121.4
4	County Durham	-4.8	-0.5	113.6
5	Wakefield District	-2.9	-0.5	114.4
6	Derby City	-2.0	-0.5	109.9
7	Bristol	-2.3	-0.3	110.7
8	Sandwell	-1.8	-0.3	132.6
9	Bassetlaw	-0.5	-0.3	105.3
10	Liverpool	-2.6	-0.3	147.3

Table 4

TOP TEN GAINING PCTS FROM REDUCTION IN HEALTH INEQUALITIES WEIGHT, IN TERMS OF 2011/12 ACTUAL ALLOCATIONS

	<i>PCT</i>	<i>Change £m</i>	<i>Change %</i>	<i>u75 SMR</i>
1	Norfolk	+17.0	+1.5	84.6
2	North East Essex	+6.9	+1.3	93.5
3	South Staffordshire	+9.0	+1.0	96.4
4	Bedfordshire	+2.9	+0.5	92.2
5	Hertfordshire	+4.4	+0.3	85.9
6	Dorset	+1.7	+0.3	75.7
7	Gloucestershire	+2.3	+0.3	86.5
8	Devon	+2.0	+0.2	82.4
9	West Sussex	+1.9	+0.2	85.6
10	Buckinghamshire	+1.0	+0.1	79.9

Source: Allocations—PH Manchester analysis of DH exposition book

u75SMR—APHO 2005–09 data

Note on calculation of 2011–12 effect: The pace of change (PoC) algorithm was set up to be as similar as possible to the actual one used while growth on the two main gradients was constrained so that the actual overall pace was maintained ie movement of £74.5 million from over target to under target PCTs.

September 2011

Written evidence from DrugScope (PH 147)

ABOUT DRUGSCOPE

DrugScope is the UK's leading independent centre of expertise on drugs and drug use and the national membership organisation for the drugs field, with around 500 members. It also incorporates the London Drug and Alcohol Network (LDAN). DrugScope is a registered charity (charity number: 255030).

Further information about our work is available on the DrugScope website at www.drugscope.org.uk

SUMMARY OF KEY POINTS

- It is proposed that the public health service will assume responsibility for the current spend of about £1 billion a year on drug and alcohol treatment services—approximately one quarter of the public health budget, and as much as half of the budgets of local Directors of Public Health (DoPH).
- The specific “ring fence” is due to be removed from the nationally allocated drug treatment budget as it is integrated into the wider public health budget.
- In 2012 the National Treatment Agency for Substance Misuse will be abolished and Public Health England and DoPH will take responsibility for ensuring a range of specialised health interventions of an appropriate quality are available for people with drug and alcohol problems.
- There is overwhelming evidence that properly funded and evidence-based drug and alcohol treatment delivers substantial benefits for individuals, families and carers, local communities, society and the economy. This applies to the whole range of services required for a balanced treatment system, from needle exchange programmes to abstinence-based residential programmes.
- The success of the public health reforms will be critical to the delivery of the ambitions set out in the Drug Strategy 2010, with a greater emphasis on recovery and social re-integration, and other areas of Government policy (including criminal justice and welfare reform).
- Bringing drug and alcohol policy into a broader public health remit creates opportunities for innovative approaches that can support the delivery of these policy objectives. DrugScope particularly welcomes the potential for more focus on prevention and early intervention, greater flexibility to respond to local needs and priorities and improved integration of drug and alcohol services.
- DrugScope welcomes the commitment in the “Healthy Lives, Healthy People” White Paper that the NHS Constitution will apply in full to public health, including, by implication, the provision of drug and alcohol services.
- There is, however, concern among DrugScope's membership about the very limited reference to and detail about drug and alcohol services in the recent public health consultation; what is perceived as a lack of adequate engagement with this aspect of public health in planning and preparation in some local areas; and the risk of significant disinvestment in drug and alcohol services and supporting recovery. We note, for example, that in the Government consultation document on outcomes for public health only two of over 60 proposed outcome indicators were directly concerned with drug and alcohol services.
- We believe the Health Select Committee's Inquiry provides an opportunity for public scrutiny of this critical aspect of the public health reforms.

DRUGSCOPE'S RESPONSE

1. The Government's proposals for public health are critical for the future of drug and alcohol policy and treatment in England, and the delivery of prevention and early intervention programmes. Success will be crucial to the delivery of the outcomes described in the Drug Strategy 2010 (Reducing demand, restricting supply, building recovery), and to other areas of Government policy—for example, crime reduction and reducing re-offending, and the DWP's Work Programme and its success in supporting people affected by drug and alcohol problems off benefit and into education, training and work.

2. The public health service will assume responsibility for around £1 billion of current drug and alcohol spending. This will account for a quarter of its overall budget, and as much as 40% to 50% of the public health budgets controlled by local authorities and DoPHs.

THE ROLE OF DRUG AND ALCOHOL SERVICES AND THE RISK OF DISINVESTMENT

3. The allocation of £570 million of central government funding for community and prison-based drug treatment by the Department of Health for 2011–12 was a welcome signal of the Government's commitment to maintain funding during a period of financial austerity. There is strong support in the drug and alcohol sector for the greater focus on recovery and social reintegration in the 2010 Drug Strategy. However, **a concern among DrugScope members is that the proposed transfer of an estimated £1 billion of drug and alcohol money into the public health service, and removal of the specific “ring-fence” around the “pooled drug treatment budget”, could result in significant disinvestment.** One DrugScope member who contacted us

expressed concern that “without ring-fencing it is difficult to discern what aspects of public health may be prioritised” (and expressed particular concerns that “clients with complex needs etc will not be specifically catered for”).

The National Audit Office’s “Tackling Problem Drug Use” (2010) concluded that £1 invested in drug treatment resulted in savings of £2.50 from reduced criminal justice, health and social costs.

4. The Drug Sector Partnership (DrugScope, Adfam, EATA and The Alliance) has developed a “Drug Treatment Consensus Statement” supported by over 70 organisations involved in delivering drug and alcohol services. It concludes that “decision makers and opinion formers have a responsibility to make sure that taxpayers “money is spent wisely, on services that deliver on public priorities and with public benefits. We recognise that tough decisions need to be made between competing priorities, particularly at a time of spending restraint. But we also know that disinvestment in drug and alcohol treatment services will leave some of the most excluded and marginalised in our society with no second chances and no route back. It will also result in greater costs in the long run”.

A DrugScope/ICM public opinion poll reported in February 2009 that nine out of ten respondents (88%) agreed with the statement that drug treatment should be available to anyone with an addiction to drugs who is prepared to address it.

Available at <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/MarcusreportICM.pdf>

5. There is a particular challenge in ensuring the provision for people affected by drug and alcohol problems is given sufficient priority at local level when there will be competing demands on public health funding, particularly given the levels of stigma they (and their families) can experience. Drug and alcohol dependency often develops in response to problems in people’s lives, such as childhood neglect and abuse, trauma, mental health issues and experience of social exclusion (for example, homelessness or loss of employment). Despite this, drug and alcohol problems can be viewed or represented as largely self-inflicted. There is a broader challenge for Government in an age of localism of ensuring that services for the most marginalised sections of the community receive sufficient continued investment, particularly at a time when there are overall significant reductions in local authority budgets. A particular concern has been expressed by DrugScope members about local disinvestment in services for young people with drug and alcohol problems.

The NTA’s Chief Executive, Paul Hayes, has expressed concerns about local disinvestment in a letter announcing the central allocations for drug treatment spending for 2011–12 (11 February 2011): “The biggest threat to those ambitions [ie for a recovery-orientated drug and alcohol treatment system] is the potential for local disinvestment. With the impending abolition of PCTs and severe budgetary pressures on local authorities, there is legitimate concern across the treatment field that the vital funding provided from local sources will be squeezed”.

A telephone survey conducted by DrugScope’s London Drug and Alcohol Network (LDAN) (January/February 2011) reported that out of 18 young people’s drug and alcohol treatment providers contacted in the capital, only three saw their service’s current funding situation as “safe”. Of those respondents who had been informed of definite cuts in their funding, most expected reductions of around 40%, although one service was facing cuts of up to 75%.

OPPORTUNITIES AND POTENTIAL REALLOCATIONS OF FUNDING

6. The potential benefits of a public health approach to drug and alcohol issues include the opportunity for an increased focus on prevention and early intervention, greater flexibility to respond to local needs and priorities, and opportunities for engagement with a wider range of drug-related health problems (including poly-drug use) and improved integration of drug and alcohol policy and services.

7. We anticipate within the new public health framework some reallocation of spending within available drug and alcohol funding—for example, increased investment in alcohol treatment and prevention. **DrugScope has suggested that Government supports a programme of national and regional events for public health and other local partners to facilitate discussion of their role in drug and alcohol treatment**, including contingency planning to explore the possible consequences of alternative allocations of drug and alcohol budgets.

8. **There is the opportunity for more local investment in public health campaigns, but it is vital that Public Health England provides guidance and support for “what works” in this area.** For example, evidence suggests that “shock tactic” public campaigns are generally ineffective and a poor use of public money unless they address a particular public health issue and are consistent with the everyday experiences of their target audience (as applied to the more successful drink driving, smoking and HIV/AIDS campaigns). Similarly, there is no evidence that simplistic “just say no” approaches to drug education are effective for prevention.

PUTTING DRUG AND ALCOHOL ISSUES AT THE HEART OF PUBLIC HEALTH

9. There is concern among DrugScope’s membership about the limited reference to drug and alcohol services in the Government’s “Healthy Lives, Healthy People” (HLHP) consultation documents, and in the wider public

discussion of health reform. Despite the fact that drug and alcohol treatment and other services will represent a quarter of the national and up to half of the local public health spend, the White Paper contained only a handful of references to drugs and alcohol.

In 2009–10 there were estimated to be over one thousand services supporting drug treatment in England, employing over 11,000 people, accessed by 206,000 adults with serious drug problems and nearly 25,000 under 18s.

Based on NTA figures

10. Only two of over 60 proposed indicators in the consultation document on “Transparency of Outcomes” were directly concerned with drugs and alcohol:

- “numbers leaving drug treatment free of dependency”; and
- “rate of hospital admissions per 100,000 for alcohol related harm”.

We understand that the final public health outcomes framework will consist of around 15–20 indicators. Even so, consideration of only two drug and alcohol outcomes is not proportionate to either their contribution to the overall public health budget or their importance for Government policy. DrugScope members have reported concerns about what is perceived as a low level of engagement in, and understanding of, drug and alcohol issues for emerging public health structures in some localities.

SUPPORTING RECOVERY

11. A key challenge for public health will be to integrate the delivery of drug and alcohol services through public health structures and the wider recovery and reintegration ambition set out in the Drug Strategy 2010. **It is important that public health is integrated into recovery-orientated approaches to local service delivery, which will be developed as part of the NTA’s Action Plan for 2011–12 and the follow up to the NTA’s “Building Recovery in Communities” consultation.**

The 2010 Drug Strategy set out eight “best practice outcomes” for “successful delivery of a recovery-orientated system”:

- Freedom from dependence on drugs or alcohol;
- Prevention of drug related deaths and blood borne viruses;
- A reduction in crime and re-offending;
- Sustained employment;
- The ability to access and sustain suitable accommodation;
- Improvements in mental and physical health and well-being;
- Improved relationships with family members, partners and friends; and
- The capacity to be an effective and caring parent.

12. *Health and Wellbeing Boards (HWBs)*. The proposed “minimum membership” of HWBs comprises elected representatives, GP Consortia, DoPH, Directors of Adult Social Services, Directors of Children’s Services, local Healthwatch and, where appropriate, the NHS Commissioning Board. The 2010 Drug Strategy suggests that membership might be expanded locally to include Police and Crime Commissioners, employment and housing services and prison and probation to provide local leadership on recovery. How far it is practicable to expand HWBs in this way is questionable, but getting the relationship between public health and recovery and reintegration structures right will be critical. (We believe that the statutorily required membership of HWBs should also include appropriate representation for the voluntary and community sector.)

13. *Police and Crime Commissioners (PCCs)*. There is a need for clarity about the relationship between public health and PCCs. Our understanding is that PCCs will assume responsibility for some of the funding for the Drug Intervention Programme and for core Community Safety Funding (including Young People’s Substance Misuse funding). Decisions made by local DoPH and HWBs will have a significant impact on drug and alcohol-related crime, but PCCs will be democratically accountable for crime rates. There may be an argument that it would be more appropriate for the PCCs to assume overall responsibility for offender health (including drug and alcohol treatment).

14. *Prisons and the community*. The issue of responsibility for prison treatment and the relationship between prison and community services is also critical. DrugScope welcomed the decision to transfer the budget for prison drug and alcohol services from the Ministry of Justice to the Department of Health, included in the 2010 Drug Strategy. The HLHP consultation paper suggested, however, that the funding and commissioning routes for prisons (with responsibility resting with the NHS Commissioning Board) may be different from those for community services. We would welcome clarification on how public health reforms will co-ordinate support across the community and criminal justice system.

15. *Payment by results*. “Payment by results” was not discussed in the HLHP consultation, although the Government is planning to launch eight “Drug Recovery Payment by Results” pilots in September/October 2012. We are seeking clarification on the relationship between the development of payment by results approaches and the public health reforms. Issues relating to the pilots include the proposed exclusion from services paid by results of people with a dual diagnosis.

16. *Harm reduction.* The introduction of needle exchange and related services in the UK in the 1980s and 1990s resulted in one of the lowest rates of HIV infection among injecting drug users (at around 1%) in the world. We have asked for further clarification from Government on what requirement (if any) it is envisaged there will be for DoPH to provided services such as needle exchange, screening and testing for blood borne viruses and vaccination and treatment for hepatitis and other health problems associated with the use and administration of drugs, or what alternative arrangements are proposed for these vital services. We are also unclear what role and/or responsibilities are envisaged for GP Consortia in the provision of harm reduction services, and drug and alcohol treatment more generally.

THE NHS CONSTITUTION

17. DrugScope welcomed the statement in the HLHP White Paper that the NHS Constitution will apply to the public health service. This will help to ensure provision of drug and alcohol services is meeting an acceptable standard across the country (for example, by providing access to interventions and treatments recommended by the National Institute for Clinical Excellence), by requiring all local areas to invest from public health budgets to ensure they meet their responsibilities within the NHS Constitution. We have asked for further clarification from Government of the responsibilities under the NHS Constitution, particularly as we understand that DoPHs will be employed by the local authority rather than PHE.

DUAL DIAGNOSIS AND MULTIPLE NEEDS

18. DrugScope has a particular concern about services for people with co-occurring substance misuse and mental health problems (“dual diagnosis”). Health reform provides an opportunity to improve integration of substance misuse and mental health services, but there is a risk of the unintended emergence of new “gaps” between services. We have called on Government to “trouble-shoot” the plans for public health to assess the impact on people with “dual diagnosis”.

CONCLUSION

19. The future of drug and alcohol services is one component in a much wider programme of health reform, but it is vitally important for the whole community to get it right. Public health reform presents opportunities to improve the effectiveness of local interventions and responsiveness to the issues of greatest concern to local communities. Drugscope has concerns, however, that the removal of “ring-fencing” from the drug budget, the shift of responsibilities from the NTA to the new public health structures and a more localist approach could result in disinvestment in drug and alcohol services, with a negative impact on vulnerable individuals, families and communities, and ultimately a substantial additional cost to the taxpayer. We recognise that there is potential for “efficiency savings” and scope for improving delivery within existing budgets, but there are also limits to the capacity to do this.

20. There needs to be a sufficiently robust national framework of accountability for drug and alcohol services to ensure that the levels of investment that are needed to deliver the outcomes in the 2010 Drug Strategy and to comply with the NHS Constitution are available in every area.

21. DrugScope has called for a separate consultation to ensure a full public discussion of the transfer of responsibility for drug and alcohol services to public health. This would cover issues such as transitional arrangements, the future role of local drug partnerships, skills and workforce development, accountability frameworks for DoPHs, the application of the NHS Constitution, the role of HWBs, the role of payment by results, and the integration of public health reform, criminal justice reform (including the PCCs) and recovery (from recovery champions and mutual aid to housing, training and employment). We welcome the opportunities provided the Health Select Committee inquiry to highlight the issues.

June 2011

Written evidence from the Cycle to Work Alliance (PH 148)

EXECUTIVE SUMMARY

- This submission is made on behalf of the Cycle to Work Alliance, a group of the leading providers of the government supported and industry-led cycle to work scheme, including Cyclescheme, Cycle Solutions, Evans Cycles and Halfords Plc.
- We recommend the scheme should play a central role in the Government’s public health agenda, as we provide evidence to demonstrate the tangible impact the cycle to work scheme is having on public health, and the potential for achieving greater benefits by encouraging further take up.
- Our submission focuses on the future role of local government in public health. We discuss Health and Wellbeing Boards and recommend the Committee calls for clarity about how local authorities’ duties on sustainable transport and public health can be co-ordinate and consistent.

- We demonstrate how the cycle to work scheme allows local authorities to encourage both active and sustainable travel while improving the health of local residents and show, through the findings from our recent survey, how encouraging people to cycle to work results in healthier lives and reduced CO₂ emissions.

1. INTRODUCTION TO THE CYCLE TO WORK ALLIANCE

- The Cycle to Work Alliance (the Alliance) is a group of the leading providers of the cycle to work scheme, including Cyclescheme, Cycle Solutions, Evans Cycles and Halfords Plc.
- To date over 400,000 people have taken advantage of the scheme, which involves over 2,220 bike retailers and 15,000 employers.
- The cycle to work initiative is a tax-efficient, and on the whole, salary-sacrificed employee benefit that provides a way of encouraging more adults to take up cycling.
- Introduced in the 1999 Finance Act, the scheme encourages employers to loan bicycles and cycling safety equipment to employees as a tax-exempt benefit for the purpose of cycling to work.
- Under the scheme, employers buy cycling equipment from suppliers approved by their scheme administrator, and hire it to their employees. At the end of the loan period, the employer may choose to give the employee the option to purchase the equipment.
- The savings that individuals make through the cycle to work scheme improves the affordability of, and access to, cycling. Employees who participate in the scheme on average 40% of the total cost of a new bike.

2. THE ROLE OF THE SCHEME IN IMPROVING PUBLIC HEALTH

- In a recent report, which surveyed over 44,500 cycle to work participants, the Alliance discovered that 87% of scheme users noticed an improvement in their health from their more active commute to work.³⁹⁴
- 84% of users rated the scheme as an important and easy way to keep fit.
- The health benefits noticed by scheme users include:
 - Increased fitness.
 - Weight loss.
 - Improved mental health, wellbeing and happiness.
- The health benefits of the scheme are also noticed by businesses, with 97% of businesses believing that the scheme is an important way to encourage a healthy workforce.
- The Alliance believes that making active travel and physical activity the norm in communities across the country is vital if the Government wants to achieve their commitments to encouraging people to take greater responsibility for their own health and to live healthier lifestyles.
- By using the scheme, people are able to make exercise an everyday activity, rather than having to find additional time for it, changing their behaviour and ensuring that exercise becomes part of their daily routine.
- Employers also recognise the benefits of the scheme in improving the health and productivity of their workforce. By working with employers the Government's public health agenda will have an even greater impact on improving the health of individuals.

3. WIDER BENEFITS OF THE SCHEME—SUSTAINABILITY, AFFORDABILITY

- The cycle to work scheme plays an important role in encouraging people to cycle instead of drive—particularly over short distances.
- The majority of respondents to our survey (70%) said they had reduced the number of miles they drive per week as a result of using the cycle to work scheme. We have estimated that current users of the cycle to work scheme are saving **133,442 tonnes of CO₂** per year. This is the equivalent of the CO₂ emissions of 24,000 homes per year or a city larger than Hereford.
- As well as encouraging individuals to reduce their carbon footprint the scheme makes cycling more affordable for lower paid employees. With the cost of living rising rapidly and petrol and rail fares on the increase, employees need to be supported with cost efficient modes of transport. The cycle to work scheme is used predominantly by basic rate taxpayers (73%) providing them with a low cost commute to work.
- The reduction in car usage the cycle to work scheme encourages has a clear benefit to the environment. The scheme promotes sustainable commuting, reduces car use in towns and cities and therefore the level of carbon emissions.

³⁹⁴ <http://cycletoworkalliance.org.uk/images/BehaviourImpactAnalysisFeb2011.pdf>

4. THE NEED FOR JOINT WORKING

- New cyclists are encouraged to change their commuting habits through the cycle to work scheme. 61% respondents to our survey did not cycle to work before using the scheme. This equates to 158,000 new cyclists commuting every year.
- 76% of users also declared they would not have bought their bicycle if it had not been offered it through the cycle to work scheme.
- The scheme plays a vital role in incentivising individuals to take greater responsibility for their health, reduce their carbon emissions and contribute to a more sustainable transport system.
- Local authorities have an opportunity to develop a clear strategy, co-coordinating the efforts of the new Health and Wellbeing boards and their sustainable transport teams, to embed cycling as a core aspect of local travel strategies.
- In particular, by engaging with local employers, promoting initiatives such as the cycle to work scheme, local authorities will be able to improve the health of their communities in a cost effective manner, while reducing the CO₂ emission in their area.

5. CONCLUSION AND RECOMMENDATIONS

- The cycle to work scheme is able to contribute to the Government's goals for public health by providing a proven means to encourage individuals to live healthier lives.
- Local authorities should encourage their Public Health and Wellbeing Boards to work collaboratively with their sustainable travel teams to achieve their common goals in a cost effective manner.
- We call on the Health Select Committee to demonstrate to local authorities, that they have an opportunity to foster genuine joint working across health and transport.
- The cycle to work scheme is a well established means of encouraging individuals, as well as businesses, to improve their health. The Alliance believes local authorities are best placed to delivery behavioural change. However, central Government needs to highlight the benefits schemes such as at the cycle to work scheme, to local authorities and cite them as a means to achieve their public health and sustainable transport duties.

June 2011

Written evidence from Platform 51 (PH 149)

SUMMARY

- Platform 51 is concerned that the Government's Public Health plans have not given sufficient attention to women's health.
- It is our view that providing girls and women with quality, appropriate, and gender-specific health services can help to reduce health inequalities. Women's voluntary and community sector (VCS) organisations provide a range of integrated, holistic, needs-based services which promote girls' and women's health and wellbeing. They also "add value" to existing health services by acting as a referral agent, and through reaching and representing the most marginalised women.
- The role of the VCS should be better embedded in Public Health plans. This includes through the gathering of evidence, helping to inform local health priorities, and in producing joint strategic needs assessments (JSNAs).
- All bodies and individuals involved in promoting public health must have a full understanding of gender and health inequalities in order to develop the right priorities, commission appropriate services, and hear the voices of girls and women. There should be strategies, guidance and training to support this.
- Public Health evidence and the Outcomes Framework must reflect girls' and women's particular health concerns, be able to be disaggregated by all the protected equality characteristics (Equality Act 2010), and be monitored for performance.
- Platform 51 is unconvinced that a health premium is the right way to allocate resources. In our view, public health funding should be targeted to areas of high need and not withdrawn from areas that do not appear to be performing as well as others.
- We would like to see greater attention given to *The Marmot Review's* recommendation to ensure a healthy standard of living for all, and to address the correlation between income and health.

INTRODUCTION

1. Platform 51 supports girls and women as they take control of their lives. Girls and women are at the heart of all we do. Our activities, services and campaigns are about things women need and want. We give them a platform to have their say and challenge discrimination. **We want a world where women are in control of their own lives.**

2. Platform 51 welcomes the Health Committee's enquiry into Public Health and the opportunity to submit this evidence. We welcome the Government's stated commitment to the prevention of poor health, to taking a life course approach to health, and to looking at the wider determinants of poor health.

3. We are concerned, however, that the Government's Public Health White Paper, *Healthy Lives, Healthy People*, did not give any specific attention to women's health, despite the Department of Health previously publishing documents and strategies which recognise the health differences between men and women.³⁹⁵ From our work with girls and women, Platform 51 knows that the cumulative effects of women's disadvantage can have significant impacts on their health, and this must be considered in future Public Health arrangements.

GIRLS' AND WOMEN'S HEALTH

4. Many of the social factors associated with poor health are of particular concern to women, particularly: poverty and debt; violence and abuse; unemployment, underemployment and low pay; and mental health problems. Due to the longer durations of poor health that women experience, their health and social care needs exceed that of men in each social class and area.³⁹⁶ While women can expect to live longer than men, they are also more likely to spend more years in poor health or with a disability.³⁹⁷

5. Women's voluntary and community sector (VCS) organisations work on a wide range of issues that affect girls' and women's health and wellbeing, including: gender stereotyping; self esteem; violence and abuse; poverty; unemployment; offending; pregnancy and parenthood, including teenage pregnancy; drugs and alcohol; asylum and immigration; and physical and mental health problems.

6. Platform 51's own work supports the Government's ambitions for good public health outcomes in a range of ways:

- (a) helping girls' and women's build self-esteem and confidence, increasing their choices, opportunities and personal responsibility;
- (b) building women's resilience to poor health, promoting healthy behaviours, preventing health problems from arising or worsening, and tackling the root causes of poor health;
- (c) working with women around key transition points in their lives, when things can go wrong and have a damaging affect on their lives;
- (d) supporting mothers, including teenage parents, to give their children the best start in life; and
- (e) and supporting women into meaningful volunteering and job opportunities, moving them on from the bottom rung of low-skilled and low-paid work.

7. Providing girls and women with quality, appropriate, and gender-specific health services can help to reduce health inequalities. As a report from the National Mental Health Development Unit found, "local voluntary sector women's centres have a clear and important role in engaging women and fostering well-being, particularly women who are marginalised."³⁹⁸ The work done by women's organisations is estimated to save the state millions of pounds each year, through improving women's prospects and preventing problems from arising or worsening.³⁹⁹ Without them, women would have a greater need for health services to address their acute problems, which could have been prevented in the first place.

8. For example, women-only services have an important role to play in promoting positive mental health in women. Platform 51 is very concerned by the extent of low level mental health problems, including stress and depression, amongst girls and women. Our recent report showed that in England and Wales, 63% of girls and women have been affected by mental health problems of some kind—the equivalent of 15.2 million girls and women. Of the 2,000 women we polled for our recent report into women's mental health and wellbeing, 82% felt it was important to have access to women-only services.⁴⁰⁰ Women-only space is particularly important for women who have experienced abuse or isolation as they can feel unsafe in mixed settings.

9. The women's VCS also contribute "added value" to existing health services and public health by acting as a referral agency, both in to and out of the health system, through reaching and representing some of the most marginalised women who either do not engage with health services or who do so chaotically, and by providing integrated, holistic, needs-based support.

³⁹⁵ Department of Health (2004) "Women's Mental Health Strategy". Accessed at: http://www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_4002408; DH (2003) "Mainstreaming Gender and Women's Mental Health—implementation guidance". Accessed at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4072069.pdf; & DH (1996) "Women's health promotion a resource pack for health care purchasers and providers". Accessed at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008303

³⁹⁶ ONS (2010) "Health Statistics Quarterly" 45 Spring 2010, p50. Accessed at: <http://www.statistics.gov.uk/hsq/downloads/HSQ45.pdf>

³⁹⁷ ONS (2008) "Focus on Gender: Health". Accessed at: <http://www.statistics.gov.uk/cci/nugget.asp?id=1657>

³⁹⁸ National Mental Health Development Unit (2010) "Working towards Women's Well-being: Unfinished business", p5

³⁹⁹ Women's Resource Centre (2007) "Why Women Only? The value and benefit of by women, for women services" London, p32

⁴⁰⁰ Platform 51 (2011) "Women like me: Supporting wellbeing in women and girls"

Public Health England

10. **Public Health England** (PHE) must ensure that it is using the full range of evidence available to inform its health priorities, including that which best captures the broader social and personal barriers to good health. Platform 51 is concerned that current evidence does not always reflect the experiences and lives of the girls and women we work with, and that gender is often not fully considered in health research. Qualitative evidence and information gathered by VCS organisations, who are often not involved in setting health priorities despite their role in contributing to them, should be included in this.

11. Where research does not exist, or where local organisations can not be called upon to help provide this information, PHE, local authorities and health and wellbeing boards should commission research that addresses the gaps, particularly around gender and health inequalities, access to services, and appropriate gendered responses to health.

12. All research must be disaggregated by all the protected equality characteristics as set out in the Equality Act (2010). PHE must also oversee how local areas are gathering data to ensure a consistent and thorough response to Public Health evidence across the country.

The future role of local government in public health

13. To comply with their obligations in the Equality Act (2010) and to effectively commission services to support girls' and women's health, the women's VCS must have representation on the relevant health bodies, including health and wellbeing boards, GP consortia, the NHS Commissioning Board, and Public Health England. These bodies must also actively engage with the women's VCS, as service providers, as referral agencies, and as patient advocates. Boards will need clear guidance and governance to do this, which must be applied consistently. Part of the ring-fenced public health funding should be allocated to engaging with, and commissioning, VCS organisations.

14. Directors of Public Health need to understand gender and health inequalities in order to take the strategic lead in meeting the health needs of both women and men in their area. It is important that they fully understand what services the women's VCS can offer, as well as the added-value these services bring. They should find ways of enabling specialist organisations, who may not have experience of working with health services, to become an equal and trusted partner.

15. The VCS must be involved in producing joint strategic needs assessments (JSNAs) to ensure a full picture of local health needs. The production of JSNAs should be jointly owned by the statutory sector, the VCS and local communities, and should ensure that all the protected characteristics are represented, including the voices and experiences of girls and women.

Public health and the commissioning of NHS services

16. Platform 51 recognises welcome extending existing arrangements so that a wider range of providers can deliver public health services. We know from our work that many socially excluded girls and women do not readily access their GP, or feel they do not receive an appropriate service when they do. As commissioners, GPs must understand the role of the women's VCS in contributing towards public health outcomes and commission them accordingly.

17. GP consortia will need given clear guidance on how to work with VCS organisations. In Platform 51's experience, where we have good relationships with local health services, we are better able to support the public health of the wider community. By referring girls and women on to us, GPs are better able to contribute to improving the wider health outcomes of their area.

18. Each GP consortia should set out a policy and strategy for addressing women's health. We look forward to seeing plans set out for meeting legal requirements under the Equality duty to tackle discrimination and gender inequality, as outlined in the department of health's working paper on the GP Commissioning Consortia.⁴⁰¹

19. To be able to mainstream a gendered approach in primary health, GP training and education must include the gender differences in health outcomes and inequalities, as well as the different ways in which women and men access and interact with services.

20. The NHS Commissioning Board (NHSCB) should work with local authorities to support the women's VCS to build the links they need to engage with health bodies, including GP consortia. They should provide GPs with guidance, training and support on how best to engage with the sector, as well as to understand the added-value the sector can offer.

21. Platform 51 would like to see further information about how local people will be able to hold their GPs and GP consortia to account. There must be active engagement with local communities, and particular efforts to engage with the most marginalised, to ensure their voices are heard and health services are improved. The NHSCB and PHE should monitor NHS and GP consortia performance and hold them to account where are not achieving appropriate standards and meeting equality objectives.

⁴⁰¹ Department of Health (2011) "The functions of GP Commissioning Consortia: a working paper"

Commissioning public health services

22. Local authorities, health and wellbeing boards and GP consortia must work together to map the services available in their areas so they can build a clear picture of existing provision, identify gaps, and understand what organisations could be commissioned to deliver services which promote public health. Health commissioners should ensure that women-only services are provided as part of a core range of support for girls and women.

23. Local areas must take responsibility to ensure that girls and women are involved in the design, delivery and evaluation of public health services to ensure they meet their needs. All health services should be young people friendly, and pass You're Welcome standards.

24. Girls and women must know what services are available to them. The Department of Health should establish a service which provides Information, Advice and Guidance (IAG) to enable girls and women to make appropriate choices about their health and wellbeing and enable a range of providers, including the VCS.

25. Platform 51 believes that there will be some minority or specialist services that may need to be commissioned by the NHS Commissioning Board and Public Health England, rather than by GP consortia or health and wellbeing boards, to ensure that they are not missed out entirely and to avoid public health being dominated by majority concerns.

The Public Health Outcomes Framework

26. The Outcomes Framework must contain measures which relate to a range of areas, including health, housing, education, welfare and employment. Platform 51 would like to see a set of indicators arrived at which reflect girls' and women's particular health concerns, and which will result in better services and health outcomes.

27. In our previous responses we stressed that we did not want to see so small a set of indicators arrived at that they become ineffective at reflecting a true picture of an area's health. Indicators should be joined up to create key indicator themes, including: experiences of violence; quality of the environment; housing and the quality of neighbourhoods; the labour market; education; offending; and economic indicators.

28. The Framework must use indicators that are meaningful to all partners to ensure collective agreement and effective joint-working. All local bodies which play a part in improving health must jointly agree and share health and wellbeing priorities through the health and wellbeing board. Performance and improvements across the Framework must be monitored.

29. Platform 51 is concerned that the Framework currently gives insufficient attention to the role of the VCS and is not clear enough on the role it can play in local partnerships. We would like to see VCS engagement made clear in plans for local delivery to ensure that this involvement is embedded from the outset.

30. We are concerned that as it currently stands, the Framework does not go far enough to reflect or address inequality in health across equality characteristics. All public health data must be able to be disaggregated by equality characteristics in order to deliver the most appropriate services, and to monitor health inequalities. *For more on our concerns around an appropriate public health evidence base, please see paragraphs 10–12.*

31. We would like to see the Framework measure inequalities in access and experiences of health services. Girls and women often tell us they have poor experiences of health services which can be inaccessible, unfriendly and not appropriate for their needs. As a result, many have little confidence in them, and so do not access services at all, which can have significant longer term consequences for their overall health.

Arrangements for funding public health services

32. Platform 51 welcomes the attention given to public health, but we are concerned that the funding allocated is not sufficient. As the Marmot Review found, only 4% of NHS funding is spent on prevention, and the estimated £4 billion that will cover public health services, of the approximately £100 billion NHS budget,⁴⁰² goes no further to redressing this. Current and forthcoming spending cuts will place a significant strain on vital public and VCS services that contribute to public health in a number of ways. In addition to a reduction in services, the loss of staff, knowledge and expertise will further compromise public health.

33. Platform 51 is unconvinced that a health premium is the right way to allocate resources. In our view, public health funding should be targeted to areas of high need and not withdrawn from areas that do not appear to be performing as well as others. This could be for a variety of reasons, including increasing unemployment rates, poor educational attainment and reductions in welfare payments, all of which would be out of the direct control of Directors of Public Health.

34. We are concerned that a health premium could result in some areas doing better than others, and funding continually going to those which have already improved upon their outcomes. Reducing funding from deprived areas like these will result in worse outcomes for people in those areas. This method may also provide a

⁴⁰² HM Treasury (2010) "Spending Review 2010": Baseline £ billion—98.7 (2010–11), 101.5 (2011–12), 104 (2012–13), 106.9 (2013–14), 109.8 (2014–15).

perverse incentive to create JSNAs around indicators which are easier to measure or reduce. It may mean that wider factors not included in the framework are ignored entirely. Creating areas which have increasingly better services while others have funding removed or reduced, may mean that people who have the facility to will travel to areas that have better services, creating pockets of deprivation and poorer services.

The Marmot Review on health inequalities

35. Platform 51 was particularly supportive of the attention *The Marmot Review* gave to income, and welcomed the recommendation to develop standards for minimum income for healthy living.⁴⁰³

36. Women are at greater risk of poverty, are more likely to suffer recurrent and longer spells in poverty, and are the main managers and shock absorbers of family poverty.⁴⁰⁴ Around two-thirds of low-paid jobs are held by women, so the National Minimum Wage is a key tool for lifting girls and women out of poverty, as well as tackling the gender pay gap. Evidence also shows that benefits paid directly to women substantially improve the health of them and their children.⁴⁰⁵

37. Platform 51 is concerned that, whilst recognising the evidence put forward by *The Marmot Review*, *Healthy Lives, Healthy People* did not take seriously enough the Review's recommendation to ensure a healthy standard of living for all, or to address the correlation between income and health and would like to see this given more consideration.

June 2011

Written evidence from St Mungo's (PH 150)

1. WHO WE ARE

1.1 St Mungo's has been in operation for over 40 years. Based mainly in London and the South, we provide over 100 accommodation and support projects to homeless men and women, providing over 1,500 beds every night. Our service is divided into prevention of homelessness, emergency response, and recovery.

1.2 In our rough-sleeper focused hostels we are working with a population characterised by tri-morbidity (34% of our clients have physical health problems, mental health problems, and substance dependencies) and institutional neglect—they ignore services, and services ignore them. Our clients have vulnerable backgrounds:

- 11% of our clients were in care as children.
- 43% have been in prison.
- 51% do not have the literacy skills of 11-year-olds.
- 96% are unemployed.

2. OUR CLIENTS' HEALTH OUTCOMES

2.1 Our clients have high levels of need. In a 2010 snapshot survey of our clients we found that:

- 43% had a significant medical condition.
- 55% required regular medication.
- 25% had a disability.
- 70% had a mental health issue (diagnosed and suspected).
- 64% had a substance use problem.

2.2 This high level of need corresponds to high levels of mortality. To illustrate this we have looked at ONS mortality data for the male population in England and Wales aged between 25 and 65 as our clients are predominantly male and aged between 25 and 65.⁴⁰⁶ This is not a perfect comparison but gives an indication of the differing rates of death between homeless people and other groups in the population.

2.3 Among male routine and manual workers, generally considered to be a group with high levels of mortality, 0.5% of this population died between 2001 and 2003 (the most recent time period for which we could find data). Male managers have a lower level of mortality in this period; 0.2%. However, among our homeless clients the rate of deaths is much higher; nearly five times that of routine and manual workers and 12 times that of managers. Between 2001 and 2003 90 men died while resident of St Mungo's this corresponds to 2.4% of all male St Mungo's clients over this period.

⁴⁰³ Marmot, Sir Michael (2010) *Fair Society, Healthy Lives: The Marmot Review*, p 125

⁴⁰⁴ Women's Budget Group (2003) "Women's and children's poverty: making the links"

⁴⁰⁵ Glennerster, H Bradshaw, J Lister, R Lundberg, O (2009) "Reducing the risks to health: the role of social protection". Report of the Social Protection Task Group for the Strategic Review of Health Inequalities in England Post 2010 Published in June 2009; CASE/139 London

⁴⁰⁶ June 2011 Office of National Statistics, Health Inequalities data
<http://www.statistics.gov.uk/cci/nugget.asp?id=1899>

2.4 We have implemented a number of successful interventions in recent years and we have also seen the rate of death among St Mungo's clients go down. Between 2007 and 2009 63 men died, a rate of 1.8%. However, this is still unacceptably high and is an indicator of the very high levels of ill health in this population.

2.5 Despite these very high levels of multiple disadvantage, and the often critical nature of our clients' health conditions, the great majority are not deemed needy to meet social services assessment criteria. The great majority of these people are therefore supported through Supporting People funded services, which are currently under great threat (the budget cuts imposed on us by local authorities this year alone range from 15–40%).

3. BARRIERS TO BETTER HEALTH AND WELLBEING

3.1 Homeless people have this high level of need for a number of reasons. For some their health conditions will have caused or be linked to their homelessness, for example those with mental health problems or substance use problems often cite these as causal factors in them becoming homeless.

3.2 It is clear also that homelessness and poor housing exacerbate and cause health problems which are then poorly managed as a result of a person's homelessness. Untangling the cause and effect of health problems for some people is difficult, however, providing an effective safety net of health support to ensure they are able to break that cycle can be more straightforward.

3.3 Homeless people have high levels of need. If they are not supported by charitable organisations or the Government those needs will go unmet as homeless people rarely have the social networks or family to provide support. As a result we see individuals trapped in a cycle of poor health and homelessness, using substances as a means of coping with their needs.

4. OUR OVERALL VIEW OF THE PUBLIC HEALTH REFORMS

4.1 We welcome the creation of Public Health England and a ring-fenced grant for public health. We also applaud the focus on tackling health inequalities and the wider determinants of health and the inclusion of public health in Health and Wellbeing Boards.

4.2 We are however concerned that the proposed commissioning systems risks the further fragmentation of commissioning leading to the withdrawal of services that our clients need such as, the mobile TB Bus which goes travels around London homeless projects offering on site screening or access to timely and appropriate substance use support. Homeless people form a relatively small group with high levels of need and poor health outcomes. These factors combine to make it vital that services our clients rely on are protected.

4.3 The changes to Supporting People funding suggest that local authorities will not prioritise homeless people automatically: although SP funding was not cut by the Treasury significantly at a local level, now it is no longer ring fenced, much more significant cuts have been made ranging from 13% to 60%. This is likely to trigger even worse health outcomes for homeless people, and increase the use of A&E etc. It is illustrative that homeless people are not a priority for local authorities and that they are not currently taking a system wide approach.

4.4 The mechanism through which a Director of Public Health will be responsible for improving the health outcomes of our clients is unclear. Our concern is that the Outcomes Framework will drive local assessment of need, constraining the JSNA so that if homeless people do not feature within an indicator on the Framework it will be less likely that their needs will be separately included in the JSNA. In the current Framework our clients are not included as a group despite extremely high levels of need.

4.5 The Health Premium which, if well designed, has the potential to drive resources towards the most disadvantaged is in danger of incentivising commissioners to direct services *away* from our clients as they are harder to deliver improved outcomes for.

4.6 We feel strongly that local responsibilities should be clarified through local authorities being mandated to provide certain services to adequate levels. For example, all Directors of Public Health should be mandated to commission drug and alcohol misuse services that are available to all who require them.

4.7 Our clients' experience across the health and social care system suggests that those who are hardest to help are often at the back of the queue. They therefore need a targeted approach.

5. EMPHASIS ON THE POOREST

5.1 St Mungo's welcome's the principles behind the renewed emphasis on public health and the creation of Public Health England as the means of improving the health of "the poorest, the fastest". Homeless people are more likely to die younger, have a long term illness and multiple conditions. The NHS, and in particular public health initiatives must focus on helping the poorest and must see homeless people as a priority group. **We believe success should be judged on whether those in the worst circumstances benefit from the strategy and reforms.**

5.2 We are pleased to see that many of the reforms to public health are underpinned by Prof Marmot's review of health inequalities and that his approach of "proportionate universalism" has been embodied in the

notion of improving the health of the poorest the fastest. We believe the Government needs to give additional consideration to Prof Marmot's review and to focus on his recommendations as a means of reducing health inequalities. Only specific and targeted efforts will ensure that the strategy is a success in improving the health of the most disadvantaged, and for this to happen in a period of deep and widespread financial cuts, there has to be someone senior with direct accountability.

5.3 We believe that there is a need for a stated local mechanism to address the needs of those with the worse health outcomes. Such a mechanism could be, for example, a sub group of the Health and Wellbeing Boards with a remit to tackle multiple disadvantage. We would, therefore, welcome a requirement on local authorities as part of the reforms to public health to establish an inclusive mechanism to address entrenched health inequalities in specific communities in their area.

5.4 We believe the public health reforms would benefit if the principles of Inclusion Health⁴⁰⁷ were incorporated as a statutory requirement across Public Health England, the individual Health and Wellbeing Boards, as well as the GP Consortia and NHS Commissioning Board.

6. WIDER DETERMINANTS OF HEALTH

6.1 As mentioned above, we are also pleased to see that the Government have adopted Professor Marmot's life course approach and will look at the "wider determinants of health" alongside other Government departments. The health of homeless people is determined by a range of factors. Poor health is linked to housing status and rough sleeping contributes to a range of physical and mental health problems while in turn, for many, poor mental health leads to rough sleeping and chronic homelessness. Chronic homelessness could be defined as a public mental health issue. We also know that support through education and training can be a way out of substance dependence and can support people's mental health.

6.2 We would like to see the minimum membership requirement for Health and Wellbeing Boards widened to include the strategic lead for housing. In addition there is a need for co-ordination from the top with high level joint action from DH and CLG on the health of homeless people.

7. HEALTH PREMIUMS

7.1 We are pleased that there will be a ringfenced public health budget and health premiums for "*progress made against elements of the proposed public health outcomes framework, taking into account health inequalities.*" **We believe that dedicated resources for those experiencing the most profound health inequalities will be the key to addressing the health problems of homeless people and sustainably supporting them out of ill health and homelessness.**

7.2 However, we have concerns that the Health Premiums will not reward areas who target their resources at improving the health of those at the very bottom of the pile. Those experiencing the most disadvantage are a small group of the population and as such sensitive measures are needed to capture improved outcomes for them. These may not be achieved through larger, population level, measures. **The most disadvantaged groups, such as homeless people, require additional resources to be spent on them in order to achieve improved health outcomes.**

8. JSNAs

8.1 We are pleased to see a renewed emphasis on the JSNA and that all parties will have a duty to contribute. Currently data on homelessness is rarely included as a dedicated part of JSNAs. It is essential that this is improved under new JSNAs if help for the poorest fastest is to be achieved.

8.2 We are aware that little central direction will be given to local areas on how to conduct the JSNAs and we are working with Homeless Link to put together guidance for local areas on how this could be achieved in areas where this would be appropriate.

8.3 We acknowledge the need for local variation and discretion and believe that this could help to ensure more locally sensitive documents. However, **we do think the JSNA would benefit from some common standards in particular relating to vulnerable groups.** For example:

- The inclusion of wider sources of information beyond that collected by the state and including the wealth of information held by voluntary sector providers.
- The principles used to define whether an area should be a priority or be included in the JSNA (for example if there is a demonstrable level of need in a locality).
- The requirements to include users and providers locally in the development of the JSNA and ensuring that there are appropriate opportunities for challenging the domains included if organisations or individuals believe things have been missed out.
- Clearer direction on how the JSNA should be used to inform commissioning priorities.

⁴⁰⁷ Department of Health, *Inclusion Health*, 2010
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114067

8.4 For JSNAs to identify the needs of homeless people, we need them to focus on “communities of need” not just categories of need. Populations with high intensity of need but small numbers are not well-documented by the approach which measures eg cardio-vascular disease across a borough.

9. HEALTH AND WELLBEING STRATEGIES

9.1 We are pleased that all areas will be required to translate their JSNA into a Health and Wellbeing Strategy. We hope this will be a prominent document which is used to strategically inform the local authorities’ decisions across a range of areas. However, if this is to be the case then it is vital that housing’s contribution to health is clearly acknowledged in the process.

9.2 For any Health and Wellbeing Strategy to be locally owned, and part of “Big Society” rather than town hall officialdom, requires a participative process. We believe that key points in this process would be:

- The integration of the principles of Inclusion Health—there is no point in doing work again that was well done in the first place.
- Clear public accountability, which also entails clear and published targets.
- A mechanism for participation by lay groups: for example, the Board should have sub-committees focusing on locally relevant issues, for example homelessness, which locally significant participants could attend.
- Communities should be involved in devising their own solutions, in partnership with local public health and other agencies.

10. DATA, OUTCOMES AND ACCOUNTABILITY

10.1 Existing data

10.1.1 We have some strong concerns about the feasibility of capturing useful and consistent data at the same time as getting rid of many requirements for local authorities to capture standard sets of information. If a key criteria in determining whether something should be an indicator is whether data is already captured about it the number of options available to choose from will shortly be significantly reduced.

10.1.2 **We urge the Government to be joined up in its approach to data**—in particular between Department of Health and Department of Communities and Local Government. We, along with other agencies, strongly believe that there is a lot of valuable information being gathered by local authorities which can and should be used for public health. No doubt there are some current data collections which society does not significantly benefit from being captured; however, we also believe that there is much to be said for using what we do gather in a smarter way.

10.1.3 Clear accountability for services needs to be determined at both national and local level. The clear collation of data relating to the delivery of the public health strategy will be crucial to measuring its value. As mentioned above, we feel strongly that local responsibilities should be clarified through local authorities being mandated to achieve certain outcomes to adequate levels.

10.2 Missing criteria

10.2.1 We are surprised, given the overarching vision of the public health strategy, that one of the criteria is not “*By improving this indicator will the health of the poorest improve the fastest*”. Given the stated intention of the public health reforms and the importance for society of narrowing health inequalities we believe this criteria would enhance the quality of indicators and ensure they are focused on the most challenging aspects of improving the nation’s health.

10.3 Outcomes

10.3.1 As we have said elsewhere, we believe a crucial driving principle of the reforms to public health has to be “*improving the health of the poorest the fastest*”, or “proportionate universalism” as Professor Marmot describes it. This approach should ensure that resources are targeted, proportionately, towards those in most need in order to reduce the widening inequalities between rich and poor in our society. We believe there are a number of ways in which this can be enhanced:

- **Target resources to groups with high levels of health inequalities linked to shared characteristics**, for example homeless people.
- **Address the wider determinants of health.**
 - Housing is a crucial factor alongside education, employment and mental wellbeing which must be included in the Government’s approach.
- **Address multiple disadvantage.**

- The groups of people with the worst health are those who have more than one support need. We believe that people often become homeless because the system is so poor at addressing the needs of people who have more than one condition. This is illustrated by the needs of our client group many of whom have tri-morbidity of substance use, mental health and physical health problems (with some individuals having multiple mental health, poly-substance use and a range of physical health conditions) which mainstream healthcare is currently ill-designed to treat together. It is estimated, conservatively, by the DH that homeless people directly cost the NHS £85 million per annum: much of this cost is as a result of multiple unmanaged conditions. In addition there are indirect costs to criminal justice, social housing and in lost tax and benefits payments etc. The public health reforms are a real opportunity to improve this situation, improve healthcare for homeless people, and reduce these costs.

June 2011

Written evidence from the Allied Health Professions Federation (PH 151)

1. INTRODUCTION

1.1 The Allied Health Professions Federation (AHPF) is a federation of twelve Allied Health professional bodies representing over 130,000 professional members across the UK of whom 84,000 work in the NHS in England. (See Appendix for full list of member organisations).

1.2 The purpose of the AHPF is to promote the value of Allied Health Professionals (AHPs) and integrated professional working. The AHPF believes that AHPs, as key specialist clinicians, are an essential part of the health and care workforce who are well placed to deliver high quality care to patients, clients and service users across the whole of the health and social care sectors. The AHPF also believes that in the emerging health and social care environment and in particular in the developing public health arena there will be a need to involve AHPs in all spheres of decision making. Therefore maintaining and developing professional expertise over time will be important to ensuring the sustainability of the system.

1.3 The AHPF is uniquely placed to draw on the expertise and experience within the professional bodies in order to inform and engage with consultations, issues and opportunities impacting upon Allied Health Professionals across the health and social care sectors.

1.4 This consultation response has been put together on behalf of the whole of the AHPF. It has deliberately been confined to broader comments. Individual professional bodies have submitted separate responses where a profession specific response adds value to the consultation process.

2. OVERVIEW OF RECOMMENDATIONS

2.1 There should be an Allied Health Professions Director in Public Health England.

2.2 AHPs should have a guaranteed role in commissioning services across the whole of the local decision making process including the clinical consortia, the Health and Well Being Boards and the local public health structures.

2.3 AHPs should be involved in joint strategic needs assessments and developing joint health and wellbeing strategies.

2.4 Whilst public health is focused on prevention it is important the link to intervention services is clear.

2.5 It should be highlighted that many services, whilst not supporting prevention or cure, are based on rehabilitation and increasing quality of life eg stroke services.

2.6 It is essential that the establishment of new commissioning bodies within the broader public health remit result in greater coordination and integration of AHP services in order to safeguard access for vulnerable groups.

FURTHER COMMENT

3. LEADERSHIP

3.1 The new central Department of Public Health will provide vital input to the overall well being of the nation. It will require AHP input at the highest level and consideration should be given to mandating an Allied Health Professions Director at the same level as the Nurse Director already announced.

3.2 In the current DH structure the senior allied health professional role (Chief Health Professions Officer) reports to the chief nursing officer effectively putting AHPs under the nursing umbrella. The AHPF believe that it is inappropriate for the top level AHP representation to remain under nursing for these reasons:

- Nursing and AHP roles have diverged over the years and now occupy very different niches within health and social care with different professional needs and capabilities.

- The sheer volume of nursing related activity driven by staff numbers could inadvertently take priority over AHP professional initiatives.

3.3 We would welcome early guidance to clarify the role of Public Health England. At present there seems to be potential for confusion in the lines of accountability between the directors of public health within local government and Public Health England. The AHPF hopes that Public Health England will take the lead responsibility and determine clear direction for the public health agenda at both the national and local level.

3.4 Top level accountability to government must remain the remit of the Secretary of State for Health.

3.5 The AHPF recognises that the ageing UK population is placing an increasing burden on health and social care services across the UK. Therefore the Secretary of State has a vital leadership role to ensure that long term strategies which improve the overall health of the population and prevent avoidable ill-health are put in place at national and local level, and are adequately funded.

4. THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

4.1 The AHPF is concerned that services may become disjointed under the new plans. It is vital that when public health, currently undertaken by the NHS, is transferred to local authorities, there is no resultant fragmentation in service commissioning. For example early years services will continue to be funded from local authorities under public health funding however this has an overlap with health care intervention. Interventions such as screening programmes need to be commissioned as a whole programme without a potential separation of the screening element or universal public health services from the assessment and intervention elements, including rehabilitation (often health, education and social care).

4.2 In the transition period AHPs will have an increasingly important role to play as the responsibility for public health moves to local authorities. AHPs are well placed to act as integrators of care and can often help form the “bridge” for patients between hospital clinicians and GPs or community-based health and social care services.

4.3 AHPs preventative and early intervention work is often funded by local authorities. Against the backdrop of local authority budget cuts the AHPF is concerned that this new public health responsibility will be under threat. This will impact upon some of the most vulnerable people in society.

5. THE FUTURE ROLE OF DIRECTORS OF PUBLIC HEALTH

5.1 Public Health Directors will require access to allied health professional expertise and input to exercise their role. It is essential that the Directors of Public Health are aware of the range of services that AHPs provide in preventative care and the potential impact in other areas such as mental health, social and emotional development and reducing inequalities.

5.2 Given this important role of AHPs in integrating care, and the key contribution that they can make to improving public health, a wider clinical involvement in strategic planning, joint strategic needs assessment development and decision making will help deliver better, cost effective outcomes for patients and for public health.

5.3 It is essential that when Directors are appointed they are fully apprised of the risks within their local population where AHPs have particular expertise.

6. THE ROLE OF HEALTH AND WELLBEING BOARDS

6.1 Allied Health Professionals have an important role in many aspects of care including improving public health and wellbeing, reablement, management of long term conditions, providing integration across health and social care and delivering care within the education and justice contexts. In order to make informed decisions Health and Wellbeing Boards, Directors of Public Health, the NHS National Commissioning Board, commissioning consortia and other commissioners will need a wide range of skills and must have broad representation from a range of healthcare professionals. AHPs should be guaranteed a place at all levels in the new NHS structures.

6.2 AHPs are in a unique position as the only clinical professions able to combine knowledge and skills from all areas of health, social care and education. Their involvement in commissioning provides innovative ideas for redesigning services, integrating teams and sectors and delivering the QIPP agenda. The inclusion of AHPs on Health and Wellbeing Boards and other commissioning structures will ensure that commissioning across a pathway is identified, designed and implemented in a co-coordinated way.

6.3 Health and Wellbeing Boards must not operate separately from the work of the NHS. Their role is integral to health promotion. There are different cultures across health and local government and there is a risk that a lack of health representatives will prevent close health scrutiny and result in further fragmentation of services and patient pathway delivery.

6.4 While we welcome the establishment of Health and Wellbeing Boards, the Bill currently appears to grant them insufficient powers to join up commissioning effectively between the NHS and local authorities.

7. JOINT STRATEGIC NEEDS ASSESSMENTS (JSNA) AND JOINT HEALTH AND WELLBEING STRATEGIES

7.1 As it stands there is little to encourage local authorities or partner commissioning consortia to consult with appropriate individuals. Given the importance of ensuring integrated working, particularly with regard to services for children or vulnerable adults, there should be a duty to consult with appropriate health professionals who work across sectors such as education, health and public health and who have expertise with regard to children and vulnerable adults.

7.2 Correct membership of the Health and Wellbeing Boards is essential as they are vital to ensure that appropriate health and social care provision in line with the Joint Strategic Needs Assessment is planned and provided for as well as providing scrutiny to local budget allocation.

7.3 In developing the joint Health and Wellbeing Strategies the workforce should include AHPs. AHPs are the third largest health care group. Their involvement and input is crucial to all commissioning decisions.

7.4 At the local level much can be achieved by AHPs contributing to the development of the local Health and Wellbeing Strategies, agreeing priorities and delivery mechanisms designed to deliver best outcomes for communities. This joined up approach across health and local government will help to align priorities and services according to patient need, ensuring that public services are responsive to meet patient need. Often AHPs are the key individuals in identifying and providing expertise in areas of health inequality or vulnerable groups.

8. THE INTEGRATION OF PUBLIC HEALTH AND THE COMMISSIONING PROCESS

8.1 There is an underpinning assumption that GPs and GP practices have a good understanding of public health and the needs of the population they are serving. Building the capacity to address public health commitments will need to be a priority for consortia. This may need to be specifically incentivised through Public Health England and the National Commissioning Board.

8.2 The AHPF calls for AHPs to have a guaranteed role in commissioning services and to be named as part of the workforce to contribute to the JSNA. AHPs are woven into the fabric of public health in this country. They are in the vanguard of creating a service based on people being healthy rather than a service based on fixing ill-health.

8.3 The AHPF recommends that Consortia board members be appointed against a series of competences needed for commissioning—which includes the ability to understand and commission evidence based public health interventions. It is likely that to achieve this Commissioning Consortia boards will need to be made up of a wide range of professionals who can demonstrate the breadth of experience, knowledge and expertise across health and social care commissioning pathways. This should include AHPs.

8.4 Commissioning should be undertaken on the basis of whole pathways of care and not for individual single elements of care. Commissioning pathways should include where relevant population and prevention aspects.

9. THE UK WIDE CONTEXT

9.1 AHPs are already represented at a strategic level across Northern Ireland and Scotland. In Northern Ireland the commissioning structure for health and social care services includes AHPs. The Health and Social Care Board operates through five commissioning groups and each has representation from allied health professionals. In Scotland community health partnerships and community health and care partnerships include representation from allied health professionals at Board level. The AHPF fully endorses the representation of allied health professionals at a strategic level and recommends that this is adopted into the English health and social care system without delay.

10. THE FUTURE OF THE PUBLIC HEALTH WORKFORCE INCLUDING REGULATION OF PUBLIC HEALTH PROFESSIONALS

10.1 The future of the public health workforce is at risk from a lack of understanding of professional roles by commissioners, by fragmentation of education and training and by localised workforce decisions which will marginalise smaller professional groups.

10.2 We are concerned that a model with plurality of providers will destroy the pipeline of future clinicians so that the model fails in five to 10 years. How will the longer term implications of potential damage to the education and training of future clinicians be addressed and resolved?

10.3 The AHPF supports any process that ensures the development of regulated professional expertise leading to enhanced clinical outcomes, experience and safety for patients. The allied health professions are regulated by the HPC and this or similar models should be in place for other public health professionals.

10.4 Due to the likely increased choice in providers under Any Qualified Provider, registration would provide assurance to the service user that the professional meets the relevant standards for their training, professional skills, scope of practice, conduct behaviour and health.

11. THE MARMOT REVIEW AND HEALTH INEQUALITIES

11.1 The Marmot review “*Fair Society, Healthy Lives*” was clear that health inequalities result from social inequalities and that there is a need for action to tackle the social determinants of health inequalities.

11.2 The Marmot Review showed that poor health in adulthood is strongly related to poverty and to factors in early childhood that affect development. What happens during the early years has lifelong effects on many aspects of health and well-being—from obesity, heart disease and mental health, to educational achievement and economic status. Marmot identified as a priority objective reducing inequalities in the early development of physical and emotional health, and cognitive, linguistic and social skills—and put giving every child the best start in life as the review’s highest priority recommendation.

11.3 There is a concern about ensuring that health inequalities are not increased. In the current transition phase there is already evidence of increased rationing. For example one GP consortia is only commissioning one assessment session and one treatment session of physiotherapy (even though this is not evidence based). In the future if there is not effective initial commissioning regulated professionals will need to challenge such practice to prevent them breaking their codes of practice.

11.4 The AHPF is concerned that the Government proposals in the Health and Social Care Bill will not improve health inequalities. Involving the private sector in the responsibility deal has been helpful in supporting change but “nudging” people into change risks widening health inequalities by only influencing those who are ready to change. For example the removal of the cap on the amount of money that Foundation Trusts can generate from private patients has the potential to reduce choice for poorer patients and exacerbate health inequalities.

12. THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

12.1 There are now three aligned frameworks the *NHS Outcomes Framework*, the *Outcomes Framework in Adult Social Care* and the new *Public Health Outcomes Framework*. We are concerned that there may be a risk of a fragmented approach to public health, with some health inequalities “falling through the gap” between the NHS, Public Health, social care and other sectors.

12.2 Building the capacity to address public health commitments should be a priority for consortia. The AHPF supports the proposal that incentives and drivers for GP activity should be specifically designed with public health concerns in mind, and that a proportion of the current value of QOF be devoted to evidence based public health and primary prevention indicators.

12.3 Public Health Outcomes framework should consider the overall lifestyle and reasons for health behaviour not just one aspect of a person’s life eg obesity.

12.4 Some public health outcome measures can take years to implement and need sustained action. Both long term and short term targets are required. Additionally budgets must be allocated accordingly, with recognition that the resultant savings from interventions may be seen in different education or welfare areas.

12.5 We recommend that the outcomes should be aligned to and reflect the Marmot 6 priorities through the life course.

12.6 We would welcome more qualitative evidence being considered as part of the evidence for public health interventions.

June 2011

APPENDIX

The Allied Health Professions Federation (AHPF) member organisations are:

The Society of Chiropodists and Podiatrists (SCP);
 The Society and College of Radiography (SCoR);
 The Royal College of Speech and Language Therapists (RCSLT);
 The College of Paramedics (COP);
 The Chartered Society of Physiotherapy (CSP);
 The British Association of Occupational Therapists/ College of Occupational Therapists (BAOT, COT);
 The British and Irish Orthoptic Society (BIOS);
 The British Association of Prosthetists and Orthotists (BAPO);
 The British Dietetic Association (BDA);
 The British Association of Drama Therapists (BADT);
 The British Association of Art Therapists (BAAT); and
 The Association of Professional Music Therapists (APMT)

Written evidence from the Audit Commission (PH 152)

SUMMARY

1. The Audit Commission welcomes the opportunity to submit evidence to the Health Committee's inquiry into public health. Our response focuses on three points in the terms of reference.

The future role of local government in public health—section 1 of this submission

- We recognise the opportunities for greater integration and a joint approach to funding and commissioning public health services between councils and local health bodies.
- The proposed composition of health and wellbeing boards successfully reflects key local interests. However, the boards are only advisory in nature and they will have no powers to compel organisations to act. The balance of membership will be determined locally, but local authorities are likely to ensure that their accountability is reflected in the boards' composition.
- The combination of outcome-focused health and wellbeing strategies with the publication of a public health annual report can provide a basis for accountability through transparency. Strategies should set out priority actions to address inequalities, and explain what the contributions of different partners will be.

Arrangements for commissioning public health services—section 2

- We have concerns that the proposed arrangements for public health expertise (in councils) do not match with commissioning responsibilities (GP consortia). Furthermore, the NHS Commissioning Board will be separate from Public Health England, which will be part of the Department of Health.
- We recommend that there should be a statutory duty on Directors of Public Health and GP consortia to cooperate. This would ensure that Directors of Public Health provided public health advice to GP consortia in their area, and would be related to the obligation to prepare a joint strategic needs assessment.
- GP consortia should be situated within local authority boundaries. Local authorities may find it hard to engage with consortia that cross several boundaries or are not within their area.
- Areas of responsibility should be clarified, so as to avoid cost, service and complaint “shunting” between organisations. Unless there is clarity, the results could for example include both organisations withdrawing from funding or providing a service, believing it is the responsibility of the other, or where a particular area of public health spans a wide range of services.

Arrangements for funding public health services—section 3

- Information on how much is spent on tackling the causes of ill-health and reducing health inequalities is currently very limited. It would help both national and local accountability if there was a clear commitment to publish data on resource allocation.
- Too much separation of budgets (for provision of health care, the promotion of good health and prevention of ill health) has risks attached. These include making it more difficult to move spending between budgets and so make allocative efficiencies.
- The proposals may create doubt around sources of funding for specific services. This could lead to a lack of clarity about organisational responsibilities. For example, the NHS, rather than local authorities, should fund and commission some early presentation services.
- The group developing the grant formula should include some local government sector representation, and also representation from those currently overseeing the local government resource review. It should consider geography, council type and political control.
- We do not have a view on what the conditions on the grant should be, but we would expect them to be few and mainly related to any relevant national minimum standards or key requirements (for example to cover any transitional arrangements for specific services). The principles of localism should apply, giving each area the maximum flexibility to address their local priorities and contexts.
- If properly designed and established, payment for performance schemes can be effective and could work in public health.

SECTION 1: THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

2. The new public health arrangements have the potential to improve joint working between health, local government and other public bodies. Strong partnerships with well-developed performance arrangements are essential for making the best use of scarce public funds. One agency working alone cannot tackle problems of smoking, poor diet, physical inactivity, excessive alcohol consumption or child health. Sexual health, for example, spans a wide range of services, from safe sex advice in schools to the commissioning of termination services.

3. Work by the Audit Commission and other organisations has found that local success in tackling public health issues is linked to:

- leadership;
- good information that enables money and activity to be targeted;
- strong partnership working; and
- engagement with local communities that builds community capacity.¹

4. However, we also found that proven ways of tackling health issues were not being adopted consistently, and that few areas were successfully addressing the causes of health inequalities.

5. Much of our research provides examples of effective joint working between public sector bodies to improve health. For example, we have reported action on homelessness, fuel poverty, overcrowding, and other forms of poor housing.^{1, 2, 3, 4} However, maximising value for money requires councils to align their internal activities as well as to work well with health bodies. We have previously found that different departments within councils have not always communicated well with each other.²

Health and wellbeing boards

6. The government intends that local statutory health and wellbeing boards will support collaboration across the NHS and local authorities. The proposed composition of health and wellbeing boards successfully reflects key local interests. The boards should be suitable bodies to develop joint strategies guiding the use of the public health budget.

7. However, we note that health and wellbeing boards will have no powers to compel organisations to act. Organisations under financial pressure are likely to avoid or transfer responsibilities where there is no clear dividing line, for example, during 2004–05 and 2005–06 when London local authorities complained about NHS actions.

8. Local authorities are the accountable body for the budget. The balance of membership will be determined locally, but local authorities are likely to ensure that their accountability is reflected in the boards' composition.

9. Joint strategic needs assessments (see below) will offer opportunities for local people to influence priority setting. Health and wellbeing boards should ensure they maintain a focus on the wider public interest. Past experience of overview and scrutiny committee work on public health shows some inconsistency across the country in the ability and willingness to hold local healthcare organisations to account for their delivery of health improvement programmes and services. On occasion, members appeared to be ill-equipped to ask pertinent questions about population-wide issues—such as local variations in health—rather than queries about individual services.⁵

Joint strategic needs assessments

10. The government intends that GP consortia and local authorities will each have an obligation to prepare a joint strategic needs assessment, and to do so through the arrangements made by the health and wellbeing board.

11. Joint strategic needs assessments are an important tool for improving health by addressing local public health needs. One of the challenges in delivering public health programmes is to understand the needs of the local population and directly to target action in response. In the past, the lack of timely, accurate and available data (for example, for sexual health or obesity) has prevented effective commissioning, as there were limited standardised measures of local need in some health areas. This made developing, commissioning and performance managing targeted programmes a challenge.⁵

Joint health and wellbeing strategies

12. In the past, a systematic strategic approach to improving health and wellbeing has been the exception rather than the rule. The key to an effective strategy is to be able to draw a clear logical thread from local need through the strategy to its implementation plan and clearly communicating the outcomes. Strategies should clearly set out priority actions to address needs and explain what the contributions of different partners will be.⁶

13. The combination of outcome-focused health and wellbeing strategies with the publication of a public health annual report can provide a basis for accountability through transparency. Improving mediocre performance through greater transparency is as important as identifying and helping those at the bottom and sharing the good practice of those at the top.

SECTION 2: ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

14. Once primary care trusts are abolished, some of their public health roles will transfer to local authorities. This could mean that, locally, GPs and GP consortia will have less access to public health expertise. Nationally, the NHS Commissioning Board will be separate from Public Health England, which will be part of the Department of Health. The government should ensure that NHS commissioners receive public health advice, from councils locally or from Public Health England nationally.

15. Furthermore, splitting responsibility for public health between local authorities and Public Health England may give rise to uncertainty, particularly from the public.

16. We therefore consider that:

- There should be a statutory duty on Directors of Public Health and GP consortia to cooperate. This would ensure that Directors of Public Health provided public health advice to GP consortia in their area, and would be related to the obligation to prepare a joint strategic needs assessment.
- Public Health England could have a similar role in providing public health towards the NHS Commissioning Board.
- GP consortia should ideally be situated within local authority boundaries. Local authorities may find it hard to engage with consortia that cross several boundaries or are not within their area.
- Areas of responsibility should be clarified, so as to avoid cost, service and complaint “shunting” between organisations, which may, for example, result in both organisations withdrawing from funding or providing a service, believing it is the responsibility of the other. Or, where a particular area of public health, such as sexual health, spans a wide range of services, from safe sex advice in schools to the commissioning or termination services. One end of this range seems to lie better with the local authority but the other seems to lie better with GP consortia. The public should have a clear route for complaints covering the health service, regardless of commissioning responsibilities.

SECTION 3: ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES

17. Both the potential benefits and the potential challenges of reforming public health funding are increased by the fact that information on how much is spent on tackling the causes of ill-health and reducing health inequalities is currently very limited. The Commission published research into this issue in 2010.⁷ It drew attention to the difficulty of knowing how much to ring-fence, and showed how little of the estimated public health spend was on interventions where local flexibility was possible.

18. Our research also found evidence that non-ring-fenced funding directed to deprived areas had simply led to higher spending on secondary care because there was more money available. These areas had higher hospital costs that were unrelated to the cost of treating their patients.⁸ However, where funding had been ring-fenced (to address teenage pregnancy) there was little relationship between the amount spent and the outcomes achieved.⁷

19. Both allocation mechanisms (complete freedom with no incentives, and wholly directed spending irrespective of local priorities) have weaknesses.

20. No matter how it is allocated, there should be better targeting of money and services and close attention to outcomes at a local level. This requires a clearer sight of what is being spent and sharper evaluation of its impact. This is why the Commission’s recent report *Giving Children a Healthy Start*⁹ included a sample analysis of local spending aimed at improving the health of children, which other local areas can follow.

21. It would help both national and local accountability if there was a clear commitment to publish data on resource allocation. This is important because resources and responsibility for improving the health and healthcare of a local population will be divided between GP consortia, the NHS Commissioning Board, Public Health England and local authorities. All of these will have different geographical footprints and, potentially, resource distribution. The public may find it difficult to understand the differing responsibilities of the organisations and hold them properly to account.

22. Too much separation of budgets (for provision of health care, the promotion of good health and prevention of ill health) has risks attached. These include that it becomes more difficult to move spending between budgets and so make allocative efficiencies.

Allocating public health funding

23. Developing an allocation formula depends on several factors, such as the extent of universal coverage of services. If most services are to be universal, there will be less need for a health inequalities element to the formula. For example, water fluoridation need only be calculated on a population basis.

24. The Department of Health should therefore be clear about the purposes of the grant, the services it covers and the extent to which those services are universal.

25. Without such clarity, the proposals could create confusion about sources of funding for specific functions. This could lead to unclear organisational responsibilities. For prevention and early presentation for example, it is not clear where the boundary of responsibilities will lie between the local authority and the local NHS for healthy living campaigns and achieving earlier diagnosis.

26. We recommend the group developing the grant formula should include some local government sector representation. It should also have representation from those currently overseeing the local government resource review. It should consider geography, council type and political control.

27. We do not have a view on what the conditions on the grant should be, to ensure the successful transition of responsibility for public health to local authorities. However, we would expect them to be few and mainly

related to any relevant national minimum standards or key requirements (for example to cover any transitional arrangements for specific services). The principles of localism should apply, giving each area the maximum flexibility to address their local priorities and contexts.

Applying the Public Health Outcomes Framework to the health premium

28. We understand from the Department's response to its *Transparency in outcomes* consultation that it may not now pursue payment for performance for outcomes in social care.⁴⁰⁸

29. If payment for performance schemes are designed and carried out properly, they could work in public health. However, "payment by results" is not well-established in local government. Its introduction will need careful handling to ensure it is well understood and planned for locally, with contingencies for different levels of success.

30. Incentive schemes are unlikely to have an effect on public health outcomes where the amount involved in the grant is very small and/or is largely spent on specified universal services. Such schemes are also less likely to be successful if improvement depends on much wider action and larger sums of money, for example in housing and/or education.

31. The Commission has conducted some research into payment for performance schemes in health care. Based on our research, several factors should be considered when applying a health premium.

- First, the strength of the evidence base for cost-effective interventions. If the evidence is weak, then putting too much emphasis on outcome-based payments is risky.
- Second, the degree to which one can credit the effect on outcomes to the actions of any one body. Unless one can show a link, with confidence, then there is a risk of incentivising the wrong activities or rewarding the wrong organisation.
- Third, the best payment for performance schemes are not just based on outcomes. Including input (or structural) and output (or process) measures creates a more balanced and effective performance framework.
- Fourth, research into behavioural economics suggests the proportion of payment put at risk does not need to be large. However, where the proportion of payment is likely to be very small—as could be the case if many services are to be universal—then the motivational effect may be non-existent.
- Finally, financial incentives work well with other levers, like public reporting. But where there are already strong levers in place—such as legal duties—then financial incentives do not offer good value for money.

REFERENCES

¹ Audit Commission, Care Quality Commission, Ofsted, Her Majesty's Inspectorate of Constabulary, Her Majesty's Inspectorate of Probation, Her Majesty's Inspectorate of Prisons, *Oneplace national overview report*, February 2010.

² Audit Commission, *Building better lives: getting the best from strategic housing*, September 2009.

³ Audit Commission, *Lofty ambitions: the role of councils in reducing CO₂ emissions*, October 2009.

⁴ Audit Commission, *Rising to the challenge: improving fire service efficiency*, December 2008.

⁵ Audit Commission and Healthcare Commission, *Are we choosing health? The impact of policy on the delivery of health improvement programmes and services*, June 2008.

⁶ Audit Commission, *Improving health and well-being*, June 2007.

⁷ Audit Commission, *Healthy balance: a review of public health performance and spending*, March 2010.

⁸ Audit Commission, *Reference costs and allocations*, March 2008.

⁹ Audit Commission, *Giving children a healthy start: a review of health improvements in children from birth to five years*, February 2010.

June 2011

⁴⁰⁸ Paragraph 5.7 states that the government "agrees with the weight of respondents that national approaches to financial incentives would not fit in the current adult social care system".

Written evidence from the Health Statistics Users Group (PH 153)

The Health Statistics Users Group exists to bring together producers and users of official health statistics. It has over 300 members who are statisticians and data analysts working in the NHS locally, regionally and nationally, in local and national government, universities, statutory and voluntary organisations and consultancies throughout the UK. It provides a regular forum for users and providers of health information to discuss the availability of, access to, and use of health, health services and social care statistics. Further information about the Group is found at www.hsug.org.uk. It is a member of the Statistics Users Forum, hosted by the Royal Statistical Society.

This submission is based on discussions at a workshop on the White Paper “Healthy lives, healthy people: our strategy for public health in England”, held on 25 March 2011, to inform the Group’s response to the consultation on that White Paper and two related consultations on “Funding” and “Transparency of outcomes”. We have a particular concern for Public Health Intelligence, which includes the data needed to inform the development of public health, the metadata which define the data and how they are derived and collected and the staff who have the skills to analyse and interpret the data.

Our response to the consultation on the White Paper is appended, together with responses produced in collaboration with the Public Health Action Support Team (PHAST) to the consultations on “Funding” and “Transparency of outcomes”.⁴⁰⁹ This response was drafted by Margaret Eames, Sylvia Godden, Richard Willmer, and Alison Macfarlane, who together with the Group’s chair, Deana Leadbeter, would be willing to elaborate on any of these points further.

SUMMARY

In our response we have considered each of the 11 areas set out for the Inquiry. Our response has been based on the following key points:

1. There is a need for an integrated role between Public Health England and the national commissioning board to ensure the probity of health commissioning. For budgetary and ethical reasons we would ask the Select Committee to seriously review and clarify the function of GP consortia. The provider and commissioning function of GP consortia must be separated for financial, ethical and accountability reasons.

2. The success of Public Health in the future will depend critically on the availability of, and access to reliable public health information and intelligence. Also it depends on the NHS capacity to effectively analyse and interpret it in order that there is a proper evidence based approach to Public Health. Organisational arrangements and responsibilities should reflect this. In particular:

- (a) There should be a coherent Public Health Intelligence strategy in place, set and overseen by Public Health England covering each local authority and GP Commissioning consortium—for the whole country, with accountability for health care outcomes overviewed by the local DPH. This must ensure that the underpinning health evidence for a population continues to be collected and analysed at Local Authority level, and at GP practice level, so that GPC commissioners and other commissioners of healthcare provision are locally held accountable for health outcomes, as indicated in the White paper. (This is not included in the NHS “Information revolution” white paper-nor clarified in other White papers).
- (b) Responsibilities for Information & Intelligence, nationally, regionally and locally (including the analysis of local authority, Hospital and GP practice data) should be agreed as part of this strategy. Some consultation would be helpful regarding where these functions are best performed. The future and position of organisations should be considered in the light of this work.
- (c) Existing flows of information in the system should not be lost in transition by default as PCTs disappear and functions change.
- (d) It is vital the population based approach to public health is not lost in the changes and that there are responsibilities for defined populations. It is vital that NHS boundaries be aligned with local authority boundaries so that commissioning and planning services are conducted in an efficient and effective way.
- (e) Existing staff capacity in the NHS to analyse and interpret I&I should not be lost.

3. Public Health England should take a lead role now in ensuring these things happen.⁴¹⁰

MAIN ISSUES FOR CONSIDERATION BY THE INQUIRY

1. *The creation of Public Health England within the Department of Health*

1.1 Public Health England should not be located within the Department of Health as it should be independent and perceived as such by the public. We support the views that it should be an arm’s length body, established as a Special Health Authority in the NHS.⁴¹¹ It should oversee the transition to the new arrangements with

⁴⁰⁹ Not printed here.

⁴¹⁰ McKee M, Hurst L, Aldridge R, Raine R, Mindell JS, Wolfe I, Holland WW. Public health in England: an option for the way forward? Viewpoint. www.thelancet.com Published online February 28, 2011 DOI:10.1016/S0140-6736(11)60241-9

⁴¹¹ *Ibid.*

sufficient time to ensure that essential datasets and skilled staff are retained and relocated and that access to other key data are maintained for public health purposes.

For local public health departments and observatories this would have the benefits of:

- (a) Enabling staff with scarce public health analytical and intelligence skills to be retained in the NHS.
- (b) Maintaining access to NHS data sources through existing arrangements with the Office for National Statistics, the NHS Information Centre and other organisation without disruption.
- (c) Establishing a model in which the independence of the public health function is more likely to be retained rather than being compromised by local cost pressures.
- (d) Permitting easier access to training and development, and the continuation of established formal and informal Public Health networks. For example having a central employing organisation would make it easier to arrange placements for public health trainees, to share and exchange skills and to keep up to date with professional knowledge.

1.2 Public health started as a local authority function in the nineteenth century and remained in local authorities from 1948 to 1974, as a component of the tripartite NHS. There is a good case for local public health departments to be physically located in local authorities but with staff employed by Public Health England within the NHS.

2. The abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse

For similar reasons, these organisations should remain independent of government and their functions should continue within an independent Public Health England.

3. The public health role of the Secretary of State

The Public Health role is welcomed and the Secretary of State should take a stronger lead in championing the role of Public Health England and ensure that public health evidence is used to ensure that GPs and other health professionals commissioning services do so in a way which is linked to the need to improve public health. The Secretary of state should also own the role of public health in overseeing outcomes from commissioning by GP consortia.

4. The future role of local government in public health (including arrangements for the appointment of Directors of Public Health ; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

4.1 Moving public health functions to local authorities provides an opportunity to coordinate existing local authority health functions and those transferring from primary care trusts. There is, however, a risk that roles and responsibilities for public health will become fragmented and that the NHS and the commissioners will not see it as a key part of their role. It is vital this does not happen.

4.2 If Local government actions in public health are to be effective, the populations for whom GP consortia are responsible should align with local authorities boundaries. The Director of Public Health is responsible for the public health of the whole population of all ages and the wider determinants of this, so should be accountable to the Chief Executive of the local authority, rather than the head of adult services, as currently proposed.

4.3 The future location of public health analysts currently working locally in primary care trusts should be clarified. These key staff have been ignored in documents which have so far mentioned only those working in regional public health observatories. "Equity and Excellence" refers to directors of public health, leading public health in local authorities and having "a team". This should include public health analysts.

4.4 To ensure the continuing availability of public health intelligence at a local level, it is essential to address practical issues in good time, including information governance requirements for continuing access to data, and transfer of software and data, including historic data.

4.5 Arrangements for training and retaining established networks still have to be developed. The Health and Wellbeing Boards appear to be the only structure so far outlined for enabling public health intelligence and evidence to be used in the commissioning decisions of GP consortia. Public health intelligence specialists play an essential role in preparing **Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies**.

4.6 Currently Public Health Intelligence has strong links with commissioners in primary care trusts. These are essential to ensure that plans are aligned with the needs of the needs of the population for which they are responsible. if GP consortia are not coterminous with any one local authority or if there is more than one consortium within a Local Authority area, these keys links will be broken.

5. Arrangements for public health involvement in the commissioning of NHS services

5.1 Proposals to date lack any strategy for the continuation and development of meaningful, robust, and cost effective health statistics. This endangers the future ability of public health teams to measure health outcomes

and does not acknowledge the key role of local public health intelligence in documenting trends and variations in health, based on stable, well defined local geographical populations in England. This builds on the population of PCTs, most of which became coterminous with local authorities, or clusters of local authorities in 2007. Such health measures are essential to keep commissioners accountable by measuring the health outcomes of health care provided to a population on a regular basis.

5.2 The NHS White papers, “An Information revolution” and “Healthy People, Health Lives” and related papers have failed to show any understanding of the needs of public health intelligence at a local level. The commissioning of health services for the population should clearly indicate outcomes, and trends. To allow “free” geographical boundaries for commissioning is likely to cause chaos, and incur much further expense in terms of irregular units of data collection and analysis.

5.3 We agree with the statement in the letter from Faculty of Public Health President Lindsey Davies to the Prime Minister that “To ensure that the health needs of the whole population are appropriately and adequately addressed and that resources are used to best effect then GP (commissioning) consortia must be responsible for defined geographical population which is coterminous with local authority boundaries”.⁴¹²

5.4 In the appended paper we have summarised how cost effective local collection of public health intelligence can be managed, and how this is critically important for protecting the public’s health and preventing poor commissioning of health care in future. This is instrumental in reducing local inequalities in health, and informing both local and national public health policy.

5.5 Ethically there should be a distinction between the provider function of GPs and a body which will commission on behalf of the GP commissioners. We believe there should be a close communication and an accountable link between public health intelligence and commissioning bodies so that local commissioning can improve in response to health outcomes and, in the future, local public health evidence.

6. *Arrangements for commissioning public health services*

To inform the commissioning of public health services, there should be a public health intelligence team as part of a well-qualified and adequate public health workforce located in the local authority under the Director of Public Health. This should be employed by Public Health England.

7. *The future of the Public Health Observatories*

7.1 The Observatories currently perform a vital function at regional level in making public health intelligence available and used. They have considerable skills that should not be lost to the system. The proposed information and intelligence strategy should identify roles required at regional level and judge the future of the observatories on that basis. The observatories should be retained in the interim, liaise with and given the role of ensuring an orderly transfer to new information and intelligence arrangements within Public Health England.

7.2 Public health intelligence is not restricted to public health observatories. Local and regional have complementary roles. Much local knowledge is needed for correct inference about the causes of changes in local population health outcomes from year to year and this is often not known at regional level.

7.3 Good training in statistical methodology and modelling is needed, and the observatories have taken on a leading role in this, with modules taught in each region. It is important that this function continues.

8. *The structure and purpose of the Public Health Outcomes Framework (PHOF)*

8.1 Setting up an outcomes framework is welcomed, but it will be important to ensure that systems are in place to capture and make available relevant and appropriate data. The framework should be tested before being rolled out.

8.2 We have heard from grassroots public health intelligence staff, that much valuable data collection or analysis, possibly including jobs, may be cut from April 2012. We believe Public Health England should take a critical role now in reviewing current data collection and analysis, and for protecting and developing the public health intelligence workforce.

8.3 It is important to ensure that data are not lost in transition in the way that much hospital data and information were lost in 1993 when as a result of the abolition of regional health authorities, regional computer centres were closed, hospital data lost and key NHS statisticians were made redundant and lost to the NHS. Indeed seen in most national trend charts, 1993 then became “Information year zero” for monitoring population health for England, despite some valiant attempts at the time to save the previous hospital data. The historic statistics and data were not valued by political decision makers then, except in Scotland.

8.4 We should learn the lessons now from this. It is essential that the NHS and GP consortia do not suffer losses in public health intelligence that requires them to start yet again at information year zero in 2013. No new information system has been planned or costed so far, but this would be needed if GP consortia are not coterminous with local authority populations. Although some demographic and primary care data can be mapped in several ways, this is only one component of the public health intelligence. To change the whole

⁴¹² Davies L. Letter to the Prime Minister. London: Faculty of Public Health, 12 May 2011.

current Public health information system would be very costly across England and a great waste of taxpayers' money.

8.5 Much of these data could be crucial to the proposed Public health outcomes framework. We need to preserve these services which complement the regional observatories and are producing the evidence which protects the population's health locally. PHE could ensure the key public health datasets, and reports are protected from the possibility of being cut by local health service managers, who do not appreciate their significance, simply to achieve short-term financial gains.

9. Arrangements for funding public health services (including the Health Premium)

As currently designed, the Health Premium would not necessarily be fair, due to variable case-mix (severity of cases) in different hospitals, and variable GP diagnostic load. Rewards through publicity of good outcomes such as high level of smoking cessation in hard to reach, high smoking attributable mortality areas might be more appropriate.

10. The future of the public health workforce (including the regulation of public health professionals)

It is very important that regulation of all public health staff is put into place including the recognised register for defined specialist Consultants. Since 2005 non-medical public health staff have become an essential part of the public health workforce.

11. How the Government is responding to the Marmot Review on health inequalities

11.1 The government should understand **the importance of the local authority population boundary for public health intelligence data collection and for commissioning**. Data about the wider determinants of health, mentioned in the Marmot review, including housing, unemployment, education, transport and green spaces are also collected at local authority level. Social care data (likely to become part of a shared health and social care programme budget in future) are also measured and monitored through the JSNA on the local authority populations. Unless all the data are collected within the same units of analysis then they will not be able to measure the effect of factors such as housing, transport on the outcomes of health.

11.2 Whilst the clustering of GP practices to form GP consortia for **providing** GP/Primary care health services in a collaborative way may be more cost-effective and could be within a "free boundary", **the commissioning function will not work without a coterminous boundary with the local authority** because the information required, should fit with other data. To constrain local GP **commissioning** to the local authority population boundary for measuring health outcomes would be the least costly, most accountable strategy for the NHS and would facilitate long term trend analysis. Commissioners (to include Public Health specialists, GPs, Hospital experts, and finance staff) could be accountable to several GP clusters besides the DPH of the local authority (if the local authority contains a jigsaw of GP consortia), but the local authority unit would remain the best way to examine health outcomes robustly, to be able to incorporate wider determinants of health in models and to progress genuine health improvements.

11.3 We have described a way forward to make the GP consortia model work in the attached papers. Most of London's shadow GP consortia are now coterminous with the local authorities because they can see the financial benefits of using the currently existing public health intelligence for a smooth handover of the commissioning structure to a new GPC commissioning body with a bridge to public health intelligence in the local authority.

June 2011

Written evidence from London Directors of Public Health (PH 154)

EXECUTIVE SUMMARY

1. We recognise the need for change within the public health system and welcome the opportunity to consider how public health could be strengthened. We are particularly conscious of the current economic climate and we want to play a full part in creating effective, efficient and integrated public services that prevent ill-health, protect against disease and tackle health inequalities.

However, we have fundamental concerns about the current proposals which we feel may have an adverse effect on these goals and fragment rather than integrate the public health system at a time in which cohesion is needed most.

2. Directors of Public Health need to be authoritative, work in a setting where their advice and outputs can be independently trusted, and work across organisational boundaries on all the three domains of public health:

- health protection (infectious diseases, environmental hazards and emergency planning);
- health improvement (lifestyles, inequalities and the wider social, economic and environmental influences on health); and
- health services (service planning, commissioning, audit, efficiency and evaluation).

3. Directors of Public Health need to be mandated to challenge local decisions affecting the public's health and ensure Local Authorities and the NHS are fully cognisant of evidence and population need in the planning of local services. To do this, Directors of Public Health need to be supported by an adequately resourced local public health team which is part of a broader, integrated public health system. We are concerned that the current proposals would fragment, diminish and narrow local public health functions; positioning Directors of Public Health as part of Local Authorities with a primary focus on health improvement. We are concerned that the vital and unique role local public health has in relation to health protection and health services will be lost and the ability of public health professionals to influence across local systems will be reduced. We are also concerned that such close alignment with the Local Authority may reduce the impartiality and independence of Directors of Public Health and their teams.

4. London's public health workforce has historically faced significant resourcing challenges and it has taken considerable time and effort to develop, recruit and retain the talented resources we now have. We are deeply concerned about the impact the current proposals will have on the workforce and feel urgent action needs to be taken to reduce the period of uncertainty and halt the potential erosion of public health skills from the Capital. We believe that consolidating the public health workforce into Public Health England (PHE) would provide the best opportunity to safeguard the workforce, maximise expertise and develop a coherent, integrated and flexible system. PHE could develop mechanisms to second expertise to localities to work with the full range of organisations that need to work together to improve the health of the population including Local Authorities, the NHS Commissioning Board and GP Consortia.

5. We welcome the creation of PHE and the potential this offers in terms of national leadership and coordination an integrated system of public health. We feel the consolidation of the Health Protection Agency (HPA) and Public Health Observatories into PHE must be undertaken in a manner which does not adversely affect their national and international reputations, their resourcing and their ability to provide independent and authoritative services. In order to achieve this we believe PHE must be independent of the Department of Health and have a national role in all three domains of public health. We believe PHE would be best constituted as a Special Health Authority and the employing body of all public health professionals in England. This model has been widely proposed in other responses from across the public health system including the Faculty of Public Health, The HPA, and in the *Lancet*.⁴¹³

The future role of local government in public health

6. Local Authorities have a vital role to play in improving and protecting the health of their local populations and we welcome the intention to strengthen public health's role in this. We recognise that Local Authorities will face some difficult challenges on the deployment of scarce resource and we are committed to supporting Local Authorities to make decisions in light of the best available evidence on effectiveness and population need. However, as Directors of Public Health we have equal concern to ensure that the same goals are achieved in local NHS systems. We are concerned that this duality of focus is not adequately recognised in current proposals which heavily align Directors of Public Health with Local Authorities. It is not clear if, and how, Directors of Public Health will relate to the local NHS and the broader remit of health protection and health services.

7. Local Authorities can and ought to play a role in public health which extends beyond health improvement; to both health protection and health service planning. We are concerned that current proposals too narrowly define the role of Local Authorities in public health and reduce local accountability for health protection and health service planning. The move of Directors of Public Health to Local Authorities only makes sense if mechanism can be developed to ensure they have the highest possible level of influence across the spectrum of Local Authority and NHS activities and do not narrow the focus of local public health to health improvement. To enable this Directors of Public Health should be:

- either employed by PHE and seconded to Local Authorities or be jointly appointed by PHE and Local Authorities;
- accountable for the three domains of public health: health protection, health improvement and health services;
- accountable to the Chief Executive of the Local Authority and have access to councillors and elected members;
- mandated to work across the local health and social system;
- empowered to challenge, assure and support decisions made that affect health; and
- supported by a properly resourced, professionally trained team.

8. Whilst the proposals clearly indicate that there will be Directors of Public Health at a local level, there is little clarity on how this role will be supported and resourced. At the very least, there must be a core minimum set of appropriately trained and accredited public health professionals supporting an agreed set of functions. It is vital that Directors of Public Health have an adequately resourced public health team to if they are to effectively discharge their public health functions.

⁴¹³ McKee M. *et al* (2011) Public health in England: an option for the way forward? *Lancet*. DOI:10.1016/S0140-6736(11)60241-9.

9. The recent exercises to identify the public health budget need to be repeated within the Local Authority to establish a baseline. We are concerned to learn that many Local Authorities have been considering cost shunting current schemes onto the new ring-fenced Public Health budget which they are proposed to receive in 2012–13. It is currently unclear what, if any, conditions will be attached to ring-fenced public health budgets, but we are concerned that at a time when Local Authorities are making considerable savings, public health funding could be used to supplement other financially challenged schemes or services. This could lead to a reduction in overall public health spending at a local level with obvious detrimental effects on public health outcomes. Public Health monies should not be used to get services up to baseline—rather Public Health monies should be used to complement and enhance core services so as to enable local people to be better able to use them in a health improving way.

10. Health and Wellbeing boards offer potential to be an integrating and aligning force between the NHS and Local Authorities. However, in order to achieve this, the formal powers of Health and Wellbeing Boards need clarifying and strengthening. In particular, the role of Health and Wellbeing Boards in relation to the Boards of GP Consortia, the NHS Commissioning Board and the Board of Local Authorities need definition. To ensure Health and Wellbeing Boards can fulfil their potential it is recommended that they are:

- accountable for delivering a comprehensive joint needs assessment for the local population which is utilised in strategic planning and commissioning;
- have a formal role in signing off GP Commissioning plans. In the spirit of true partnership, the Boards should also play a similar role in relation to signing off Local Authority commissioning plans; and
- accountable for the three domains of public health: health protection, health improvement and health service.

Arrangements for public health involvement in commissioning of health services

11. Public health plays a critical but much overlooked role in the commissioning of health services. The competencies required to effectively commission services align more closely with the competencies of public health specialists than they do with any other professional group. Key tasks, such as assessing need, planning and designing care in line with evidence and appraising investment and disinvestment decisions, are all fundamental public health skills. The role that public health can and needs to play in relation to the commissioning of health services must therefore not be underestimated or undervalued. It is disappointing and concerning that the current proposals do not clearly define what, if any, relationship public health will have to the commissioning of health services. We feel that public health must have a strong and well-defined role in relation to both the National Commissioning Board and local GP Consortia. As a minimum, formal mechanisms need to be established to ensure health service commissioning is cognisant of public health advice and all commissioning entities have a qualified public health professional on their Board.

12. National as well as local experience suggests GP consortia will need and want considerable support in their new commissioning roles, especially in relation to health intelligence. Much of this support is currently provided from within public health teams in Primary Care Trusts, together with regional Public Health Observatories and the broader public health system. The current proposals do not address this significant public health role and we are concerned that left unrecognised, a range of alternative providers could be brought in to support GP Consortia in these areas. Not only is this likely to be at great financial cost but it is also likely to be variable in terms of quality and approach and may exacerbate inequities in the provision of services. We are concerned to ensure public health continues to play a vital role in GP Commissioning which we feel requires:

- well-resourced public health teams organised locally, regionally and nationally that work together to support GP Consortia in an efficient and responsive way;
- Directors of Public Health providing oversight of, and input into, GP consortia commissioning, supported by additional resources and expertise held within PHE. Directors of Public Health should quality assure public health input into local GP Consortia, if not be the direct provider of services;
- that the population size of GP consortia should be based on evidence of effectiveness, as should decisions as to whether services are commissioned and delivered nationally, regionally or locally. Consortia should be encouraged to develop structures for stable joint commissioning where these would best serve their population; and
- that GP Consortia adopt boundaries which match or fit within existing Local Authority boundaries—enabling a relationship with one Local Authority and Director of Public Health and their team.

13. The range of organisations requiring public health support and input is likely to rise, especially considering many GP Consortia cover smaller geographical areas than that of former PCT's. In order to support the range of organisations requiring public health support, it will be imperative to operate from a position of critical mass. Diluting or fragmenting local teams between organisations will not give the breadth and depth of skills that can be brought to bear by a team and will risk spreading scarce resource ever more thinly. We

believe PHE ought to become the employing body of public health professionals to help mitigate these risks and create a more independent and flexible resource base.

Arrangements for commissioning public health services

14. There is increasing complexity in the commissioning and provision of health and social services, including the commissioning and provision of public health services. The range of providers offering public health services continues to grow and, perhaps more challengingly, the range of commissioners of public health services is also set to grow under the new proposals to include GP Consortia, the NHS Commissioning Board, PHE, Local Authorities as well as a range of other, smaller organisations. We are concerned that without simplification and coordination there is a very high risk that localities will not have sufficient oversight of the mix of services provided locally and will find difficulty in assessing if and how the services adequately address population need. In addition, multiple commissioners and providers are likely to create fragmentation and confusion for patients and the public and ultimately be less safe and effective than a more collaborative and integrated system.

15. Public Health intelligence is an integral function that underpins all three domains of public health. The current proposals alternate between positioning this as a core function of public health and a service that can be commissioned like others. We recognise that some public health intelligence services can be commissioned but the majority need to remain embedded within the core public health system.

The future of the Public Health Workforce

16. In order to provide effective strategic leadership for public health, the public must have confidence that the Director of Public Health and his or her team is able to provide informed, independent and professional advice. As currently drafted, both the public health White Paper and the Health and Social Care Bill would allow someone to be appointed as a Director of Public Health without the relevant training or qualification required by the Faculty of Public Health, the UK standard setting body for public health. Public Health professionals give advice and take decisions that impact on the lives of many thousands of people and we strongly oppose any erosion of the current requirements regarding registration and qualification of the public health workforce. We feel it essential that Directors of Public Health, specialists and consultants in public health are appropriately trained and accredited under the current Faculty system.

17. There is currently considerable uncertainty as to which public health functions will transition to which organisations in the new system and a fear that local public health teams may be fragmented. Local public health professionals are concerned that they may be forced to sub-specialise in one area of public health and potentially face the deskilling impact this could have. It is also unclear if organisations “receiving” public health functions, such as Local Authorities, will have any obligation to employ public health staff currently employed within Primary Care Trusts. There is therefore considerable anxiety about the future of the public health workforce and an understandable concern that local redundancies may be a possibility. There have already been de facto cuts to local public health as NHS colleagues have handed over functions to public health departments previously covered by other departments with no funding to support these, such as immunisations (often previously led by primary care); infection control (often previously led within nursing or governance teams) and emergency planning.

18. The public health workforce has a major role in sharing its competencies with other health professionals, notably in General Practice, Acute and Community Trusts and Local Authorities. This capacity and capability building role helps ensure that health improvement, well-being and addressing the determinants of health is integral to the role of all health professionals and organisations and not the sole responsibility of a discrete group described as the “public health workforce”. It is important that this role is recognised and supported and that reforms in other parts of the NHS and local government make clear the responsibilities of every organisation and health professional to public health.

The future of public health observatories

19. Public Health Observatories provide a critical service to local public health teams and must be transitioned to PHE in a manner which allows them to continue to do so. Health intelligence plays a vital role in informing decisions that affect the public’s health and assuring patients, the public and the health and social care system of the rationale, evidence and outcomes of those decisions. Independence and impartiality in the work of Public Health Observatories is therefore paramount and we are concerned that unless PHE is established independently from the Department of Health, these defining features of good health intelligence will be lost.

Managing the public health transition

20. The changes proposed by the White paper on public health represent the biggest reform and reorganisation of the public health system in a decade. In order to transition to new arrangements effectively, there must be a clear, coordinated plan in place that ensures transitions happen in an equitable way across the

country. Across London we are already beginning to see the development of a fragmented public health service with slightly different models in each Borough depending on historical and financial positions.

Dr Peter Brambleby, Director of Public Health for Croydon

Dr Quentin Sandifer, Director of Public Health for Camden

Dr Jackie Chin, Director of Public Health for Ealing

Dr Ruth Wallis, Director of Public Health for Lambeth

Dr Hilary Guite, Director of Public Health for Greenwich

Dr Ann Marie Connolly, Director of Public Health for Southwark

Dr Angela Bhan, Director of Public Health for Bromley

Dr Val Day, Director of Public Health (Interim) for Sutton and Merton

June 2011

Written evidence from Sexual Health organisations (PH 155)

The following written evidence is submitted by a number of individual sexual health organisations who also sit on the Sexual Health Forum, a stakeholder advisory group that provides advice to the Department of Health.

Individuals and Organisations that have contributed to the evidence

Baroness Gould of Potternewton

Dr Gabriel Scally, Regional Director of Public Health for the South West

Family Planning Association (fpa)

Terrence Higgins Trust (THT)

Sex Education Forum

National Children's Forum (NCB)

Marie Stopes International (MSI)

Faculty of Sexual and Reproductive Health

British Association for Sexual Health and HIV

Key issues which need to be addressed under the new arrangements are:

- The availability within local authorities of sufficient high quality clinical public health skills to support commissioning of a complex range of services across the acute, community and primary care sectors. Also, services in non-traditional settings such as schools, FE colleges, pharmacies and outreach work. It is particularly important to commission against national standards to ensure quality, clinical governance etc and that meet national training standards.
- The importance of and promotion of nationally recognised standards for workforce training.
- Ensure that all needs, for all age groups are met, including those of vulnerable groups for example sex workers, prisoners etc.
- Prevention and education is key to sexual health and is value for money.
- Ensures a continuing focus on service modernisation and integration.
- Improves sexual health outcomes, including those set out in the draft Public Health Outcomes Framework for sexual health.
- Links to issues such as coercion, sexual violence, mental health and wellbeing and gender.
- Access to factually and clinically accurate information through a range of mediums including helplines, websites and social media
- Improving patient involvement and engagement in service design and delivery.
- Our sexual health affects our physical and psychological wellbeing and is an issue that affects the vast majority of the population from adolescence through to old age. There is a strong link between social deprivation, STIs, abortions and teenage conceptions. Some groups have much higher levels of sexual ill-health including young people, men who have sex with men and some black and ethnic minority groups.
- The consequences of poor sexual health can be serious. HIV therapies are complex, expensive and can be very demanding on the patient. Untreated chlamydia infection can result in pelvic inflammatory disease, which can lead to ectopic pregnancy and infertility. Unplanned or unwanted pregnancies can have negative impacts on women's health, social and financial situation. Teenage pregnancy is associated with a range of poor outcomes for the mother and child.
- Key public health measures have been in place for many years to protect and improve the public's sexual health.
- It is enshrined in legislation that certain PCT functions must be open to all-comers, these include:

“facilities and services for testing for, and preventing the spread of, genito-urinary infections and diseases and for treating and caring for persons with such infections or diseases” (regulation 3(7)(b)(iii));

“services which the Secretary of State has a duty to provide under section 5(1) (b) of the NHS Act 1977. This section states ‘...it is the Secretary of State’s duty to arrange, to such extent as he considers necessary to meet all reasonable requirements in England and Wales, for the giving of advice on contraception, the medical examination of persons seeking advice on contraception, the treatment of such persons and the supply of contraceptive substances and appliances’.”

- Many aspects of sexual health remain stigmatised, which can deter people from accessing treatment services. Self-referral to NHS sexual health services without fear that sensitive and personal information will be disclosed wider than is needed has successfully underpinned UK sexual health services for many years.
- Prescribed contraception is provided free of prescription charge
- Prescriptions for STI treatment, including HIV treatment, are free of prescription charge when supplied in a hospital
- STI (and HIV) services are covered by specific legislation on confidentiality and disclosure of information.⁴¹⁴ While they are not absolute, the Regs/Direction provide that information on STIs/HIV will not be shared with GPs and other healthcare professionals without the explicit agreement of the patient. Ensuring patient confidentiality is recognised as a key component of public health prevention strategies to control the spread of infection and reduce undiagnosed infections.
- Considerable progress has been made over the past few years, for example, the continued decline in teenage pregnancy rates, which is at its lowest level for 30 years, in bringing the different elements of sexual health together in a holistic and integrated way. This includes development of integrated sexual health services that provide both STI and contraceptive provision. There is much to be gained from retaining this approach within the new public health system.
- The consultation document, *Healthy Lives, Healthy People; consultation on the funding and commissioning routes for public health* closed on 31 March. We support the proposals in the consultation document that in future local authorities should be responsible for commissioning open-access sexual health (contraception, STIs and termination of pregnancy) services using funds from the ring-fenced grant for public health. This will help to ensure a holistic approach to sexual health in particular the opportunity to join up with some of the drivers of poor sexual health including drugs and alcohol.
- We also agree that rapid open access sexual health services should be provided in a universal fashion in all areas limiting any inconsistency in provision.

June 2011

Written evidence from the Nuffield Council on Bioethics (PH 156)

Paragraph numbers refer to paragraphs in the Council’s report *Public health: ethical issues*: www.nuffieldbioethics.org/public-health

THE STEWARDSHIP MODEL

1. Chapter 2 of the Council’s report *Public health: ethical issues* reviews the role of the state in public health and then outlines a framework for a public health policy, based on a classical liberal conception of the state’s role. While this framework is suitable to address some of the principal issues arising in the context of public health, it also has certain limitations. We therefore propose a revised and extended version of the initial framework, which we call the stewardship model.

2. The report concludes that the state has a duty to help everyone lead a healthy life and reduce inequalities in health. Our “stewardship model” sets out guiding principles for making decisions about public health policies.

Concerning goals, public health programmes should:

- aim to reduce the risks of ill health that people might impose on each other;
- aim to reduce causes of ill health by regulations that ensure environmental conditions that sustain good health, such as the provision of clean air and water, safe food and decent housing;
- pay special attention to the health of children and other vulnerable people;
- promote health not only by providing information and advice, but also with programmes to help people to overcome addictions and other unhealthy behaviours;

⁴¹⁴ NHS (Venereal Diseases) Regulations 1974 and the NHS Trusts and PCTs (Sexually Transmitted Diseases) Directions 2000.

- aim to ensure that it is easy for people to lead a healthy life, for example by providing convenient and safe opportunities for exercise;
- ensure that people have appropriate access to medical services; and
- aim to reduce unfair health inequalities.

In terms of constraints, such programmes should:

- not attempt to coerce adults to lead healthy lives;
- minimise interventions that are introduced without the individual consent of those affected, or without procedural justice arrangements (such as democratic decision-making procedures) which provide adequate mandate; and seek to minimise interventions that are perceived as unduly intrusive and in conflict with important personal values (para 2.44).

3. We were pleased to see many of these characteristics recognised in the Government's recent White Paper for public health in England, *Healthy Lives: Healthy People*. However, we have suggested that it would be helpful to see explicit reference to the Government's programme to **reduce health inequalities** in England, and how the public health strategy will link with this. We therefore welcome that the Select Committee stresses the reduction of health inequalities as an important aim in its inquiry.

THE INTERVENTION LADDER

4. The White Paper includes the Council's 'intervention ladder', as set out in our report on public health, which shows the range of interventions available to policy makers, from the least to the most intrusive.

5. The intervention ladder is not in itself a model or strategy for public health (as suggested in the Government's press release on the White Paper).⁴¹⁵

It is the stewardship model that provides the main basis for designing public health programmes and justifying interventions. The function of the intervention ladder is to compare alternative approaches in terms of their intrusiveness and likely acceptability. Different interventions will be appropriate depending on the problem and the context. Any intervention implies value judgements about what is or is not good for people, and requires justification. The higher the rung on the ladder, the stronger the justification has to be in order for the intervention to be proportionate (para 3.37).

THE INTERVENTION LADDER

Eliminate choice. Regulate in such a way as to entirely eliminate choice, for example through compulsory isolation of patients with infectious diseases.

Restrict choice. Regulate in such a way as to restrict the options available to people with the aim of protecting them, for example removing unhealthy ingredients from foods, or unhealthy foods from shops or restaurants.

Guide choice through disincentives. Fiscal and other disincentives can be put in place to influence people not to pursue certain activities, for example through taxes on cigarettes, or by discouraging the use of cars in inner cities through charging schemes or limitations of parking spaces.

Guide choices through incentives. Regulations can be offered that guide choices by fiscal and other incentives, for example offering tax-breaks for the purchase of bicycles that are used as a means of travelling to work.

Guide choices through changing the default policy. For example, in a restaurant, instead of providing chips as a standard side dish (with healthier options available), menus could be changed to provide a more healthy option as standard (with chips as an option available).

Enable choice. Enable individuals to change their behaviours, for example by offering participation in a NHS 'stop smoking' programme, building cycle lanes, or providing free fruit in schools.

Provide information. Inform and educate the public, for example as part of campaigns to encourage people to walk more or eat five portions of fruit and vegetables per day.

Do nothing or simply monitor the current situation.

ROLE OF THIRD PARTIES

6. Although the state should be guided in its public health policies by the concept of stewardship, this does not absolve other parties, in particular the corporate sector, from their responsibilities. We discuss the concept of corporate social responsibility, and note that while companies may have different motivations for pursuing social responsibility strategies, they increasingly recognise that they have obligations beyond simply complying with relevant laws and regulations. If industry fails to meet these obligations and the health of the population is significantly at risk, the market fails to act responsibly. In such cases, we argue, it is acceptable for the state to intervene (paragraphs 2.47–2.50, 5.26, 5.16–5.25, 6.18–6.31, 8.24).

⁴¹⁵ Department of Health. *Public Health England—A new service to get people healthy*. 30 November 2010. http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_122249

EVIDENCE

7. Evidence about, first, causes of ill health and, secondly, the efficacy and effectiveness of interventions is important to public health policy. Ideally, evidence should be based on peer-reviewed research, and not on preliminary results or unpublished reports. Selective use of evidence or “policy-based evidence” that has been commissioned or interpreted to support existing or planned policies is unhelpful.

8. We support the statement in the Government’s White Paper that “A culture of using the evidence to prioritise what we do and test out innovative ideas needs to be developed, while ensuring that new approaches are rigorously evaluated and that the learning is applied in practice.”

June 2011

Written evidence from a Coalition of biomedical research stakeholder organisations and research funders (PH 157)

1. This is a joint response from a coalition of biomedical research stakeholder organisations and research funders with shared interests in the Health and Social Care Bill. The Health & Social Care Bill provides an opportunity to promote good health and reduce health inequalities in the UK, and research and the use of evidence are key to achieving this goal. We welcome the Health Committee’s focus on public health, among these wider ranging reforms, and are pleased to have the opportunity to respond to this inquiry.

KEY MESSAGES

- The Health and Social Care Bill proposes to abolish the Health Protection Agency (HPA), which is currently responsible for providing independent public health advice to Government. We propose that the functions currently performed by the HPA must remain independent from the Department of Health, for example as part of an NHS Special Health Authority or Executive Agency.
- Research, evaluation and the use of evidence must be embedded in public health practice and should be supported by legislative duties on Public Health England and local authorities.

THE IMPORTANCE OF INDEPENDENT PUBLIC HEALTH ADVICE

2. The HPA is independent from Government. It has several important functions, including conduct of research, gathering evidence and providing advice on public health. Currently the HPA provides the Government with advice on a variety of issues, some of which can be contentious, such as the strategies for responding to pandemic influenza. In these cases impartial expert advice is particularly important.

3. The Health and Social Care Bill makes provision for the abolishment of the HPA and the transfer of its functions to Public Health England, which will be established within the Department of Health. This proposed structure, however, does not take account of the role of the HPA in providing independent advice to Government. A Government Department is not in a position to provide independent advice to itself, or other parts of government. This loss of independence would seriously undermine the provision of evidence for public health policy and practice.

4. During the BSE crisis, loss of public trust in Government advice was attributed to a perception that Government scientists lacked independence and this contributed to the establishment of the independent HPA. Furthermore, independence enables the HPA to obtain external funding, which is important in retaining the expertise necessary for providing advice. For example, the experts leading the UK response to the recent Fukushima nuclear accident were supported by external research funding.

5. *Recommendation: The functions currently performed by the HPA must remain independent of the Department of Health, for example as part of an NHS Special Health Authority or Executive Agency.*

ROLE OF RESEARCH, EVALUATION AND THE USE OF EVIDENCE IN PUBLIC HEALTH

6. Research and evidence are vital for the development of informed and effective public health policies and practice. For example, findings from studies on the health effects of high salt intake have led to a reduction in the salt content of processed foods; and research has guided the introduction of new immunisation programmes, such as the meningitis C vaccine that has been extremely successful in controlling the disease.

7. Research is also critical to evaluate whether public health policies and practice are effective. For example, studies have shown that the number of hospital admissions for heart attacks has reduced since the introduction of the ban on smoking in public places.⁴¹⁶

8. The public health strategy “Healthy Lives, Healthy People” emphasises the importance of evidence in informing public health policy and practice and it is therefore disappointing that the Health and Social Care Bill does not implement mechanisms to realise this goal. This opportunity to embed research and evidence-based policy across the public health system and the NHS must not be missed if we are going to encourage and support people to lead healthier lives in the future.

⁴¹⁶ <http://www.bmj.com/content/340/bmj.c2161.full>

9. The fragmentation of public health services across local authorities may make it more difficult to deliver evidence-based services and to provide a coordinated national approach to public health because local authorities do not have experience of managing public health services or commissioning research at a local level. It is essential that research, evaluation and the use of evidence are embedded in the public health system and that an appropriate level of national oversight is maintained to refine public health practice to help people live healthier lives.

10. The importance of a national coordinated approach to address public health problems is highlighted by the recent Government commitment to invest in anti-smoking and healthy living campaigns following a Department of Health report into the negative consequences of the Government's decision to drastically decrease publicly funded advertising last year.⁴¹⁷

11. *Recommendation: A culture of research and the use of evidence must be fostered in all components of the public health system, notably Public Health England and the local authorities. This should be supported by legislative duties on these bodies to promote research and the use of evidence in public health services.*

Supporting organisations:

The Academy of Medical Sciences	Alzheimer's Research UK
Alzheimer's Society	AMRC
Biochemical Society	Breast Cancer Campaign
British Pharmacological Society	Genetic Alliance UK
The Prostate Cancer Charity	Society of Biology
Wellcome Trust	

June 2011

Written evidence from Directors of Public Health from the South West of England (PH 158)

1. OVERVIEW—CONCERNS FOR THE PUBLIC HEALTH SYSTEM

All 14 Directors of Public Health in the South West of England welcome the opportunity to provide the Select Committee with evidence for its Inquiry into Public Health.

Whilst welcome, the “listening period” in the passage of the Health and Social Care Bill has heightened concern in respect of many aspects of the proposals for public health in England, and anxiety about the future exists across the public health workforce. The evidence that is enclosed will, we hope, ensure that the Select Committee is armed with the knowledge to scrutinise the Health and Social Care Bill to achieve the best configuration of public health expertise to support health improvement and the reduction of health inequalities in England.

2. SPECIFIC ISSUES IDENTIFIED BY THE COMMITTEE

This submission deals with all the issues identified by the Health Select Committee, drawing on the knowledge and expertise of all the Directors of Public Health from the South West of England, and is a joint submission. What follows is an examination of those issues and the opinions of these senior public health professionals.

2.1 *The creation of Public Health England within the DH*

We do not consider this to be a good idea. Public Health England (PHE) needs to be arms length so it can be seen to be independent and free of political influence.

The independence of PHE is essential, and the public health workforce should remain independent of the civil service. Public health needs to be free to have an advocacy role in such situations as those exemplified by the successful lobby for legislation for banning smoking in public places. Independence would allow PHE to speak authoritatively to the public on a variety of issues, and doubts exist as to whether being part of the DH will promote this. The credibility of the public health advice given by specialists comes both from respect for their professional training and knowledge, and from the integrity and credibility that arises from working for an impartial and independent organisation. We suggest alternative models of: an arms length body; a special health authority or an executive agency. There exists a range of opinions on whether PHE should employ all consultants and specialists in public health.

Public Health England can only effectively operate as a national public health service if it encompasses all three domains of public health: Health protection (infectious diseases, environmental hazards and emergency planning); Health improvement (lifestyles, inequalities and the wider social, economic and environmental influences on health); and Health services (service planning, commissioning, audit, efficiency and evaluation). The Consultant Public Health workforce is particularly concerned about revalidation (a requirement for

⁴¹⁷ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_126449.pdf

professional re-registration) and whether this will be possible in the new arrangements as revalidation requires Public Health Consultants to work across all ten areas of public health competence.

The establishment of PHE could embody the devolution principles of the Coalition Government so that only those things that cannot be delivered locally should be addressed at the national level. It is therefore important to make sure attention is paid to the links between PHE and local PH teams, who should have some involvement in the design of the PHE.

There exists a range of opinion across the UK's senior public health workforce as to whether DPHs should be employed by PHE and seconded to local authorities, or employed by them directly. The recommendations of the Association of Directors of Public Health (ADPH) are noted.

2.2 The abolition of the HPA and the NTA for Substance Misuse

This represents a good opportunity to bring resources and functions together at a local level, although there are current concerns about the distance of the HPA from local PH teams and whether or not the suggested new arrangements would improve this relationship. In particular we would want the DPHs to be responsible for health protection but would be deeply concerned if this was not accompanied by the effective resources to support them. The public health system has worked best when it is all part of the same organisation. Since the establishment of the HPA as a separate organisation, we have coped by working very hard across organisational boundaries to ensure that systems and services are safe and that together we are resilient.

The response to H1N1 influenza within the South West clearly illustrated that working together on the response was only possible because we all understood the system and we were skilled at operating across the whole spectrum of health protection and health service response. We were able to redirect a wide complement of staff to the task in hand and respond quickly and effectively. We are as yet, unable to see how this sort of response would work in the new system or indeed whether the operational delivery of the full range of public health practice has been taken into account. There are very genuine concerns about ensuring that we keep the full range of emergency response around health protection safe through this period of transition. If health protection is separated from the local role of the DPH the outcome would be to seriously undermine public health services including response to emergency or epidemic situations.

DPHs welcome the challenge of tackling substance misuse and would wish it to be explicit that prevention of both alcohol and substance misuse is part of their role in the future. There are concerns regarding pressures on local drug and alcohol treatment services with the removal in many areas of Supporting People grants.

2.3 The public health role of the Secretary of State

We welcome the proposed new duties on the Secretary of State (and National Commissioning Board and Commissioning Consortia) to have regard to the need to reduce health inequalities. However these duties are narrowly drawn, only applying to the role of the NHS in providing services to patients. The duties should reflect the broader role of the NHS in promoting public health as a provider, commissioner and major employer. The accountability of the Secretary of State for public health must be clear and it is vital that the Secretary of State retains ultimate responsibility.

2.4 The future role of local government in public health

We are supportive of public health residing in local government with this local public service being the right mechanism for promoting population health across all the determinants of health. That said, any legislation must ensure that a critical mass of public health skills is retained to deliver core public health functions; and that action on core national outcomes is not seriously distorted by local politics. This can be achieved by ensuring that the commissioning objectives and budget allocations are clearly mandated by PHE.

There are risks to the specific arrangements for health service response to major incidents and health protection emergencies. The current components of health protection delivery should integrate with local authority public health teams, which could also bring together environmental health, service public health and health protection under one management at a LA level. This does of course require more structured arrangements in two tier authorities.

It is essential that there is ring fencing of the budget going to the local authority for the additional public health functions being transferred.

2.4.1 Arrangements for the appointment of Directors of Public Health

The Director of public health (DPH) will need to be appointed jointly and have direct accountability to the Local Authority Chief Executive. They should be appointed by means of a statutory process and an Advisory Appointment Committee (AAC). They should have the independence and increased protection such as that afforded to Section 151 officers within local government, and they should be difficult to remove without good cause. The duties and responsibilities of DPHs must be supported by relevant powers in the legislation. For example, they should have control over the budget for health and wellbeing. The DPH will require strong links with Public Health England.

We note that, whilst proposed for DPHs, there are also no equivalent duties on the Secretary of State or on local authorities in respect of their roles in promoting public health, and we would welcome these.

2.4.2 Health & Wellbeing Boards/JSNAs

Health and Wellbeing Boards (HWBs) need to focus strongly on the Joint Strategic Needs Assessment (JSNA). The HWB needs to be able to hold people to account. Its primary function is not to be a commissioning body; its focus is on health, and as such they should consider local health protection arrangements.

The HWB should take on the role of co-ordinating system wide improvements in services, such as reconfiguration of services or the location of a new hospital. In order to do this the role needs strengthening through appropriate powers so it is seen to have an overall leadership role for health and social care locally. Ultimately, HWBs need power or else they will be of little use.

2.5 Arrangements for public health involvement in the commissioning of NHS services

Current proposals need attention as they are inadequate and do not reflect the very significant contribution public health professionals make across many sections of the NHS. Public health influence on local health service commissioning is almost absent in current proposals with the only link being through the HWB and the requirement for NHS commissioning to “have regard to the JSNA”. A more integrated approach is needed between public health and health service commissioning, to ensure that disinvestment has minimal adverse population health impact. One approach may be to place requirement on local public health teams to provide direct public health advice to commissioning consortia and that appropriate budget is included in the transfer of budgets from the NHS to local public health teams.

How public health relates to Commissioning Consortia is not yet clear and thought should be given to this so that public health is able to ensure evidence based commissioning through the JSNA and based on available research evidence. The skills, knowledge and experience of public health specialists who can deal with healthcare public health is absolutely essential for ensuring that commissioning decisions are based on evidence of best-value, fairness, efficiency and effectiveness at national and local level. Public health brings a population perspective and technical skills that need to be set out clearly in any memoranda of understanding between public health teams and Commissioning Consortia.

Public health commissioning input currently comes from senior staff who make contributions across the breadth of public health domains and as such it will be vital to ensure that legislation promotes and enables this contribution while ensuring that the public health workforce at a local level remains as a coherent whole. Public Health expertise and input should be mandatory and part of the accreditation of commissioning bodies.

In order to ensure PH skills are available to Commissioning Consortia it should be mandatory for the DPH (or their nominee) to have a seat at each of the Commissioning Consortia in their capacity as technical lead for public health; quite separate from their role in local government.

2.6 Arrangements for commissioning public health services

The current proposals concern us as they have the potential to fragment aspects of commissioning (& service delivery) across organisations. This area needs more work to ensure a clear coherent line of sight across commissioning arrangements within a given programme of work or set of outcomes.

If any particular commissioning arrangement is providing an inadequate service, Public Health England will be able to change the funding and commissioning route, subject to contractual and other constraints. Individual commissioners will manage contracts with providers to achieve the best possible outcomes. GP practices are currently the preferred provider for a range of public health services under the GP contract, such as childhood immunisations, contraceptive services, cervical cancer screening and child health surveillance. These arrangements will continue and will be funded from the public health budget. However, there may be a case for Public Health England and local authorities in the future to have greater flexibility to choose how such services are commissioned, as circumstances change or if services can be better delivered another way.

All the evidence around the quality, effectiveness and outcomes of services and for safeguarding argues for a coherent, joined up and integrated approach to children’s services. It is essential that there are smooth transitions between the NHS and social care, between primary and secondary care, and between children’s and adult services. Commissioning of children’s services is very fragmented in the current proposals and there is risk that this will result in incoherent services. There is also a high degree of a risk around safeguarding, in the absence of clear guidelines about who is responsible for commissioning effective safeguarding. To ensure the comprehensive commissioning of a seamless Healthy Child Programme we feel consideration should be given to commissioning key services from the same source. Current plans are for GP’s to commission maternity, the NCB to commission increases to health visiting numbers and local authority to commission school nursing and health visiting services. Commissioning of children’s services needs to be across both consortia and LA as much of work is preventive.

2.7 The future of the Public Health Observatories

The new system must ensure that all those working in public health have access to timely, comprehensive and appropriate data and analysis to inform their decisions and advice. The reforms could result in disruption of existing flows of data and the loss of analytical expertise. Arrangements for maintenance of the public health observatory function and for ensuring access to health service data at local and national levels need urgent clarification. The Public Health Observatories between them deliver an essential service. It is very important to continue this, but they must remain independent of politics and be outward facing organisations, closely linked to and informing the work of PHE and local Public health teams. An alternative model could be to bring them into a national intelligence service in which—if regional outposts were to remain, they should demonstrably serve local population and needs.

2.8 The structure and purpose of the Public Health Outcomes Framework

The Outcomes Framework is a useful construct. It provides an essential measurement to ensure we close the gap in life expectancy and health outcomes and continue to improve the health of the population with a focus on increasing healthy life expectancy for all. Reliable data and information are essential to the understanding of health needs, modelling of future scenarios and assessment of impact and efficacy. This is relevant both for service planning and design and for the recognition of and response to hazards and outbreaks. The Framework does however need refinement. We suggest a significant reduction in the number of indicators while ensuring they are robust enough for local collection, analysis and action. We particularly support the linkage of population level health outcomes to social and health care outcomes, ensuring that care pathways can link up.

2.9 Arrangements for funding public health services (including the Health Premium)

There is insufficient clarity in current proposals to understand this. However we must ensure through this process that the NHS is open and transparent about public health resource allocation returns and these are properly scrutinised and align clearly with programmes & outcomes. There is a danger that the health premium may widen inequalities if it is not tied into tackling inequalities. It is vital that public health budgets should not be able to be asset-stripped by local authorities.

The proposals in the White Paper will cause a great deal of confusion around what a proposed public health budget would cover. Public health work should continue to be an integral part of the services provided in primary care, and will continue to be funded from within the overall resources used by the NHS Commissioning Board to commission these services. This includes public health activity carried out by GP practices as part of the essential services they provide for all patients, preventative services provided by dentists under their NHS contracts, and services provided under the community pharmacy contractual framework (CPCF). The CPCF includes provision of prescription-linked healthy lifestyle advice and participation in public health campaigns, which will both need to involve close liaison with the relevant public health experts.

2.10 The future of the public health workforce (including the regulation of public health professionals)

There must be statutory regulation for all Consultants in Public Health, regardless of primary qualification, on a par with other specialties, for example in pathology where not all pathologists are medically trained. This is essential to maintain standards and protect the public. We thus fully accept and strongly support the recommendations of the Scally Report.

We particularly support statutory regulation so that the titles of senior public health professionals can be protected. It is extremely important that the public can be sure that their DPH is fully trained and qualified to carry out the duties of their post.

The DPH must be a Consultant in Public Health and have a team of Consultants in Public Health to support them in their role. Current proposals risk local public health teams becoming relatively junior, non-specialist health improvement teams with no link to health services or health protection. Public Health covers all three domains of public health (health protection, health service public health, and health improvement) and PHE will have a key role in professional formation and development.

We look forward to seeing the workforce proposals that the Department of Health is developing for the new system. We would wish them to promote the highest standards of training and expertise to ensure that England continues to have one of the best public health systems in the world.

2.11 How the Government is responding to the Marmot Review on health inequalities

The current proposals do not represent an explicit response by Government to the Marmot Review, and as such are a missed opportunity. It can be read that the current proposals contain too much reliance on personal behaviour change approaches rather than the macro measures around income, regulation and upstream / societal changes proposed by the Marmot Review.

3. CONCLUSION

We, all 14 Directors of Public Health for the South West of England, are responsible for improving, protecting and restoring the health of more than five million people. We believe that the future public health system for the country needs to be well designed in order to meet not just national objectives but also to meet the needs of local populations across England. In order to build the very best system we believe that the starting point and foundation should be the creation at a local level of a dynamic, highly professional public health structure, based in Local Authorities and with strong continuing links to the NHS, that can deliver the needed improvements in the health of local communities and neighbourhoods.

June 2011

Written evidence from Dr Ingrid Wolfe, Dr Hilary Cass and Professor Sir Alan Craft (PH 159)

THE IMPLICATIONS FOR CHILD HEALTH OF REMOVING PUBLIC HEALTH FROM THE NHS

Authors:

- Dr Ingrid Wolfe, Child Public Health Research Fellow and Paediatrician, London School of Hygiene and Tropical Medicine; Whittington Hospital.
- Dr Hilary Cass, Paediatric Neurodisability Consultant, Evelina Children's Hospital, Guy's and St Thomas' NHS Foundation Trust, London.
- Professor Sir Alan Craft, emeritus professor (child health) Newcastle University, Newcastle.

SUMMARY

- Children's health services in the UK are not delivering the highest quality care to children and families.
- One major explanation is that currently child public health services lack the expertise, data, and workforce to plan, commission, and improve children's health care to world-class standards.
- Child health data must be improved. This is essential if we are to improve the planning and commissioning of children's health services to improve outcomes and ensure the NHS is prepared to meet children's health needs in the future. The role and funding of Public Health Observatories should be strengthened to achieve this important function.
- Public health services, which are currently located in Primary Care Trusts, are too far removed from the front line of health care to provide the expert support necessary to advise on service delivery priorities, measuring service outcomes, and improving children's health services.
- Child public health should be developed as a specialist field of expertise, with professionals working at all levels of the health service, as well as within senior levels of Local Authorities.

1. Ill health and social disadvantage start before birth and accumulate through life. Hence investment in health and social welfare early in life has a disproportionate benefit accrued throughout the life course. Giving every child the best start in life is therefore the first recommendation of the Marmot Review.⁽¹⁾

2. We will confine the content of this submission to addressing the role of public health in health services for children because there are distinct differences between children's and adults' health services that are frequently overlooked.

3. Indications of the quality of children's health care suggest that the UK performs poorly in many regards. Examples follow:⁽²⁾

3.1 A confidential inquiry into a sample of children's deaths showed that there was an identifiable failure in 26% of deaths and a further 43% of deaths were potentially avoidable.⁽³⁾

3.2 Around 50% of children who were subsequently diagnosed with meningococcal infection were sent home after their first consultation with the health service.⁽⁴⁾ The cost to the NHS is over £20 million in legal settlements alone for the past 12 years.⁽⁵⁾

3.3 Over a third of admissions for asthma could have been prevented with better primary care.⁽⁶⁾ The cost of these is over £7,000,000 per year.⁽²⁾

3.4 Over a third of short-stay admissions for infants are for minor illnesses that could have been managed in community settings,⁽⁷⁾ costing over £100,000,000 per year.⁽²⁾ Improving this would mean greater convenience for the family and lower cost to the taxpayer.

3.5 More children in the UK die from illnesses that rely heavily on first-access care (primary care and emergency departments) and which should be preventable, than in comparable European countries. These include pneumonia, asthma, and meningococcal disease.⁽²⁾

3.6 Survival rates for some childhood cancers are lower in the UK than Europe.⁽⁸⁾

3.7 Only 3% of children with asthma have written plans (which are known to be effective) for preventing managing complications at home.⁽⁹⁾

3.8 Only 4% of children with diabetes receive care consistent with guidelines, and many children have preventable complications including death from diabetes.⁽¹⁰⁾

3.9 It is estimated that over a third of outpatient referrals from General Practitioners to Paediatricians would be avoidable with better primary care.⁽¹¹⁾

3.10 Around half of Acute Trusts are weak in paediatric outpatient care, with planned services fitting in around acute care.⁽¹²⁾ However the evidence on disease prevalence and trends shows that efforts should be focused much more strongly on planned care for children with chronic diseases, together with preventive services to improve health in the future.⁽²⁾

4. What underlies these problems in children's health services?

4.1 NHS health care evaluation focuses on adults' health conditions and services. There are no comprehensive assessments of children's health services in the UK. One reason for this is that evaluation methods for NHS care are often more suitable for adults' health services than children's. For example waiting times and complication rates for surgery are much more applicable to adults' than children for whom planned surgery is a minimal part of usual health service use. A further important reason is the lack of reliable routinely collected data on children's health needs and service outcomes.

4.2 The General Practitioners' Contract and remuneration and incentive scheme (Qualities and Outcomes Framework) makes scarce mention of children, focusing strongly on adults' chronic disease management.

4.3 General practitioners are not required formally to train in paediatrics

4.4 There is a serious shortage of paediatricians available to safely fill the number of hospital posts. The workforce shortage causes existing staff to be over-stretched, with acute demands necessarily taking precedence over planned care for children with long-term conditions. One consequence of this is the fragmented poorly coordinated care that so many families complain of, and the poor outcomes associated with many chronic diseases.

4.5 Paediatricians are trained in specialised children's medicine, whereas an increasing numbers of children are presenting to hospital with minor illnesses. The result is inefficient use of health services and frequently dissatisfied parents.

4.6 Health service planners and commissioners are forced to rely mainly on existing patterns of services use, rather than on the needs of children and families, to drive service configuration, which in turn determines workforce training, numbers, and distribution. This lack of data on children's health needs leads to a flawed system becoming self-perpetuating.

5. What could public health do to improve children's health services?

5.1 We believe that Primary Care Trusts have not been as effective at planning and commissioning children's health services as they should have been. There are three major reasons:

5.1.1 First, the location of the public health function, situated at a distance from the front line clinical world.

5.1.2 Second, the increasing distance between public health professionals and clinicians over the past several years.

5.1.3 Finally, there is a lack of reliable regularly collected data on child health need with which service planners, commissioners, and regulators can monitor and improve services.

6. What are the implications for children's health services of the current proposed changes to Public Health?

6.1 Removing public health functions from the NHS and locating them within Local Authorities risks further reducing the ability of public health to plan, commission, and improve children's health services.

6.2 The public health workforce currently is slowly developing skills in child public health, and these risk being undermined as the workforce is further fragmented by removing public health from the NHS.

6.3 We believe public health has a strong role to play, at the highest levels, in Local Authorities. Their role there is essential in tackling the determinants of illness, and in strengthening the determinants of health.

6.3 However, in order to be best-placed to improve children's health services, public health needs to be brought closer in to the front line of health care.

6.4 Public Health Observatories are essential in providing data on health needs. Progress is being made in improving the paucity of child health data, but there is a great deal more that needs to be done. Reliable data is of fundamental importance in delivering high quality care and in planning and improving services, so the future of public health observatories must not be imperiled if we are to improve our abilities not meet children's health needs.

7. Our recommendations:

7.1 Planning, commissioning and improving children's health care is a specialised area of expertise, requiring skills distinct from general public health, health service planners, and commissioners. A child public health specialty should urgently be developed to fill this role.

7.2 Public health observatories must be supported and strengthened in their roles in providing reliable child health data on which to evaluate, plan, commission, and improve children's health services.

7.3 Child public health specialists should work at the front line of the health service in planning and improving care, and in delivering preventive care. They should work at regional and national strategic levels in planning and commissioning larger scale services, and in planning workforce numbers and distribution.

7.4 Child public health professionals should be involved at all levels of the health service, from advising on service delivery priorities and outcome measures, to assessing quality and advising on improvement measures. To do this well, child public health must develop as a specialty, and work closely with professionals in all aspects of the NHS as well as Local Authorities.

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June 2011

Written evidence from Northern Housing Consortium Limited (PH 160)

1. Submission from Northern Housing Consortium Limited.

1.1. The Northern Housing Consortium (NHC) represents organisations responsible for housing in the north of England.

2. In summary:

- The NHC supports the creation of Public Health England and welcomes the focus on helping people live longer, healthier and more fulfilling lives, and improving the health of the poorest fastest. This is a key issue for the north where health inequalities persistent.
- We support the decision to devolve public health responsibilities to local authorities but there must be some form of housing representation on Health and Wellbeing Boards (HWB) and in the development of Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS). This is particularly important in two tier areas where the responsibility for housing lies at district level.
- Housing organisations have a key role to play in tackling health inequalities and in supporting people to be healthy and independent. Linking housing to the HWB, JSNA and JHWS will strengthen local approaches to health and wellbeing.

- We welcome the development of a public health outcomes framework and urge the inclusion of indicators which will tackle persistent health inequalities and which encompass the indicators in the national outcomes framework for Supporting People. Aligning the outcomes framework with the NHS and social care outcomes is welcomed although a better approach would have been to develop a common outcomes framework from the outset.
- We welcome the ring fenced public health fund and the health premium. However housing organisations must be involved in delivering integrated approaches funded through the public health fund. To incentivise improvements in the most deprived areas the health premium must be linked to indicators of deprivation and must follow comparative progress. Unless this happens the gap in inequalities will widen and we will see many communities in the north fall further behind.
- We have concerns that cuts in funding will jeopardise opportunities to tackle the wider determinants of health as set out in the Marmot report.

3. THE CREATION OF PUBLIC HEALTH ENGLAND WITHIN THE DEPARTMENT OF HEALTH

3.1 The NHC welcomes the Government's decision to establish a dedicated body within the Department of Health—Public Health England—to achieve improvements in public health outcomes and oversee the local delivery of public health services. We welcome the aim to help people live longer, healthier and more fulfilling lives, and improve the health of the poorest fastest. The NHC has long argued for the need to focus on tackling health inequalities—a key issue for the north of England. In the health deprivation and disability domain of the 2010 Indices of Multiple Deprivation, 96 of the most deprived 100 LSOAs are in the north of England. Despite policy interventions the gap in inequalities grew steeply between 2000 and 2008 and research now shows that people are 20% more likely to die before they reach the age of 75 in the north of England than in the south of England.⁴¹⁸

3.2 The priority of the new public health agenda should be on tackling the wider determinants of health. It is important that the focus is not simply on the clinical aspects of public health but harnesses the opportunity to engage a wider range of partners and think creatively about how to do things differently.

3.3 According to research by BRE⁴¹⁹ England's poorest quality housing stock could be costing the NHS £600 million a year to treat the health problems of home occupants. The overall cost to society could be as much as £1.5 billion when additional costs such as occupants' loss of earnings are taken into account. Of 2.7 million home accidents per year, about 1 million are children under 15. The estimated cost of a seriously injured home accident casualty is £45,600 and it can cost as much as £250,000 to treat one severe bath water scald.⁴²⁰ One in 20 children are disabled and more than half of disabled children live in unsuitable homes. The care costs of a seriously disabled child whose home is unsuitable are £690 per day (£0.25 million per annum). Falls often occur while waiting for adaptations. The average cost of a fractured hip is £29,665, five times the cost of an average adaptation and 100 times the cost of fitting hand and grab rails.⁴²¹

3.4 People living in poorer neighbourhoods are more likely to suffer a life limiting illness or disability, and this is likely to develop 13 years earlier than in richer neighbourhoods⁴²². People with long-term conditions are the most frequent users of healthcare services. Those with long-term conditions account for 29% of the population, but use 50% of all GP appointments and 70% of all in patient bed days.⁴²³

3.5 The Northern Housing Consortium believes that the housing sector has a strengthened and more visible role to play in health improvement, reducing the burden on health and social care services⁴²⁴ and making savings costs to the public purse. Research shows that investment of £1.6 billion in housing related support generated savings of £3.41 billion to the public purse including £315 million of savings to health service in a year.⁴²⁵ Investment in specialist housing results in savings to the public purse of £639 million pa, which includes an estimated saving of £11,751 per person to health services for people with mental health problems.⁴²⁶ Housing organisations also play a key role in supporting community activity to increase awareness of healthy lifestyle options—including healthy eating campaigns, teenage pregnancy, walking clubs, promoting health to children and young people.

3.6 However, in the current climate we are concerned about resourcing such activity and also how to demonstrate the positive impact of interventions—it is acknowledged that there can be a considerable time lag between intervention and evidenced outcomes.

3.7 Where research into health improvement identifies evidence of the benefits of commissioning certain types of intervention and service delivery, Public Health England should communicate this clearly and quickly

⁴¹⁸ BMJ 2001; 342:d508

⁴¹⁹ BRE 2010 The real cost of poor housing

⁴²⁰ www.capt.org.uk

⁴²¹ Gunn, D 2011 Adaptations Conference Presentation

⁴²² Marmot 2010 Fair Society Fair Lives

⁴²³ DH 2010 Ten things you need to know about long term conditions

⁴²⁴ DH 2010 The use of resources in adult social care: a guide for local authorities

⁴²⁵ CLG 2008 CapGemini, Research into the financial benefits of the Supporting People programme,

⁴²⁶ HCA 2010 Frontier Economics, Financial benefits of investment in specialist housing for vulnerable and older people

to commissioners. Public Health England will play an important role in working with relevant stakeholders—including the NHS Commissioning Board—to provide advice and tools which support commissioners to redesign services that deliver better outcomes.

4. THE FUTURE ROLE OF LOCAL GOVERNMENT

4.1 It is right to devolve responsibility for commissioning of public health services to local authorities, working in partnership with the NHS, with communities and with the private and voluntary sectors.

4.2 However there is a risk that skills and capacity may be lost during the transition particularly in the current economic climate. The approach that local authorities take to managing the transition will be critical eg ensuring investment in the right skills and investment in data analysis, and ensuring that a wide range partners are engaged in the health and wellbeing agenda. The Director of Public Health will have an important role in this and promoting the public health agenda throughout the local authority.

4.3 The NHC believes there must be some form of housing representation on the Health and Wellbeing Board (HWB) to champion housing issues and enable more integrated solutions to be planned and delivered. In our submission to the Health and Social Care Bill Commons Committee the NHC requested amendments to the Bill to include explicitly “Director of Housing from the local authority” and, in two tier areas, to include housing leads from local housing authorities on the HWB. In addition we requested that a power be inserted for the Secretary of State to produce regulations stating such other persons as s/he considers appropriate, to bring additional local expertise to the HWB. This would allow the inclusion of such housing and other local experts, such as the Chief Executive of a local housing provider partner (ALMO or large scale voluntary transfer association) or a representative from any local housing provider fora. At the same time it will be important that local councillors provide a housing voice on the HWB, championing local housing issues, highlighting the impact of housing interventions on health and well-being and promoting integrated solutions.

4.4 In our Health and Social Care Bill Commons Committee submission we also requested an amendment to the Bill include a duty for HWB’s to encourage integrated working across health, social care *and* housing and for the inclusion of housing partners in the development of Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing strategies (JHWS). We believe that better outcomes can be delivered by working in an integrated way and HWB’s must quickly get to grips with roles, remits and responsibilities to ensure that opportunities are harnessed. For example Liverpool Healthy Homes is an innovative partnership approach between the PCT and City Council designed to make homes healthier and safer. Liverpool has one of the highest mortality rates and lowest levels of life expectancy in England and the worst rate of fuel poverty in England. Interventions are targeted at addressing health problems linked to housing and the environment. The approach is embedded into mainstream services and an independent evaluation of the first year of operations has estimated total savings to the NHS and to wider society of over £1.5 million.

4.5 Developing a Joint Strategic Needs Assessments (JSNA) is set to become one of the primary duties of Health and Wellbeing Boards and will provide a transparent, evidence based rationale on which to base *all* local commissioning plans and investment and disinvestment decisions across local authority boundaries whether these are GP commissioning, council commissioning or joint commissioning. The new demands on JSNA require the involvement of a wider range of local partners, sharing the ‘big picture’ analysis and an assessment of needs and, importantly assets. Positive examples of JSNA being used to commission integrated solutions involving housing partners can be found in Wakefield, Bristol and North East Lincolnshire. However national studies⁴²⁷ and our own engagement with housing organisations across the north shows that involvement of housing organisations in JSNA has been patchy.⁴²⁸ The NHC is working in partnership with JSNA colleagues to engage with housing organisations and their local partners to better understand the “housing offer” and the ideal relationship between JSNA and housing. In autumn 2011 we will publish a resource which aims to support housing organisations to engage with JSNA and build a stronger role for housing in local leadership for health and well-being. We also support housing organisations to develop effective customer profiling and deploy that intelligence to shape services.

4.6 The NHC believes that housing organisations have a vital role to play in JSNA and in JHWS not only as contributors of data/intelligence on housing needs and assets but as intermediaries. Customer scrutiny is at the heart of the best governance structures underpinning housing providers—at its best, it challenges organisations to be truly responsive to customers and communities, with tenants not only setting the terms of service standards but seeking to take on service delivery through devolved budgets, transfer of assets and development of mutual services such as the Helena Partnerships food co-operative. Housing organisations can act as a hub sitting in the heart of the community, connected to those people typically categorised as “hard to reach” by those working in health, providing valuable links given the need for greater patient empowerment. Housing organisations are also community leaders, service providers and commissioners, and for many they see their primary role as “neighbourhood investors” with the housing element being only one part. Housing organisations in the north of England work with communities facing some of the worst disadvantages. The challenges include health inequalities but also higher rates of worklessness, higher levels of people categorised as NEET’s, a less stable enterprise culture and lower levels of educational attainment. The Government believes that social norms and the creation of an enabling environment will go a considerable way to providing people

⁴²⁷ IDeA 2010 Joint Strategic Needs Assessment: vulnerable adults, housing and support

⁴²⁸ NHC/ Integrated Living Network 2009 JSNA and Housing: a review of Northern approaches

with the stimulus they require to make healthy choices. Housing organisations can also act as an innovator being creative and collaborative, shaping environments that provide opportunities for people to improve the quality of their lives and encouraging social connectedness. The NHC is embarking on a project to explore how connections are changing within our communities, how this is impacting on relationships with customers, the value of community connections in improving quality of life and the opportunities this presents for improving the way we deliver services in the housing sector.

5. PUBLIC HEALTH OUTCOMES

5.1 The NHC welcomes the development of a public health outcomes framework which champions the wider determinants of health. In our consultation response we urged the prioritisation of indicators which will tackle health inequalities. We would like to see the inclusion of indicators on the “proportion of people with long-term care needs feeling supported to manage their condition” and “the proportion of people with long-term care needs who say they are confident that they can manage their own health.” We would also like to see the inclusion of indicators in the Supporting People National Outcomes Framework.

5.2 We hope that inclusion of these indicators in the final outcomes framework will encourage integrated working and will increase our understanding of the costs and benefits of this type of approach and the development of local gain share models which enable the costs as well as benefits to be shared.

5.3 Housing organisations can contribute to indicators across most of the domains, supporting commissioners to deliver more integrated services, helping to improve outcomes and deliver value of money. Many housing organisations provide assisted living solutions such as telehealthcare which can improve public health outcomes for people with long term conditions such as Chronic Obstructive Pulmonary Disease (COPD), Chronic Heart Failure (CHF) and diabetes and improve service efficiency. Studies internationally have shown that following the introduction of telehealthcare has seen an average reduction of admissions to hospital per year for patients with COPD of 54% and with heart failure of 38%.⁴²⁹ By helping a patient manage their condition from home, telehealthcare can empower individuals to better understand their own health needs, give them greater confidence in managing their own conditions and help to improve patient experience.⁴³⁰

5.4 Whilst we welcome the intention to align the Framework with the NHS and social care outcomes frameworks, we feel that a common outcomes framework would have supported greater and more effective integrated working especially for people who have complex or long-term care needs and who often need access to social care and NHS services. We have concerns around how the alignment will work in practice. Given that the NHS Outcomes Framework is focused on clinical outcomes there is a risk that the NHS and GP’s may have little motivation to engage in public health.

6. PUBLIC HEALTH FUNDING AND COMMISSIONING

6.1 The NHC welcomes the proposal to allocate a ring-fenced public health budget. We think that that the Health and Wellbeing Board could be the appropriate place to bring together ring-fenced public health funding with other budgets such as housing. Having housing representation on the HWB will help to ensure that public health funding is aligned with housing investment and housing related support funding and is informed by a comprehensive understanding of needs and assets in the community.

6.2 There must however be effective scrutiny in the new commissioning and delivery arrangements to ensure that funding it is being spent on genuine public health issues and delivering outcomes. There is a risk of costs being shifted within local authorities and between local authorities and the NHS, and this could be compounded with the interim formation of the cluster PCT’s over a much larger geographical area. Getting the right relationship between the HWB and the overview and scrutiny arrangements will be crucial.

6.3 The allocation of an incentive payment, or “health premium” is welcomed although the payments of the premium should be weighted to the level of health inequalities and the *comparative* progress made with disadvantaged areas seeing a greater premium if they make progress, recognising that they face the greatest challenges. The NHC feels that this is the most challenging issue. Ensuring areas with the greatest health inequalities do not fall further behind means that the indicators most closely linked to deprivation must be incentivised.

7. GOVERNMENT RESPONSE TO THE MARMOT REVIEW

7.1 Despite policy interventions on health inequalities in the last decade the gap in health inequalities has widened. Significant economic pressures, persistent inequalities and rising demand for services will require a more comprehensive and inclusive approach of all partners providing services in a local area. As the Marmot report concluded, tackling medical determinants of health is insufficient alone and “*success is more likely to come from the cumulative impact of a range of complementary programmes.....and from more effective, coherent delivery systems and accountability mechanisms.*”

7.2 The abrupt termination of Housing Market Renewal pathfinder funding and front loaded cuts has had a disproportionate impact on the north of England. The NHC has concerns that in the current economic climate,

⁴²⁹ Ernst and Young, *Telehealth: A review of the evidence*, 2010

⁴³⁰ Picker Institute, *Worldwide evidence of the effectiveness of patient and public engagement launched online*, March 2010

with many government departments and local authorities facing significant cuts, their commitment to investing in these types of priorities may be diminished.

June 2011

Written evidence from The Hepatitis C Trust (PH 161)

SUMMARY OF KEY POINTS

- Hepatitis C is a major public health challenge for the NHS in England and it is vital that much-needed improvements to testing, diagnosis and treatment rates are achieved through the proposed reforms. However, there is a real danger that hepatitis C could fall through the gaps created by the abolition of certain agencies and the lack of awareness about the virus amongst future commissioners.
- Public Health England (PHE) should take a lead role in refining data collection on hepatitis C. The Health Protection Agency's work on infectious diseases, particularly its role in the collection, management, analysis and interpretation of data for hepatitis C, must not be lost in the transition to PHE but should be strengthened and expanded. This data will be critical to inform local strategies and for effective commissioning.
- Local authorities should be bound by decisions of the Joint Health and Wellbeing Strategy, which are based on public health needs as identified in the Joint Strategic Needs Assessment. The strategies should be published and open to scrutiny.
- For hepatitis C low GP awareness is one of the greatest barriers to effective diagnosis and hence treatment of hepatitis C. Therefore, in order for GP consortia to play a role in public health, education on hepatitis C amongst GPs needs to increase and awareness messages should be targeted at GP and GP consortia through levers such as an indicator in the Public Health Outcomes Framework (as described below) or to include a topic for "Case finding for hepatitis C" in the Quality Outcome Framework (QOF). This is particularly relevant in the context of the new public health element which will make up 15% of the QOF.
- Hepatitis C should be commissioned by the National Commissioning Board. GP commissioning for hepatitis C is likely to increase existing inequalities in health for hepatitis C patients due to drastically low levels of awareness of hepatitis C amongst GPs. This has been the single greatest barrier to diagnosis and treatment to date.

BACKGROUND

1. The Hepatitis C Trust is the national UK charity for hepatitis C. It is a patient-led and patient-run organisation: almost all of its board, staff and volunteers either have hepatitis C or have had it and have cleared it after treatment. It provides information, support and representation for all those affected by the disease. The Trust campaigns to raise awareness, tackle stigma associated with hepatitis C and make the case to policy makers for greater education and information on hepatitis C and improved resources to prevent and treat the virus.

2. Hepatitis C is a major public health threat. It is a blood borne virus that primarily attacks the liver and can lead to cirrhosis, severe and potentially fatal liver disease and cancer. Symptoms may be generic and are frequently missed or misdiagnosed by GPs. The virus can also be asymptomatic. Therefore the majority of people currently infected with hepatitis C remain undiagnosed and may be passing on the virus to others. Prevalence estimates vary between 250,000 and 466,000 in the UK⁴³¹ but only around 100,000 have been diagnosed to date⁴³² and there are an estimated 12,000 new hepatitis C infections per year.⁴³³ However, hepatitis C is preventable and curable. The virus can be successfully treated and cured in around half of patients, preventing premature death and complicated and costly health interventions. Treating all hepatitis C patients according to NICE guidance would cost the NHS approximately £1.6 billion. The estimated cost to the NHS alone of failing to diagnose and treat existing patients could be between £4 billion and £8 billion over the next 10 years.⁴³⁴

⁴³¹ The Health Protection Agency estimate there are around 250,000 hepatitis C positive people in the UK (*Hepatitis C in the UK: Annual Report 2009*. London: Health Protection Agency, December 2009) but University of Southampton research shows a prevalence of up to 466,000 in the UK (*The UK vs. Europe: Losing the fight against hepatitis C*. University of Southampton and The Hepatitis C Trust, 2006).

⁴³² *Hepatitis C in the UK: Annual Report 2009*. London: Health Protection Agency, December 2009: there have been 68,431 reported HCV positive diagnoses in England; around 26,000 in Scotland; around 4,000 in Wales and around 1,200 in Northern Ireland.

⁴³³ *Hepatitis C in England: An Analysis of the Implementation of NICE Guidance on the Treatment of Hepatitis C*. London: Roche Products Ltd, April 2009. The HPA estimate that new infections reached a plateau of around 12,000 new infections per year in the early to mid-1990s but have not provided a more up to date estimate of incidence rates (see *Hepatitis C in the UK: the Health protection Agency report 2008*, p.19–21).

⁴³⁴ *The UK vs. Europe: Losing the fight against hepatitis C*. University of Southampton and The Hepatitis C Trust, 2006

3. Liver disease is the only one of the “big five” killer diseases in the UK for which the mortality rate is increasing.⁴³⁵ Addressing hepatitis C by testing, diagnosis and treating earlier would have a significant impact on the rising liver disease mortality curve.

THE CREATION OF PUBLIC HEALTH ENGLAND WITHIN THE DEPARTMENT OF HEALTH

4. The Hepatitis C Trust welcomes the focus on Public Health signalled by the creation of Public Health England. The new Public Health structure offers an opportunity to increase diagnosis, treatment and cure of hepatitis C. However there are significant risks that hepatitis C could fall through the gaps created by the abolition of certain agencies and lack of awareness amongst commissioners.

5. It is important that with the creation of Public Health England the definition of roles and responsibilities between Public Health England and local authorities is clearly defined. Furthermore the definition of roles between Public Health England (and local authorities) and the National Commissioning Board requires further elucidation. It is crucial, for example, that all bodies are aware of who has responsibility for each part of hepatitis C healthcare in prisons (awareness, testing, diagnosis and treatment).

6. It is important that Public Health England has adequate powers over Local Authorities to ensure they are improving public health. These should be stronger than merely requiring local authorities to “have regard” to the public health outcomes framework.

THE ABOLITION OF THE HEALTH PROTECTION AGENCY AND THE NATIONAL TREATMENT AGENCY FOR SUBSTANCE MISUSE

7. The Hepatitis C Trust is deeply concerned about the abolition of the Health Protection Agency. It is important that there is an integrated approach to diseases such as hepatitis C when the functions of the NTA, HPA and Department of Health are combined into Public Health England. The Trust is concerned about the exodus of expertise and experience that has already begun in the face of the agency’s uncertain future within PHE. It is vital that the HPA’s work on infectious diseases, particularly its role in the collection, management, analysis and interpretation of data for hepatitis C, is not lost in the transition to PHE but is in fact strengthened and expanded.

8. Public Health England should take a lead role in refining data collection on hepatitis C. It is critical that appropriate, meaningful and timely surveillance is conducted and published to inform strategies to tackle hepatitis C and commissioning of local services. Data should be made available as quickly as possible to commissioners and to local health and wellbeing boards and any evidence of declining outcomes should be immediately highlighted. For example, data is not collected on hepatitis C treatment such as the numbers being treated each year and the numbers being cured. Without this it is impossible to judge whether progress is being made in tackling this virus.

THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH (INCLUDING ARRANGEMENTS FOR THE APPOINTMENT OF DIRECTORS OF PUBLIC HEALTH; AND THE ROLE OF HEALTH AND WELLBEING BOARDS, JOINT STRATEGIC NEEDS ASSESSMENTS AND JOINT HEALTH AND WELLBEING STRATEGIES)

9. In the interests of a “joined up” local approach to public health, The Hepatitis C Trust welcomes that GP consortia will be required to take part in the local Joint Strategic Needs Assessment and develop the local Joint Health and Wellbeing Strategy alongside the local Director of Public Health and a representative from local Health Watch, among others, as part of the local Health and Wellbeing Board.

10. Given the importance of joint working across public health, the NHS and social care services, it seems appropriate that the Health and Wellbeing Board is the focus for ring-fenced public health budgets. For hepatitis C services a decision about improving diagnosis rates would lead to money being allocated to the local authority for awareness and to GP consortia in that area for testing and diagnosis. In this context, it is vital that the members of the Health and Wellbeing Board are bound by the decisions made within it. Currently, the legislation provides that members “have regard” to its decisions in the Joint Health and Wellbeing Strategy but we believe its members must be bound by its decisions. It is crucial that the strategy developed for public health in the Joint Health and Wellbeing Strategy is based on public health needs as identified in the Joint Strategic Needs Assessment.

11. In order to further improve the accountability and therefore the legitimacy of the Local Health and Wellbeing Board, the strategies developed by them should be open to scrutiny. Annual reports should include a published list of the board’s priorities and an explanation, based on publically available evidence, of how these address the specific health needs of the local population. The local population should be able to challenge their local Health and Wellbeing Board if specific local health issues are not being tackled, for instance if there is a large hepatitis C at-risk community but no plans to commission services to tackle this.

⁴³⁵ *Unmasking liver disease: the silent epidemic*. Department of Health and Bell Pottinger, May 2009 (unpublished)

ARRANGEMENTS FOR PUBLIC HEALTH INVOLVEMENT IN THE COMMISSIONING OF NHS SERVICES

12. While national screening programmes will be managed by Public Health England, it should be underlined that local authorities can undertake targeted screening programmes among at-risk groups—such as among injecting drug users in areas of high hepatitis C incidence. In its supportive role Public Health England should provide guidance to local authorities on assessing the risk for hepatitis C and guidance on implementing awareness and screening programmes. There should also be clear lines of communication with the NHS and Social Care Service to ensure that data are used to inform commissioning across the health service.

ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

13. The National Liver Disease Strategy should be used as a key resource for setting out how public health commissioning should work for liver disease. There should be coordination between the National Clinical Director for Liver Disease, Dr Martin Lombard, the liver team at the Department of Health and Public Health England. Given the scale of liver disease and its impact on public health, there should be a specific person or team within Public Health England focusing on wider liver health and hepatitis C.

14. Local Authorities should be obliged to commission services that are directly linked to the Joint Strategic Needs Assessment. This will ensure that the specific health needs of a local population, such as hepatitis C, are addressed through the public health ring-fenced funding rather than being directed to broad interventions for which the health benefit is not immediately obvious. There should be flexibility for this to change as the needs of the local population change. It should be mandatory for local authorities to commission prevention measures and testing for hepatitis C from GPs through the public health budget.

15. The Hepatitis C Trust welcomes the proposal in the White Paper that Joint Health and Wellbeing Boards should have a duty to ensure the collection and use of data on public health at a local level. Local Directors of Public Health could hold them to account on this. To enable accurate and local health economy-specific intelligence on infection rates, data should be collected on infection rates of hepatitis C at GP consortia level. Data should include inequalities groups and high risk groups including whether someone is, or has been, an IDU.

16. For hepatitis C low GP awareness is one of the greatest barriers to effective diagnosis and hence treatment of hepatitis C. Therefore, in order for GP consortia to play a role in public health, education on hepatitis C amongst GPs needs to increase and awareness messages should be targeted at GP and GP consortia. An excellent lever to ensure that GPs are aware of the need to diagnose hepatitis C at an early stage would be an indicator in the Public Health Outcomes Framework (as described below). Another way to educate GPs about hepatitis C and to test people who have risk factors for hepatitis C would be to include a topic for “Case finding for hepatitis C” in the Quality Outcome Framework (QOF). This is particularly relevant in the context of the new public health element which will make up 15% of the QOF. The Hepatitis C Trust has made a submission to the QOF topic selection process for the 2013–14 QOF suggesting a topic for case finding for hepatitis C.

17. It is critical that all parties are aware of their responsibilities in the new commissioning structure. The Hepatitis C Trust is aware of anecdotal evidence which suggests that some GPs working in “pathfinder” commissioning consortia and their local DAAT teams are unaware of who is to pay for testing for hepatitis C in settings such as DAATs. Clear guidelines on who commissions what, and where, are essential.

THE FUTURE OF THE PUBLIC HEALTH OBSERVATORIES

18. It is crucial that GP consortia and local authorities commission public health awareness campaigns and services that reflect the public health needs of their local population, and that surveillance is conducted to inform the commissioning of services. The collection and publication of local public health data is critical to ensuring that disease areas which should be local priorities are tackled, rather than simply those areas with greater awareness amongst commissioners and a mobilized, vocal patient body.

THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

19. The Hepatitis C Trust welcomes the publication of the public health outcomes framework as much work is needed to drive up standards of services to tackle public health issues in England. Hepatitis C testing, diagnosis and treatment spans a number of the domains and thus the framework offers real potential to raise awareness of hepatitis C and improve diagnosis rates among those at risk. However, responsibility for improvement against these indicators needs to be clearly shared across the NHS and Public Health to prevent each section of the health service believing it to be the responsibility of the other.

20. We particularly welcome the proposed inclusion of the indicator of “mortality rate from Chronic Liver Disease in persons less than 75 years of age” under domain five of the Public Health Outcomes framework, to be shared with the NHS Outcomes framework. This would ensure that the public health service prioritises awareness and screening of hepatitis C and that the NHS in turn offers treatment to those who are identified with the virus through the public health service. By following this approach, the burden on the NHS could be greatly reduced through avoiding preventable liver disease.

21. The Hepatitis C Trust has also recommended that an indicator be included in domain four (Prevention of ill health: Reducing the number of people living with preventable ill health) of “Number of patients diagnosed with hepatitis C who are found to have liver cirrhosis or liver cancer”. This could easily be measured as HPA routinely extracts patients with codes for HCV, primary liver cancer and end stage liver failure and matches them with data on new diagnoses of hepatitis C. This could equally well be done with the codes for cirrhosis.

22. It is important that the measures within the Public Health Outcomes Framework, including the data collected, reflect the aims of the national liver disease strategy which is currently under development and which will be an important resource in setting out how the different parts of the health service will work together and should complement what is in the outcomes frameworks.

23. It is also important that the focus on outcomes is not so rigid as to exclude sensible and much needed public health interventions where the public health benefit may not be immediately seen nor be easily measured, for example, preventing transmission of the hepatitis C virus. The time lag before the long-term benefits of public health measures are seen must be considered. For example, for those investing in hepatitis C testing the benefits on liver mortality may not be seen for a number of years. In the interim period, local authorities may decide to redirect spending in the search for fast results and thus there should be a clear focus on screening or diagnosis rates for hepatitis C within domain 4 as set out above to make sure that the longer-term benefits are achieved.

ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES (INCLUDING THE HEALTH PREMIUM)

24. It is vital that the budget for funding public health remains ring fenced. It is also vital that resource allocation is based on solid data on the greatest public health threats for a particular area.

25. The introduction of “health premiums” could be an effective way of targeting resource where it is most needed. Public health and local government partners should be able to attach this to issues that affect the local population—for example, in areas where the number of people infected with the hepatitis C virus is high, the health premium could focus on awareness and screening campaigns for at-risk groups. Local priorities should be decided at the Joint Health and Wellbeing Board and should be published to enable public scrutiny of the public health priorities of local areas.

26. Given their expertise in public health and hepatitis C in particular, Health Protection Agency staff should be represented in the group developing the health premium formula. The National Clinical Director for Liver Disease and the liver team at the Department of Health, as well as patient representatives, should also be included in the group developing the formula.

27. It is important that measures are directly linked to health improvement. Local authority budgets are being reduced and there is a risk that many activities that may be cut could be covered by a public health budget. In order to maintain a focus on reducing inequalities, there should be measures focused on disadvantaged groups—for example injecting drug users have a higher rate of hepatitis C infection⁴³⁶ and thus screening among this group should be a priority.

28. Measures for the health premium should be linked to achieving the best outcomes rather than just minimum standards. This will ensure that additional payments are targeted to local authorities that have achieved real health improvements. Data to support health premiums should be disaggregated according to gender, age, socio-economic group and at-risk group to enable effective monitoring of reductions in health inequalities. The payment should be linked to overall improvement and a reduction in the inequalities identified.

29. Incentives can help to improve the performance of providers. However it is important that this is not to the disadvantage of areas with complex needs. It is important that the health premium system does not disadvantage people who experience health inequalities because of failing local authorities in the context of a system in which local authorities who do not make progress are not given the health premium.

30. The time-lag between investing in interventions and the realisation of a clear benefit in outcomes should be taken into account. For hepatitis C, the impact on liver mortality through focusing on early diagnosis will not be seen for some time. In this way, proxies for outcomes such as the number of patients diagnosed with hepatitis C who are offered treatment could be a good way to measure health benefits in the shorter term.

THE FUTURE OF THE PUBLIC HEALTH WORKFORCE (INCLUDING THE REGULATION OF PUBLIC HEALTH PROFESSIONALS)

31. The public health workforce, including social care professionals, drug and alcohol action teams (DAAT teams) and pharmacists will play an important role in supporting and delivering public health initiatives. In the context of the new public health environment it will be important for GPs to engage with other local healthcare providers both as commissioners, for example by commissioning local pharmacies to offer hepatitis C testing, but also as practitioners, where joint working with DAAT teams and local pharmacists will be crucial to delivering effective public health interventions.

⁴³⁶ The HPA report that 92.5% of hepatitis C patients are either current or ex-injecting drug users in *Hepatitis C in the UK: Annual Report 2009*, Health Protection Agency, page 10.

HOW THE GOVERNMENT IS RESPONDING TO THE MARMOT REVIEW ON HEALTH INEQUALITIES.

32. Hepatitis C disproportionately affects disadvantaged, vulnerable and socially excluded people, particularly homeless people, prisoners and injecting drug users. The majority of hepatitis C patients have already experienced many of the social inequalities in health. For example, research conducted to inform the Scottish Hepatitis C Action Plan found that 75% of hepatitis C patients are from the two lowest socio-economic quintiles.⁴³⁷ These health inequalities are exacerbated by inequality in access to treatment and inequality of outcomes.

33. Experience has shown that the lack of central commissioning for hepatitis C has not achieved adequate outcomes for patients. The UK ranked 13th out of 14 countries on the usage of hepatitis C drugs in a recent report by Professor Sir Mike Richards for the Secretary of State *Extent and Causes of international variations in drugs usage*.⁴³⁸ The All-Party Parliamentary Hepatology Group's Report of their audit of hepatitis C services "In the Dark" found huge variations in hepatitis C services available to patients across the country through internal hospital policies, both formal and informal. Around a third of hepatitis C patients referred to hospitals are not being offered treatment. Twelve hospitals refused re-treatment to patients despite re-treatment being recommended by NICE. Around 10 hospitals refuse NICE approved treatment to all injecting drug users, despite the lack of any convincing evidence of compliance problems in IDUs.⁴³⁹ Moreover, studies of reinfection rates have shown a very low re-infection rates in people in whom the virus has been eliminated.⁴⁴⁰ These inequalities in access to effective health services need to be addressed.

34. GP commissioning for hepatitis C is likely not only to fail to reduce existing inequalities in health for hepatitis C patients but actually to increase them. Drastically low levels of awareness of hepatitis C amongst GPs has been the single greatest barrier to diagnosis and treatment. A move to commissioning treatment services for hepatitis C patients by a group with little knowledge of hepatitis C would create greater inequalities in outcomes than those already existing and would add yet another layer of inequalities to this already significantly disadvantaged group. This is quite apart from the obvious long-term cost implications for the NHS through patients, who could otherwise have been treated and cured, presenting with liver cirrhosis and cancer.

35. The NHS Commissioning Board will have a duty both to (a) Reduce inequalities between patients with respect to their ability to access health services' and (b) "reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services". By commissioning treatment for hepatitis C the board would be explicitly exercising its functions relating to inequalities in health.

June 2011

Written evidence from NHS Bristol's Public Health Directorate (PH 162)

We welcome the opportunity to submit evidence to the Health Select Committee for its inquiry into Public Health.

We have made extensive comments previously about the proposed health reforms. We attach our previous consultation responses to the white paper, "Healthy Lives, Healthy People", and supporting documents on the public health outcomes framework, funding and commissioning routes, and regulation of public health professionals.⁴⁴¹

We wish to make additional comments under some of the headings, as requested.

THE CREATION OF PUBLIC HEALTH ENGLAND WITHIN THE DEPARTMENT OF HEALTH

The independence of Public Health England is essential, and the public health workforce should remain independent of the civil service. Public health needs to be free to have an advocacy role. A previous example of this advocacy role was the successful lobby for legislation for banning smoking in public places.

THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH, (INCLUDING ARRANGEMENTS FOR THE APPOINTMENT OF DIRECTORS OF PUBLIC HEALTH; AND THE ROLE OF HEALTH AND WELLBEING BOARDS, JOINT STRATEGIC NEEDS ASSESSMENTS AND JOINT HEALTH AND WELLBEING STRATEGIES)

Role of the DPH

The duties and responsibilities of Directors of Public Health outlined must be supported by relevant powers in the legislation. For example, the Director of Public Health should have control over the budget for health and wellbeing.

⁴³⁷ *Divided Nations: tackling the hepatitis C challenge across the UK*. All Party Parliamentary Hepatology Group, November 2008.

⁴³⁸ *Extent and causes of international variations in drug usage: A report for the Secretary of State for Health*, London: Professor Sir Mike Richards CBE, July 2010

⁴³⁹ *Injecting drug users with chronic hepatitis C: should they be offered antiviral therapy?* Editorial by Professor Graham Foster in *Addiction*, 103, Society for the Study of Addiction, 2008 1412 -1413.

⁴⁴⁰ *Treatment of hepatitis C infection in injection drug users*. Backmund M., Meyer K., Von Zielonka M., Eichenlaub D. *Hepatology* 2001; 34: 188-93.

⁴⁴¹ Not printed here

Role of the Health and Wellbeing Board

The PCT, as current local leaders of the NHS, co-ordinates system wide improvements in services, such as reconfiguration of services for patients with heart attack or stroke, or the location of a new hospital. The PCT works closely with partner Primary Care Trusts and NHS Trusts/Foundation Trusts, local clinicians and patients, as well as wider stakeholders to deliver such changes across the whole health system. In the new commissioning arrangements it is not clear what the mechanisms will be for ensuring effective system wide change.

The Health and Wellbeing Board can effectively take on this function. In order to do this its role needs to be strengthened to enable the Board to be seen as having this overall local leadership role. The Health and Wellbeing Board must be central to the new health and care landscape locally such that it can effectively facilitate system wide improvements and can enable integrated working between primary and secondary care and between commissioners and providers.

Under the current proposals the Health and Wellbeing Board has the unique feature in the future health and care system of including elected members and being a committee of the council, giving it democratic accountability. This feature can strengthen its leadership role in the health and social care system locally, but only if the Health and Wellbeing Board is given sufficient powers. The Health and Wellbeing Board must be given power to take decisions about budget spends and mutually hold commissioners to account. In particular, its authority locally must not be undermined by the NHS Commissioning Board or any one member organisation of the Health and Wellbeing Board.

ARRANGEMENTS FOR PUBLIC HEALTH INVOLVEMENT IN THE COMMISSIONING OF NHS SERVICES

- (i) The skills, knowledge, and experience of Public Health Specialists who can deal with “Healthcare Public Health” is absolutely essential for ensuring that commissioning decisions are based on evidence of best-value, fairness, efficiency and effectiveness at national and local level. Public health specialists bring technical expertise in health intelligence, needs assessment, equity audits, critical appraisal of evidence of effectiveness and cost-effectiveness, advice on disinvestment, evaluation of services, and development of care pathways. In order to ensure these skills are available to GP commissioning consortia, it should be mandatory for the Director of Public Health (or their nominee) to have a seat on each of the GP Commissioning Consortium Boards. This would be in their role as technical lead for the speciality of public health (quite separate to their role in local government).
- (ii) All the evidence around the quality, effectiveness and outcomes of services and for safeguarding argues for a coherent, joined up and integrated approach to children’s services. It is essential that there are smooth transitions between the NHS and social care, between primary and secondary care, and between children’s and adult services. Commissioning of children’s services is very fragmented in the current proposals and there is risk that this will result in incoherent services. There is also a high degree of a risk around safeguarding, in the absence of clear guidelines about who is responsible for commissioning effective safeguarding.

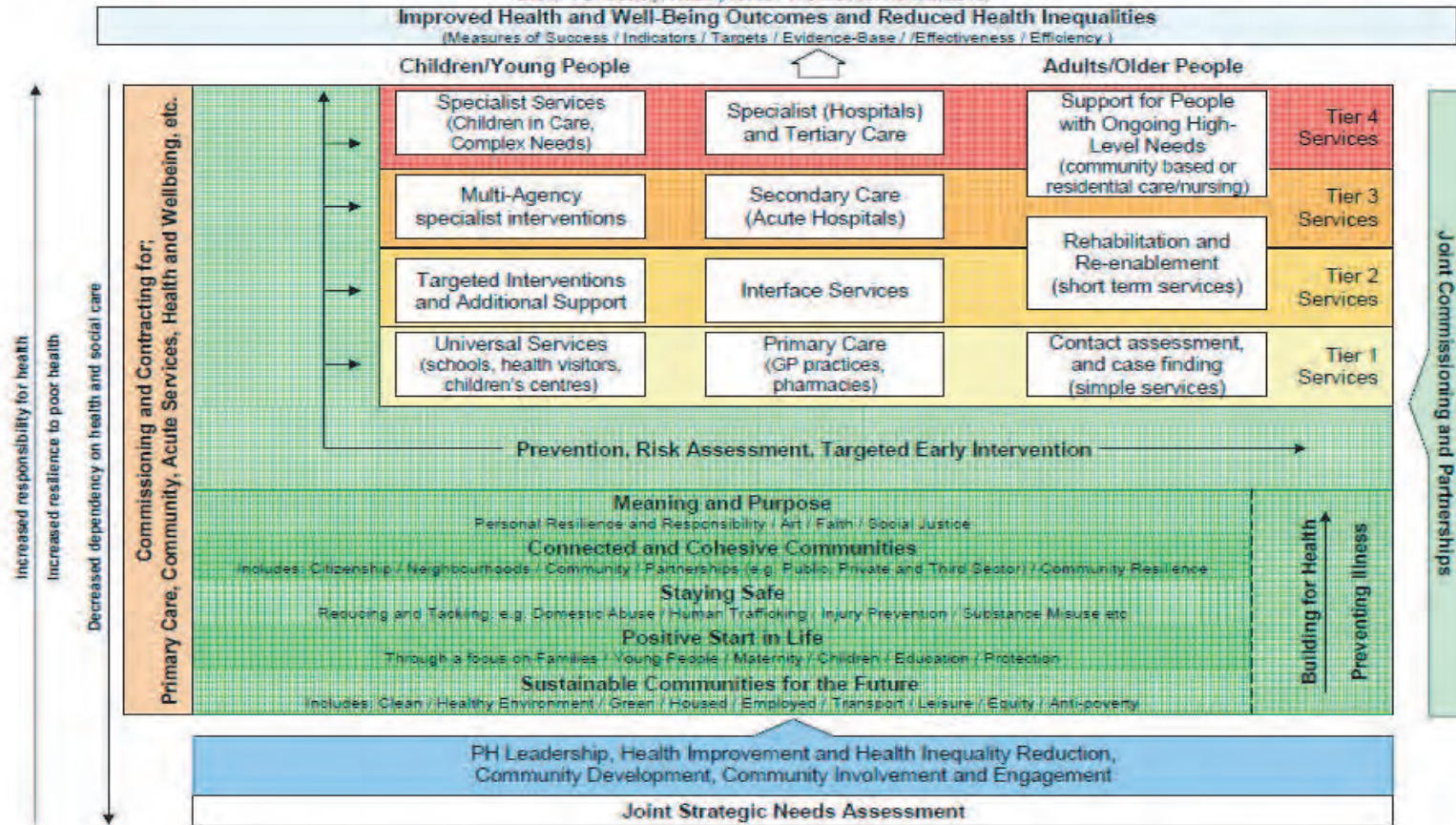
The Bristol Commissioning Model (attached as appendix) helps to illustrate how commissioning of children’s services needs to be carried out in an integrated manner, with a focus on health and well-being. The Bristol Model draws on the evidence base, linking care pathways and interventions/service delivery with commissioning decisions, population investment and outcomes. It demonstrates opportunities for commissioning and delivering in a much more aligned/integrated way—in the short, medium, and longer term—to achieve better and more sustainable outcomes.

THE FUTURE OF THE PUBLIC HEALTH WORKFORCE

- (i) Public Health covers all three domains of public health (health protection, health service public health, and health improvement), and Public Health England may need to be the employer for the whole public health workforce to prevent fragmentation.
- (ii) What support and training will there be for Public Health practitioners? How will this be funded and coordinated? We would like to see this clearly set out in both national guidance and in local arrangements. There is a danger that this area will be left unfunded and unmanaged, as regional structures disappear and local structures emerge. This is an issue for the wider public health workforce, currently employed in a range of health improvement/public health roles in the voluntary sector, the local authority and the NHS.
- (iii) We face unprecedented challenges because of the combined impacts of resource depletion, environmental degradation, and the economic shocks that are predicted to arise from “peak oil”. This has substantial implications for transport, food, jobs, health and healthcare. It is therefore essential that the proposed changes to public health services and associated changes to health services more generally, do not disrupt essential local workforce and service delivery capacity. There is a need for simpler systems that are both robust and resilient for times of hardship.⁴⁴²

The Bristol Commissioning Model for Health and Well-Being

(Commissioning Model adapted by Bristol Public Health from i) "New Horizons: A Shared Vision for Public Health, The Department of Health: Mental Health Division, December 2009" and ii) "Fair Society, Healthy Lives" The Marmot Review, 2010)



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Written evidence from I CAN and The Communication Trust (PH 163)

1. EXECUTIVE SUMMARY

1.1 I CAN and the Communication Trust welcome the Health Select Committee's inquiry into the future of public health. Speech, language and communication skills are fundamental for all children. Without effective intervention, speech, language and communication needs (SLCN) can have a detrimental impact on a child's wider health and well being, literacy development, educational outcomes, emotional and social development and for those children with long term needs on mental health. However, from our experience, one of the biggest problems for those operating within the speech and language sector is the fragmented nature of commissioning and provision, most notably between Local Authorities and the NHS, but increasingly with schools as well. Collaboration will be ever more important for speech and language services given the greater commissioning powers granted to academies and free schools. Whilst we welcome the Government's White Paper, *Health Lives, Healthy People*, and its focus on patient choice as well as improving the health of the poorest in society, we believe that more needs to be done to ensure early identification of SLCN as well as positive intervention for these vulnerable children through improved joint commissioning arrangements.

1.2 In this submission we have used our experience to highlight the following areas:

- The need to ensure that the proposed NHS reforms do not result in a fragmentation of SLCN services, particularly given the need for collaboration between the health and education sectors.
- To urge the Government to transfer responsibility for the coordination of the commissioning of children's community health services, including speech and language therapy, to local authorities as proposed by the Education Select Committee in their report on Behaviour and Discipline.
- The need to differentiate between the commissioning of low need, high incidence and high need, low incidence SLCN, with responsibility for commissioning for high need SLCN placed at the regional level, as proposed in the Department for Education's Special Educational Needs Green Paper.
- Concerns that there will be insufficient representation of children's community health expertise on the proposed Health and Wellbeing Boards and the detrimental impact this could have on the joint commissioning of children's health services.
- The strong correlation between social disadvantage and poor communication skills and the need for commissioning arrangements to ensure that services are fair, enabling children and young people who do not find it easy to access services to find help through clear methods for referral to a specialist, as well as the need for targeted early intervention.

2. ABOUT I CAN

2.1 I CAN is the children's communication charity. Our mission is to ensure no child who struggles to communicate is left out or left behind. Our vision is a world where all children and young people who struggle to communicate receive the help they need so that they can have a happy childhood, make progress at school and thrive as adults.

2.2 We do this through:

- Increasing public awareness of the problems children face.
- Giving expert advice to parents and families about what to look out for and what to do.
- Providing assessments for children so that their families know what support will meet their needs.
- Giving teachers and people working with children the skills to help children who struggle.
- Campaigning to ensure children and families get a better deal.

2.3 At the very heart of I CAN are our special schools which give expert care and education to children with problems so severe their needs cannot be met elsewhere.

3. ABOUT THE COMMUNICATION TRUST

3.1 The Communication Trust is a coalition organisation bringing together over 40 voluntary and community sector organisations with expertise in children's speech, language and communication. Supported by the Department for Education, BT and other funders, The Communication Trust works to improve the speech, language and communication skills of children and young people and to ensure that children with speech, language and communication needs are better supported and included. The Communication Trust's primary audience is members of the children's workforce and those that set workforce policy and practice.

3.2 The Communication Trust has been appointed by the Government to deliver the National Year of Communication in 2011. The National Year aims to increase public understanding of how important it is for children and young people to develop good communication skills.

4. BACKGROUND TO SPEECH, LANGUAGE AND COMMUNICATION NEEDS

4.1 Speech language and communication skills are the basis for other key life skills: learning, literacy, positive relationships and regulation of behaviour and emotions.⁴⁴³ Speaking and listening skills underpin pupil outcomes; young people with good communication skills have a wider range of life chances.⁴⁴⁴

4.2 As many as 10% of children in the UK—over one million—have speech, language and communication needs, that require specialist help. This represents approximately three children in every classroom.⁴⁴⁵ Of this group, a large cohort—between 5–7% of the child population—have specific language impairment, meaning that they have difficulties with learning and using language that are **not** associated with factors such as general learning difficulties, or other conditions, such as cerebral palsy, hearing impairment or autistic spectrum disorders. A child with SLI might be bright, but struggle to understand the language used in the classroom, and thus struggle to attain and achieve.

4.3 Speech, language and communication needs can occur both in isolation and as the result of another disability, such as autism, Downs Syndrome or a hearing impairment.

4.4 Speech, language and communication needs are also strongly associated with mental health problems as well as other social emotional and behavioural difficulties.⁴⁴⁶

4.5 Speech, language and communication is the most common type of need in primary-aged children with statements of special educational need. 26.5% all mainstream-educated, statemented children in this age group have speech, language and communication as their primary need.⁴⁴⁷

4.6 I CAN's Cost to the Nation report highlighted that speech, language and communication difficulties impact most severely on those children in deprived areas. In some parts of the UK, those with high unemployment and poor housing, the prevalence rate of SLCN rises. As many as 50% of five year olds are arriving at school without the speech and language they need to fully participate and achieve their potential at school.⁴⁴⁸ This figure rises to 80% in some areas. However, with the right support, these children have the potential to catch up with their peers.

4.7 There is evidence of a high incidence of communication difficulties (often unidentified) in those who are young offenders^{449, 450}, looked after children⁴⁵¹ and those who have conduct disorder⁴⁵² as well as other social emotional and behavioural difficulties.^{453, 454} In addition to this, limited language skills make it difficult for young people to access support or understand interventions.⁴⁵⁵

4.8 Early identification is a preventative tool and mitigates the negative impact of speech, language and communication needs in terms of future health and well being and social disadvantage.

5. COMMISSIONING OF SLCN SERVICES

5.1 Commissioning is the cornerstone of a responsive and effective health service. However, from our experience, one of the biggest problems for those operating within the speech and language sector is the fragmented nature of commissioning and provision, most notably between local authorities and the NHS, but increasingly with schools as well. Speech and language services require effective commissioning to come through from a number of areas. Speech and Language Therapists (SLTs) are employed by the NHS, while many interventions for children with SLCN take place in education or early years settings, demonstrating the need for cooperation across the education and health sectors. Therefore, a lack of coordination of services, particularly between health and education commissioners, can severely impact on the effectiveness of provision for children and families with SLCN.

⁴⁴³ Silva P, Williams S & McGee R, (1987): *A Longitudinal Study of Children with Developmental Delay at age three years; later intellectual, reading and behaviour problems*. Developmental Medicine and Child Neurology 29, 630–640

⁴⁴⁴ *Improving Achievement in English Language in Primary and Secondary Schools* (2003) HMIE

⁴⁴⁵ I CAN, *The Cost to the Nation of Children's Poor Communication* (2006)

⁴⁴⁶ Toppelberg C O, Shapiro T (2000), Language disorders: A 10-year research update review. *Journal of the American Academy of Child & Adolescent Psychiatry* 39: 143–152

⁴⁴⁷ Department for Education, *Special Educational Needs 2010: an analysis, (October 2010)*

⁴⁴⁸ Locke, A. Ginsborg, J and Peers, I (2002) *Development and Disadvantage: Implications for Early Years IJLCD Vol 27 No 1*

⁴⁴⁹ Bryan, K. 2004. Preliminary study of the prevalence of speech and language difficulties in young offenders. *International Journal of Language and Communication Disorders*, 39, 391–400.

⁴⁵⁰ Snow PC, Powell MB (2007) Oral Language Competence, Social Skills and High-risk Boys: What are Juvenile Offenders Trying to Tell us? *Children & Society* (Online Early Articles). doi:10.1111/j.1099-0860.2006.00076.x

⁴⁵¹ Cross, M. Lost for words. (1999) *Child and Family Social Work* 4(3): 249–57

⁴⁵² Gilmour, J; Hill, B; Place, M. Skuse, D. H. (2004) Social communication deficits in conduct disorder: a clinical and community survey *Journal of Child Psychology & Psychiatry*. 45(5):967–978

⁴⁵³ Toppelberg C O, Shapiro T (2000), Language disorders: A 10-year research update review. *Journal of the American Academy of Child & Adolescent Psychiatry* 39: 143–152

⁴⁵⁴ Snow, P.C. & Powell, M.B. (2005). What's the story? An exploration of narrative language abilities in male juvenile offenders. *Psychology, Crime and Law* 11(3) 239–253.

Bryan K Freer J; Furlong C Language and communication difficulties in juvenile offenders (2007) *International Journal of Language & Communication Disorders* 42 2

⁴⁵⁵ Snow, P. & Powell, M. (2004). Interviewing juvenile offenders: The importance of oral language competence. *Current Issues in Criminal Justice* 16(2), 220–225.

5.2 In addition, collaboration will be ever more important for SLCN services given the greater commissioning powers granted to schools, particularly free schools and academies, under the Government's education reforms, meaning that Headteachers will now be in a position to commission specialist support, such as speech and language services, as well as the opening up of the provider market of health services to the private and voluntary sectors. Therefore it will be important for the Government to ensure a seamless transition across commissioning bodies as well as effective joint working, not just within the health sector, but also between education and health commissioners, including schools and SureStart centres.

5.3 However, I CAN and the Communication Trust are concerned that proposals in the NHS Public Health White Paper could result in the fragmentation of the commissioning of children's health services, particularly for SLCN services which are dependent on joint working. Arrangements need to be in place to ensure that commissioners are in a position to commission in the round for services provided by NHS and non-NHS agencies, whether local or regional, and to ensure that local commissioners do not simply "shunt" responsibility up the chain. It will also be important to develop effective communication channels with voluntary sector groups to ensure commissioners have an accurate picture of provision in their areas.

5.4 In addition, with the removal of the statutory duty for Children's Trusts Boards as well as the duty on schools to cooperate with the local authority in regard to children's well being,⁴⁵⁶ it will be important for alternative arrangements to be in place which enable SureStart centres and schools, particularly special schools, to engage with relevant local bodies in regard to children's health services to facilitate adequate and joined up provision across various agencies.

5.5 While I CAN and the Communication Trust see the potential for the proposed GP consortia to help to focus provision on the holistic needs of the individual child and family, we are concerned that devolving commissioning powers down to this level will fragment services for those with low incidence, high need SLCN. Given the low occurrence of such need and the usually high cost of the intervention required, it will be both difficult and costly for GP consortia to commission specialised services at the local level, particularly if only one child in their commissioning area requires such intervention. We believe that it is important for commissioners to commission at sufficiently large volumes to ensure they have a good understanding of client needs and of what constitutes quality and productivity in provider services, particularly given that many children with high need SLCN are likely to have a range of additional SEN support needs. Therefore, we would propose that the responsibility for the commissioning of these services should take place at the regional level to facilitate better joint working for these most vulnerable children and allow for cost savings to be made.

5.6 I CAN and the Communication Trust welcome the recent proposals in the Department for Education's SEN Green Paper⁴⁵⁷ which signal a move towards joined up provision via a holistic assessment of needs through new Education, Health and Social Care plans, but would like to note that this will again only be effective with greater coordination of commissioning across these sectors, particularly at the regional level for those with low incidence, high need. We would also like to ensure that these new plans place health and social care providers on a legal footing to match the statutory duties on local authorities in terms of educational resources.

5.7 In addition, evidence shows that only 9% of referrals to speech and language therapy services in London are currently made through GPs, demonstrating the complex web of referrals through education, social care and youth justice routes. Therefore it is important that all relevant agencies are involved in commissioning decisions, with the local authority acting as the lead, to ensure joined up provision services across.

5.8 Evidence demonstrates the strong correlation between social disadvantage and poor communication skills. I CAN and the Communication Trust welcome the focus of the Government's health reforms on improving the health and wellbeing of the poorest in society and would like to highlight the vital role that the early identification of and effective intervention for underlying SLCN can have on child development and improved life chances. New commissioning arrangements must ensure commissioners work together to target provision to the most vulnerable in society, particularly through the early identification of need.

5.9 In addition, whilst we welcome the Government's plans to expand the health visitor workforce, we are cautious about focusing solely on the role of health visitors in early identification (including identification of speech and language difficulties), as many young children, particularly those from poorer backgrounds, are not in contact with such early years professionals.

6. NEXT STEPS

6.1 In our view there are a number of actions that should be taken to ensure adequate quality and provision of SLCN services can be achieved within the Government's public health reforms.

6.2 As recommended by the Education Select Committee's recent report on Behaviour and Discipline,⁴⁵⁸ I CAN and the Communication Trust would like to see the transfer of responsibility for budgets and commissioning of all children's community health services (including speech therapy services) to local authorities in order to provide a more streamlined service to young people and their families, bridging the

⁴⁵⁶ As proposed in the Education Bill 2010–11

⁴⁵⁷ Department for Education, *Support and Aspiration: A new approach to SEN and Disability* (2011)

⁴⁵⁸ Education Select Committee, *Final Report of the Committee's Inquiry into Behaviour and Discipline* (February 2011)

gap between “specialist” and “non-specialist” interventions. We urge the Government to take forward this recommendation. The idea of locating responsibility for commissioning children’s community health services within local authority children’s services is not new, and is worth revisiting given the commissioner/provider split that has recently been achieved, meaning that staff in children’s community health services can remain employed by NHS provider organisations, with only the specification of the services they provide moving to the local authority.

6.3 GP consortia will also need to commission services when the access point is through them; however, unless the child’s needs are low incidence, high need then the referral should be to the local authority, who will be expected to work closely with GP consortia.

6.4 However, for low incidence, high need SLCN, we believe that commissioning should sit at the regional level, ie those defined as falling within the Specialised Services National Definitions Set. These specialised services include communication aid services, defined as including “expert assessment, followed by demonstration, trial and provision of appropriate electronic and non-electronic communication devices, ie augmentative and alternative communication systems (AAC), user training, equipment maintenance, on-going support and periodic review.” (4.3, SSNDS Definition No 5, page 5). We would propose that the commissioning of these services is conducted by the NHS and via the regional arrangements established in due course by the NHS Commissioning Board. The *Department for Education’s Special Educational Needs Green Paper* proposed that the commissioning of highly specialised services such as ACC become a core responsibility of the NHS Commissioning Board, and we welcome this proposal.

6.5 I CAN and the Communication Trust believes that the new Health and Wellbeing Boards are best placed to ensure integrated working between commissioners of NHS, public health and social care services, but would urge the Government to ensure they include adequate expertise in children’s community health services to enable effective joint commissioning, particularly for speech and language services. In addition, Health and Wellbeing Boards ought to develop effective communication channels with voluntary sector groups to ensure they have a picture of commissioning and provision in their areas. The recently published *Special Educational Needs Green Paper* also noted that Health and Wellbeing Boards will need to consider how the needs of children and young people with SEN can best be taken into account through the Joint Strategic Needs Assessment.⁴⁵⁹

6.6 However, schools and local authorities will also need to work closely together to commission for high incidence SLCN and we would like to see a duty placed on Health and Wellbeing Boards to ensure integrated working between both health and school commissioners. We also urge the Government to consider examining how NHS technology solutions could be applied to speech and language, in particular joining up commissioners in health and education with providers. If accessible by parents in a secure manner then parents will also be able to interact with both commissioners and providers and engage in meaningful dialogue with the decisions being made on their child’s behalf. There is already a precedent for this within healthcare through developments in the Summary Care Record and we would urge the Government to consider its extension to education commissioners.

6.7 The *Special Educational Needs Green Paper* also noted the Department of Health will consider how the needs of all children and young people, including those with SEN, can best be taken into account through guidelines and standards issued by NICE in regard to commissioning.⁴⁶⁰ I CAN and the Communication Trust welcome this move and would also like to see the NHS Commissioning Board develop commissioning guidance for SLCN services, and that NICE should be tasked with producing Quality Standards for speech and language under its expanded role to ensure minimal levels of service quality.

6.8 Given that almost 50% of children from disadvantaged communities have SLCN, which can lead to other health and wellbeing issues, we would like to see provision targeted, particularly through early identification. Frank Field MP’s recent *Independent Review on Poverty and Life Chances* recommended the introduction of Life Chances Indicators to measure children’s cognitive, physical and emotional development at the ages of three and five to allow for effective intervention, with the cognitive indicator including a specific measurement of speech and language development.⁴⁶¹

6.9 We would like to see the forthcoming Foundation Years Strategy set out in more detail the plans for universal screening for SLCN at 2–2½ (to tie into the Healthy Child Programme check) as recommended in Dame Clare Tickell’s Review of the Early Years Foundation Stage⁴⁶² and Graham Allen’s review of Early Intervention.⁴⁶³ We would urge the Government to take forward these recommendations.

6.10 We would also like to see more targeted screening for young people with identified risk factors, for example, a 10 point differential between verbal and non-verbal on CATs tests, behaviour, reading age etc. In addition, we encourage the Government to look at ways of supporting parents to assess need via an initial screening tool. This need not be onerous and should always come with the advice that formal diagnosis should be sought but may help reassure parents, many of whom struggle to understand why their child displays the characteristics which indicate SLCN but are unable to get a formal diagnosis.

⁴⁵⁹ Department for Education, *Support and Aspiration: A new approach to SEN and Disability* (March 2011)

⁴⁶⁰ Department for Education, *Support and Aspiration: A new approach to SEN and Disability* (March 2011)

⁴⁶¹ Frank Field MP, *The Foundation Years: Preventing Poor Children Becoming Poor Adults* (2011)

⁴⁶² Dame Clare Tickell, *The Early Years: Foundations for Life, Health and Learning* (2011)

⁴⁶³ Graham Allen MP, *Early Intervention: The Next Steps* (January 2011)

6.11 In addition, we would like to ensure effective mechanisms are in place to hold commissioners to account on their provision of services for children with special education needs, including a specific duty in regard to speech and language services, via the new Healthwatch organisations.

6.12 I CAN and the Communication Trust believe the voluntary and community sectors can contribute significantly to local approaches to improve public health. There are a number of actions that should be taken to address SLCN amongst children and which we would be able to help deliver including:

- Provide tools to help the wider children’s workforce including GP consortia and health visitors to identify and assess speech language and communication needs (SLCN) to help identify areas for development.
- Identify clear triggers for referral for specialist help with SLCN.
- The provision of that specialist help.
- Advice on how speech and language therapists form part of the multi disciplinary health team that works effectively with children and young people.

June 2011

Written evidence from National Pure Water Association Ltd (PH 164)

SUMMARY

- National Pure Water Association is calling for the repeal of all legislation underpinning artificial water fluoridation.
- Fluoride is not an essential nutrient.
- Fluoridation is unethical.
- There is no high-quality scientific evidence to show that fluoridation is either effective or safe.
- Fluoridation is harmful.
- Fluoridation is wasteful.
- Fluoridation does not reduce inequalities in dental health and disadvantages the poor.
- Water Act 2003 and Consultation Regulations—a Parliamentary Deception?
- The UK population is over-exposed to fluoride from all sources.
- The tide has turned against fluoridation.
- There is a safe, effective, equitable and cost-effective alternative to water fluoridation.
- Conclusion.

NATIONAL PURE WATER ASSOCIATION IS CALLING FOR THE REPEAL OF ALL LEGISLATION UNDERPINNING ARTIFICIAL WATER FLUORIDATION

1. Since its inception in the 1940s, fluoridation has been highly controversial. Subsequent paragraphs in this document will support our view that all the UK’s fluoridation legislation should be repealed and present fluoridation schemes ceased forthwith.

FLUORIDE IS NOT AN ESSENTIAL NUTRIENT

2. Scientists are in general agreement that fluoride is not an essential nutrient for humans. For example:

- (a) “No essential function for fluoride (F) has been proven in humans.”⁴⁶⁴
- (b) “Fluoride is not essential for human growth and development...”⁴⁶⁵

3. As fluoride is not an essential nutrient for humans, its addition to water supplies is not in the same category as the addition of an essential vitamin or mineral to food.

FLUORIDATION IS UNETHICAL

4. *Directive 2004/27/EC* on medicinal products for human use (31 March 2004) defines a “medicinal product” as:

- (a) any substance or combination of substances presented as having properties for treating or preventing disease in human beings; or
- (b) any substance or combination of substances which may be used in or administered to human beings either with a view to restoring, correcting or modifying physiological function by exerting a pharmacological, immunological or metabolic action, or to making a medical diagnosis.

⁴⁶⁴ Department of Health, Report on Health and Social Subjects, No. 41, *Dietary Reference Values for Food, Energy and Nutrients*, 1994.

⁴⁶⁵ *Opinion of the Scientific Panel on Dietetic Products, Nutrition and Allergies on a request from the Commission related to the Tolerable Upper Intake Level of Fluoride* (Request N° EFSA-Q-2003-018) (adopted on 22 February 2005).

5. Fluoridation clearly fulfils part (a) of this definition.

6. According to fundamental principles of medical ethics, it is quite wrong to subject any competent individual to a medical intervention he or she neither needs nor wants. Article five of the *European Convention on Human Rights and Biomedicine* states:

“An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.”

7. Ergo: Water Fluoridation is an unethical act of mass-medication.

8. NPWA does not agree with the Nuffield Council on Bioethics’ report—*Public health: ethical issues* (2007),⁴⁶⁶ which concluded:

“The most appropriate way of deciding whether fluoride should be added to water supplies is to rely on democratic decision-making procedures. These should be implemented at the local and regional, rather than national level, because the need for, and perception of, water fluoridation varies in different areas.”

9. Because fluoridation is unethical, we consider it inappropriate to hold consultations, voting procedures or referenda on whether it should be implemented.

10. Suggestions have been made that it is unethical to deprive young children of the benefits of fluoridation. NPWA rejects this as Alice-in-Wonderland ethics. As will be explained, fluoridation has no health benefits. The evidence of any benefit to teeth is extremely weak and the evidence that it causes harm is mounting.

THERE IS NO HIGH-QUALITY SCIENTIFIC EVIDENCE TO SHOW THAT FLUORIDATION IS EFFECTIVE OR SAFE

11. In 2000, 55 years after fluoridation began in the USA, the York Review⁴⁶⁷ team was unable to identify one high-quality study to show that the practice is effective or safe. On 28 October 2003, because of misrepresentation of its findings by fluoridation proponents, the York team issued a statement—*What the York Review on the fluoridation of drinking water really found*, which includes:

“We were unable to discover any reliable good-quality evidence in the fluoridation literature world-wide. What evidence we found suggested that water fluoridation was likely to have a beneficial effect, but that the range could be anywhere from a substantial benefit to a slight disbenefit to children’s teeth.

This beneficial effect comes at the expense of an increase in the prevalence of [dental] fluorosis.”

12. UK BASCD surveys⁴⁶⁸ of childhood dental health were rejected by the York Review team as they did not meet the team’s minimum criteria for evidence, which was Grade C—*Low quality, High Risk of Bias*.⁴⁶⁹

13. The (US) Center for Disease Control (CDC) conceded, in 1999, that the predominant benefit of fluoride in reducing tooth decay is mainly topical and not systemic.⁴⁷⁰

14. The graph below shows that tooth decay has declined sharply over the last 30 years. The fluoridation status of any country appears to have had no significant effect on the trend.

15. The latest (2010) five year-old tooth decay figures for fluoridated Birmingham⁴⁷¹ are worse than the national average.

⁴⁶⁶ Nuffield Council on Bioethics, *Public health: ethical issues*, 2007. www.nuffieldbioethics.org/public-health

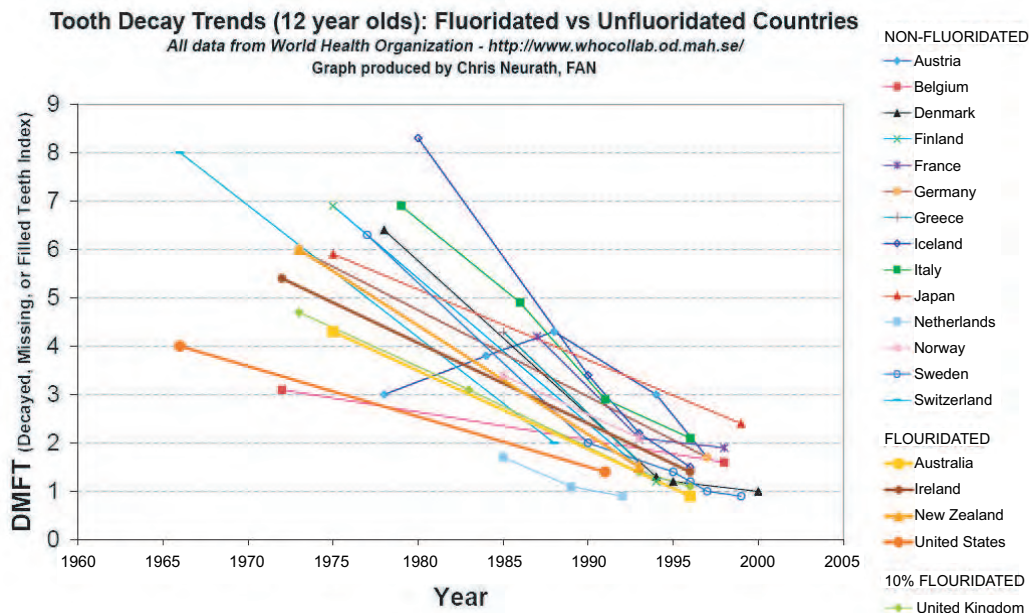
⁴⁶⁷ McDonagh et al. The NHS Centre for Reviews and Dissemination at the University of York—*A Systematic Review of Public Water Fluoridation*, 2000. www.york.ac.uk/inst/crd/fluorid.htm

⁴⁶⁸ British Association for the Study of Community Dentistry survey data—www.dundee.ac.uk/tuith/search/bdsearch.html

⁴⁶⁹ Ibid

⁴⁷⁰ US CDC, *Morbidity and Mortality Weekly Report*, 48(41):933–940,1999

⁴⁷¹ *Birmingham MCD Health Profile* (2010). Association of Public Health Observatories—www.apho.org.uk/resource/view.aspx?QN=HP_RESULTS&GEOGRAPHY=C3



FLUORIDATION IS PHYSICALLY AND PSYCHOLOGICALLY HARMFUL

16. “Dental fluorosis” is the term for the damage to the enamel of developing teeth caused by fluoride and is dose-dependent. The condition was first recognised in the 1930s and consists of opaque white patches (mottling), streaking, brown staining and pitting on up to 100% of the tooth surfaces.

17. When the so-called “optimum” level of 1 ppm for fluoridation was set, it was expected that 10% of children would be affected by very mild mottling of no more than 25% of the tooth surfaces.⁴⁷² The York Review (2000) estimated that 48% of children in fluoridated areas showed some degree of dental fluorosis *and* 12.5% had fluorosis severe enough to be of aesthetic concern. The United States, Canada, New Zealand, and the Irish Republic are all experiencing high levels of dental fluorosis and have, in recent years, reduced their target fluoridation levels to 0.7 ppm. Hong Kong reduced its level to 0.5 ppm in 1998.

18. Whenever fluoridation is implemented there will be a predictable increase in moderate and severe dental fluorosis. The unfortunate victims who cannot afford veneering at £250 to £450 per tooth suffer discrimination because their teeth are perceived to be dirty. They suffer disadvantage in the labour-market and psychological distress.⁴⁷³

19. In 2006, Bassin *et al*⁴⁷⁴ published a case control study which demonstrated a clear five- to seven-fold excess of osteosarcomas in males aged less than 20 living in a particular area if they had been exposed to a fluoridated water supply between the ages of five and eight (the time of a significant growth spurt, involving bone remodelling).

20. Ian E Packington, MA Chemistry (Oxon), Cert Tox (Barts), a scientific adviser to NPWA, has attributed the statistically significant and persistent excess of neonatal mortality in the West Midlands, compared with the rest of England and Wales, to the adverse gestational effects of fluoridation.⁴⁷⁵ This follows from the discovery that only in the fluoridated District Health Authorities were a substantial number of excess neonatal deaths found.

21. In November 2006, the American Dental Association issued an eGram—*Interim Guidance on Reconstituted Infant Formula*⁴⁷⁶ telling its members (dentists) not to recommend that mothers use fluoridated water for mixing infant formula feed. The (US) Center for Disease Control and the British Fluoridation Society, soon afterwards, also acknowledged that regularly mixing a baby’s formula with fluoridated water can cause dental fluorosis.

⁴⁷² Dean HT, Testimony of Isadore Zipkin, PhD, National Institutes of Health, Bethesda, Md, in Chemicals in Foods and Cosmetics: Hearings Before the House Select Committee to Investigate the Use of Chemicals in Foods and Cosmetics, House of Representatives, 82nd Congress (Washington, DC: US Government Printing Office, 1952), p1652.

⁴⁷³ Glasser G and Jones J. *Smile, Please—but don’t say ‘Cheese’*, published by NPWA and SPWA, July 2006. www.npwa.org.uk/files/smile_please_aug08.pdf

⁴⁷⁴ Bassin, Elise B, Wypij, David, Davis, Roger B, Mittleman, Murray A, 2006, Age-specific fluoride exposure in drinking water and osteosarcoma (United States). *Cancer Causes and Control*, 17:421–428.

⁴⁷⁵ Packington I, Perinatal Mortality and Fluoridation in the West Midlands, UK. *Fluoride Jnl*, 41(3) 243–244. www.fluoridresearch.org/413/files/FJ2008_v41_n3_p233-258.pdf

⁴⁷⁶ ADA, eGram—*Interim Guidance on Reconstituted Infant Formula*, 2006. www.fluoridealert.org/ada.egram.pdf

22. In 2006, a toxicological review of fluoride by the US National Research Council⁴⁷⁷ found that the US EPA's Maximum Contaminant Level Goal (MCLG) for fluoride of 4 mg/Litre (4 ppm) was not protective of health for severe dental enamel fluorosis, Stage II skeletal fluorosis and bone fracture in the elderly. Although the NRC Review did not evaluate the safety or efficacy of fluoridation at 1 ppm, their MCLG finding means there is legitimate doubt as to whether fluoridation allows for an adequate margin of safety to protect all consumers from fluoride's toxic effects.

23. NPWA is concerned by other issues considered by the NRC's Toxicological Review team. These are the effects of fluoride on the endocrine system (e.g. thyroid and pineal glands), cellular enzymes, cancer rates, the kidneys and the brain (and particularly the developing brain as a number of studies indicate that fluoride lowers IQ in children). Further research in these areas is warranted.

24. The late Dr George Waldbott's list of symptoms of "Chronic Fluoride Toxicity Syndrome"⁴⁷⁸ bears remarkable similarities to present-day problems of irritable bowel syndrome and ME/CFS, though these symptoms may have other causes besides fluoride. A Toxicological Profile⁴⁷⁹ by the US Dept of Health and Human Services emphasizes the inhibitory effect of fluoride on enzymes of glycolysis and the tricarboxylic acid cycle—the cellular enzymes which convert nutrients to energy. Such an inhibitory effect on enzymes is precisely what could bring about a wide range of symptoms and particularly those described by Waldbott. The Profile also notes that some subsets of the population are more susceptible than others to the toxic effects of fluoride and its compounds. These are people with cardiovascular problems, renal insufficiency, or poor nutritional status particularly in respect of calcium, magnesium and vitamin C.

25. Fluoride is a cumulative poison, the kidneys removing it at only about 1/3 to 1/2 the rate of intake, the rest being stored mainly in the bones. The effects of accumulated fluoride may not become apparent for decades, may mimic other illnesses such as arthritis and in the absence of testing may never be ascribed to fluoride. Most physicians are totally unaware of fluoride's toxic effects.

26. In India, crippling skeletal fluorosis caused by (natural) high levels of fluoride in ground water has disabled thousands of people. Professor Dr A K Susheela, a histochemist and a senior advisor to the Indian Government, is one of the world's leading researchers on the harmful effects of fluoride. In her book, "A Treatise on Fluorosis", she shows that fluoride has adverse effects on the red blood cells, calcium metabolism, tooth enamel, the gut lining, muscle, bone, connective tissue, the foetus and DNA.⁴⁸⁰ On 26 October 1998, Dr Susheela gave a presentation in the UK Parliament before the then Health Minister Tessa Jowell.⁴⁸¹ Ms Jowell asked "Why haven't we seen these health problems in our fluoridated areas?" Dr Susheela's reply was "You don't even have a government laboratory to test fluoride levels in blood and urine. If you don't look for the problems, how do you hope to find them?" Dr Susheela is strongly against fluoridation and advises "the less fluoride the better".

FLUORIDATION IS WASTEFUL

27. During the 2008 Southampton consultation, NPWA analysed where the City's water goes. We found that, if Southampton's water was fluoridated, only 0.014% of the fluorosilicic acid added would reach the target of 0- to five-year-olds—an amount so tiny it does not show on the pie chart below.

⁴⁷⁷ US NRC, *Fluoride in Drinking Water, A Scientific Appraisal of EPA's Standards*, National Academies Press, 2006.

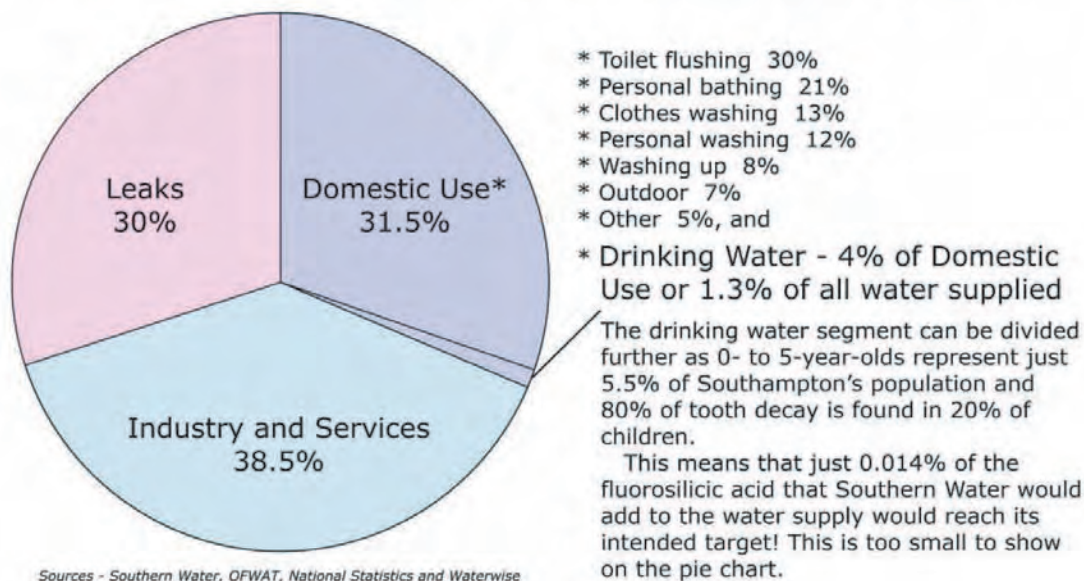
⁴⁷⁸ Waldbott G, *Fluoridation: The Great Dilemma*, Coronado Press Inc, 1978. List of Major Symptoms: Chronic Fluoride Toxicity Syndrome', pp 392–393.

⁴⁷⁹ Agency for Toxic Substances and Disease Registry (ATSDR), US Public Health Service, Toxicological Profile for Fluorides, Hydrogen Fluoride, and Fluorine, TP-91/17, Page 112, Sec. 2.7 (Health Impacts), April 1993. www.fluoridealert.org/ATSDR-Fluoride.pdf

⁴⁸⁰ Susheela, A K A Treatise on Fluorosis (2000) Fluorosis Research and Rural Development Foundation, B-1, Saransh, 34 I.P. Extension, Delhi 110 092. India. www.fluorideandfluorosis.com/Publications/Publications_Human.html

⁴⁸¹ Susheela A K, *Scientific Evidence on Adverse Effects of Fluoride on Human tissues*, Fluorosis Research Foundation of India, Presentation to UK Parliament, October 1998. www.fluorideandfluorosis.com/BritishParliament/Content.html

Where Southampton's water goes



FLUORIDATION DOES NOT REDUCE INEQUALITIES IN DENTAL HEALTH AND DISADVANTAGES THE POOR

28. The York Review team's report stated:

"The evidence about reducing inequalities in dental health was of poor quality, contradictory and unreliable."

It is therefore indefensible for anyone to claim that fluoridation helps the poor.

29. Fluoridation involves costs for anyone who wishes to avoid fluoride and thus also disadvantages the poor. The relatively inexpensive activated carbon water filters do not remove fluoride. Distillers and reverse osmosis machines can remove fluoride but are expensive to buy and to operate. The price of bottled water is prohibitive for the poor.

WATER ACT 2003 AND CONSULTATION REGULATIONS—A PARLIAMENTARY DECEPTION?

30. As the Water Act 2003 passed through both Houses of Parliament many assurances were given by Ministers that fluoridation schemes would not be imposed on communities without a majority of the population in favour. For example:

*"We do not intend that water should be fluoridated come what may in those areas which do not currently receive naturally or artificially fluoridated water at a level capable of reducing dental decay. In fact, the enactment of the amendment may not lead to any new fluoridation schemes—that would depend on what people decided locally—but it would give local communities the choice of having their water supply fluoridated."*⁴⁸²

31. The 2004 draft Consultation Regulations⁴⁸³ were in accordance with the many Parliamentary assurances given. The final Consultation Regulations, approved by both Houses of Parliament in early 2005, were not.⁴⁸⁴ The 2005 regulation allowed South Central SHA, on 26 February 2006, to ignore the local community's rejection of the proposed scheme for Southampton and south west Hampshire. Both respondents to the consultation and those who took part in the SHA-commissioned telephone poll opposed the scheme by a majority. This sham consultation was an abuse of the principles of democracy. Local Members of Parliament have declared they will do all they can to thwart the fluoridation scheme.

32. If a fluoridation scheme is imposed on Hampshire residents it will violate their right to refuse consent to a medical intervention. This is completely unacceptable to the members and supporters of NPWA. Only by repeal of the relevant fluoridation legislation may our proper democratic rights and freedoms be restored. This authoritarian legislation must be removed from *our* Statute Book.

⁴⁸² Lord Warner, PUSS, DoH, Lords Hansard, *Water Bill [HL]*, 9 July 2003: Column 300. www.publications.parliament.uk/pa/ld200203/ldhansrd/v030709/text/30709-07.htm

⁴⁸³ Department of Health, *The Water Fluoridation (Consultation) Regulations 2004*. http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4093268

⁴⁸⁴ Department of Health, *The Water Fluoridation (Consultation) Regulations 2005*. www.legislation.gov.uk/uksi/2005/921/made

THE UK POPULATION IS OVER-EXPOSED TO FLUORIDE FROM ALL SOURCES

33. In 2010, a study by Dr Peter Mansfield revealed that we are already over-exposed to fluoride, with 25% of us getting more than is safe. This figure rises to 67% in fluoridated areas.⁴⁸⁵

34. British people are nowadays more likely to obtain excessive amounts of fluoride from sources other than water. The concentration of fluoride in the water tells us nothing about any individual's dose, which depends on the quantity of water drunk and the intake of fluoride from tea, fish and other foods, toothpaste, toiletries, medicines and dental treatments. Fluoridation gives absolutely no control over any individual's fluoride intake. A fluoridated water supply can add 2, 3 or more milligrams a day to a person's toxic load.

THE TIDE HAS TURNED AGAINST FLUORIDATION

35. Worldwide, the practice of fluoridation is far from extensive. Only 6% of the world's population has fluoride administered to them via their water supplies. In Europe, only 2% of the population receive artificially fluoridated water.

36. Since 1990 at least 270 communities worldwide have rejected fluoridation. Switzerland ceased fluoridation in 2003, its scientists citing:

- (1) Lack of evidence that water fluoridation is more effective than salt fluoridation in reducing tooth decay, and
- (2) The inefficiency/wastefulness of water fluoridation.

37. To date 3,722 professionals, many of them eminent in their field, have signed the US-based Fluoride Action Network's Professionals' Statement calling for an end to water fluoridation.⁴⁸⁶

38. Slowly but surely people from around world are learning the truth about fluoride and fluoridation. The tide has turned against fluoridation and it is only a matter of time before fluoridation ends.

THERE IS A SAFE, EFFECTIVE, EQUITABLE AND COST-EFFECTIVE ALTERNATIVE TO WATER FLUORIDATION

39. A better way to improve oral health in those at high risk is the needs-based programme first trialed in Varmland County, Sweden. Initially focusing on expectant mothers in order to minimize the transmission of Strep mutans from mother to baby, this integrated dental care programme, together with the encouragement of personal responsibility for oral health, has proved highly successful in Sweden and other Scandinavian countries.⁴⁸⁷

CONCLUSION

40. Far from being a safe and effective caries intervention for children and adults of all ages, fluoridation is a singularly ineffective and harmful use of scarce NHS dental funds which could, and should, be far more carefully targeted at the families most in need of oral health education and dental treatment.

41. Politicians and health authorities are irresponsible to call for fluoridation in the face of the evidence presented above. The Precautionary Principle should be adopted, the legislation repealed and fluoridation ceased rather than extended to thousands more unwilling consumers.

June 2011

RECOMMENDED READING

The Case Against Fluoride: How Hazardous Waste Ended Up in Our Drinking Water and the Bad Science and Powerful Politics That Keep It There by Professors Paul Connett, James Beck, Spedding Micklem (2010). Chelsea Green Publishing. ISBN: 978-1603582872

Fluoride in Drinking Water—A scientific evaluation of EPA's standards (March 2006). The US National Research Council ISBN: 978-0309101288
http://www.nap.edu/catalog.php?record_id=11571

FLUORIDE FATIGUE Fluoride Poisoning: is fluoride in drinking water—and from other sources—making you sick? by Dr Bruce Spittle (2008). ISBN: 978-0473129910
<http://www.pauapress.com/fluoride/files/1418.pdf>

The Fluoride Deception by Christopher Bryson (2006). Pub. Seven Stories Press. ISBN: 978-1583227008

Susheela A K, A Treatise on Fluorosis (2000) Fluorosis Research and Rural Development Foundation, B-1, Saransh, 34 I.P. Extension, Delhi 110 092 India.
<http://www.fluorideandfluorosis.com/index.htm>

⁴⁸⁵ Mansfield P, Water fluoridation and total fluoride intake, *Fluoride Journal*, 2010, v4, n4, p223-231.
http://fluorideresearch.powweb.com/wpgeneral/434/files/FJ2010_v43_n4_p223-231.pdf

⁴⁸⁶ Fluoride Action Network, *Professionals' Statement to End Fluoridation*. <http://fluoridealert.org/professionals.statement.html>

⁴⁸⁷ Packington I, *Successful Control of Dental Caries in Sweden Without Fluoridation*, NPWA, November 2008. www.npwa.org.uk/files/varmland_general_fin.pdf

WEBSITES

www.npwa.org.uk www.fluoridealert.org

Written evidence from the Greater Merseyside Directors of Public Health (PH 165)

SUMMARY

- Consideration of the integration of health care, social care and public health and necessary structures should have preceded proposals for the reform of the National Health Service
- The fragmentation of a relatively small expert public health workforce could lead to insufficient support of GP Commissioning and Health and Wellbeing Boards in the local determination of health needs and achievement of health outcomes. Training and development of the public health workforce should retain the status of a speciality training scheme and continue to be delivered through the Deaneries.
- The Director of Public Health should have executive director status within the local authority and report directly to the Chief Executive. The leadership role of the DPH within the health economy should be apparent from the recognition of public health links within local authorities and with primary and secondary care, third sector and private organisations.
- Health and Wellbeing Boards should have the power to require data from any NHS or social care funded organisation and have the power to sign off area commissioning plans that are based on the JSNA and have been developed to achieve the outcomes of the Joint Health and Wellbeing Strategy.

THE ROLE OF PUBLIC HEALTH IN THE REFORMS

1. In response to the call for evidence to be submitted to the inquiry into Public Health, we would wish to suggest that the scheduling of health and care reform as put forward by the Government has been incorrectly ordered, leading to confusion about the role of public health in the local authority, the role of the local authority in public health and the need to integrate NHS services, social care and public health. Proposals on the future of population health since April 2010 have lagged behind proposals on the intended form of healthcare structures.

2. The introduction of the health and social care bill after the government's response to Liberating the NHS but before a response to the Public Health White Paper has meant that public health staff have been working with a future NHS model that does not include public health, while the future relationship of population health with health and care services is still the subject of consultation. It was notable that the "Pause, Reflect, Listen, Improve" listening exercise was based on the future NHS model without public health and there was no reference to public health even under the "Advice and Leadership" topic.

3. The web channel on health and care changes on the Department of Health website is titled "Modernisation of health and care" rather than NHS reform, highlighting the barrier of regarding the NHS as a static entity dealing with "health" or "ill-health" rather than as part of a complex system. We would suggest that a return to the aims of improving health, care and wellbeing outcomes through modernisation may clarify possible relationships of health system elements and the role of public health as part of that system.

ROLE OF THE DIRECTOR OF PUBLIC HEALTH

4. Directors of Public Health will oversee and direct work in all three areas of public health. The DPH role is that of the linchpin of the local NHS, social care and public health system, bringing structures together and making them stronger by their presence. In order to fulfil the "Vision of the role of the Director of Public Health" (Annex A Healthy Lives, Healthy People) the prime importance of the DPH role must be recognised and the following will need to be implemented:

- The DPH must be required to have specialist public health registration and be appointed through an equivalent formal Appointments process to that currently in place.
- Every first tier local authority must appoint a DPH with accountability to the Chief Executive, executive team membership and direct access to elected members and their executive group.
- The DPH must be able to express professional, independent views as the advocate for the health of the local population.
- The DPH will be the principal adviser to the Health and Wellbeing Board on health matters and all local authority functions and their impact on the health of the population.
- The DPH must have sufficient resources including professionally trained staff with the knowledge and skills to deliver strategic public health advice and plan and implement public health programmes across the three public health domains.

5. The role of Directors of Public Health is at the heart of these health and care reforms yet there is little recognition of the excellent public health links built within the NHS and local authorities and between the NHS, local authorities and the third and private sectors. The appointment of joint DsPH and the extensive exercise of their influence and leadership within local authorities has meant that the interest of local authorities

in taking responsibility for health improvement through health prevention has been refreshed and executive teams are very much aware of the health impacts of social determinants. Equally, DsPH have worked closely with primary and secondary care in relation to effective prevention, but also on identifying and modelling disease populations and profiling practice populations.

6. There is a remarkable level of expectation, both personal and professional, of Directors of Public Health in implementing these reforms, yet the reciprocal expectation they might have, such as recognition of their professional position within local authorities, their continuing professional accountability, and clarity as to the staff and resources they will be able to direct, has not been met.

PUBLIC HEALTH WORKFORCE

7. All public health staff need to retain their link with NHS health services and should be part of the national public health service through their terms of employment, wherever their working location (public health specialists have roles in universities, trusts and other locations and may in future work in other areas in addition to local authorities and consortia).

8. Taking public health staff out of the NHS in entirety would mean the loss of expertise developed since the function moved into the NHS, especially the positive advisory relationship with other health services and organisations that needs to be maintained and enhanced from local authorities.

Public Health Training

9. PHE having the role of public health staff employer would mitigate against fragmentation of the public health workforce and enable the continuance of the public health specialist training scheme to build necessary capacity. Public health training should be equivalent to that for other health professionals and delivered through Health Education England via the existing Deanery network.

Public Health Specialists

10. The public health workforce has been categorised as specialists, practitioners and the wider public health workforce who may not be working within public health teams.

11. Consideration of the future of the public health workforce has primarily been in terms of specialists, who have achieved or are working towards, registration by the GMC or UK Public Health Register according to Faculty of Public Health standards. Registration can be achieved through the Faculty training scheme, by conversion from another medical or dental specialty, or through voluntary registration by submission of a portfolio for those who have public health expertise but have not been on the training scheme.

12. Those public health professionals who are not clinically registered are not statutorily regulated and cannot be held to account. Statutory regulation of public health specialists will provide equity and public accountability.

13. Consideration needs to be given to registration for existing practitioners and future routes into such roles. Beyond these two categories it is possible that all NHS and local authority staff may be said to have public health aspects to their roles, and therefore to be available to DsPH as a resource to deliver on population health, but it is not clear whether only staff in specialist and practitioner roles would be designated as public health staff in local authorities. GP training and continuing professional development in public health should be strengthened and some form of accreditation considered.

ROLE OF PUBLIC HEALTH ENGLAND

14. Public Health England (PHE) is expected to form through taking on the functions of the Health Protection Agency, and the Public Health Observatories (PHOs). PHE would become part of the Department of Health. Both the Health Protection Agency and the Public Health Observatories have two functions that are not compatible with PHE becoming part of the Department of Health: recognition of the independence of their advice and expertise, and the generation of income from supplying knowledge and expertise. Additionally, they both require a sub-national structure in order to perform their functions effectively.

Health Protection

15. The structures through which health protection will be delivered and the accountabilities within those structures are not clear which is concerning given that these proposals form the majority of the specification of PHE. The responsibilities of local health protection units and DsPH need to be specified more completely, both for ongoing health protection work and emergency situations. DsPH must have the power to require any agency to respond if needed in preparation for or during incidents.

Public Health Observatories

16. Public Health Observatories (PHOs) located in universities are a valuable academic link and take both a regional perspective and a lead on agreed areas of public health intelligence. Nationally, public health

information needs to be more closely linked to the Information Centre which will process inputs and outputs relating to the NHS and Social Care Outcomes Frameworks. PHOs provide input at all stages of the population health commissioning cycle and its subsets. Clarification on what resource would be available through the PHOs for local authorities and NHS bodies would be necessary. The reduction in funding for PHOs and the loss of expert staff through uncertainty will result in a lack of capacity for an already scarce resource just as GP Consortia and Local Authorities need intensive support.

17. If the NHS is to become a “health” service rather than an “ill-health” service then the logic of removing a population prevention and protection function from it is not apparent, particularly if part goes to the Department of Health and part into Local Authorities, breaking the NHS link in two directions.

Public Health Leadership

18. PHE has been proposed as a “national” public health service but currently has only specified roles for the agencies that are to form it, and for Directors of Public Health (DsPH). It is unclear how PHE expects to fulfil its national leadership role for the whole of public health across the three domains of health improvement, health protection and health services, or what its relationship would be with the National Commissioning Board. PHE needs to be established as an NHS body such as a Special Health Authority to fully utilise its specialist public health functions..

FUNCTION OF HEALTH AND WELLBEING BOARDS

19. Health and Wellbeing Boards (HWBs) should be the driving force behind needs assessment, prioritisation and collaborative commissioning for local population health. They will work towards the integration of NHS services, social care and public health, with the aim of ensuring provision of seamless, person centred services. HWBs will oversee local commissioning for populations and for services to individuals. HWBs should take responsibility for ensuring health equity in all policy.

20. HWBs should aim to implement person centred elements of Liberating the NHS such as provision of appropriate information and involvement in decision making across all locally commissioned health, care and wellbeing services. HWBs will have the responsibility for Strategic Needs Assessment and Health and Wellbeing Strategies and should have the power to sign off commissioning plans that should deliver within the population health commissioning cycle.

- Health, care and wellbeing needs should be determined for local authority populations.
- Health, care and wellbeing outcomes should be agreed in accordance with the local authority responsibility for population health improvement, health protection and reduction of health inequalities, to be achieved within agreed time periods and performance measured by agreed instruments.
- A Health, Care and Wellbeing Strategy should set out how the outcomes are to be achieved.
- A set of commissioning plans should set out the specifications for the services to deliver the outcomes and how resources will be used.
- Activity should be performance managed, performance should be evaluated and population needs reassessed.

UNDERSTANDING NEEDS

Joint Strategic Needs Assessment

21. The Joint Strategic Needs Assessment process has been a joint responsibility of Local Authorities and Primary Care Trusts. Much of the input to JSNA will have been public health expertise, addressing all three of the domains of public health: health improvement, health protection and health services. The Strategic Needs Assessment process should not be “Joint” in name, but through the requirement on all parties to engage. The current proposal to share responsibility for ensuring the process is undertaken between GP Commissioners and Local Authorities with a lead role for the DPH needs to be underwritten with a requirement for any health and social care funded body to contribute information and expertise, and for Local Authorities to be able to require the same in relation to economic, social and environmental determinants of health. GP Consortia will need to be engaged in and provide leadership for the JSNA process as it will form the foundation of commissioning decisions. Public Health expertise will be invaluable in changing primary and secondary care culture to consider population need as part of the commissioning cycle and in designing care pathways.

Public Health Intelligence

22. Public health intelligence is needed at national, regional and local levels to specify what data is collected, and in what way, to analyse it and interpret it in context. Public health intelligence is the driver for evidence based commissioning for population health. Public health provides some of the strongest tools for assessment, such as asset based approaches, impact assessment and participatory research. Public health also takes a population view of consultation, engagement and involvement, recognising that health, care and wellbeing are whole population issues, rather than just the population accessing services.

23. The Public Health Intelligence workforce has always been a highly skilled but scarce resource that does not necessarily sit within NHS Public Health departments. Given the current lack of incentive for public health intelligence staff to define themselves as such, the reforms could precipitate the loss of this resource just as it comes under pressure to support the new roles of GP commissioners and the Health and Wellbeing Boards. Developing secure training routes for the public health intelligence workforce will be a priority as well as ensuring continuing professional development opportunities and support networks for this distributed workforce.

Public Health Outcomes

24. The Public Health Strategy for England and the Public Health Outcomes Framework were both issued for consultation some months after the proposals in Liberating the NHS and the NHS and Social Care Outcomes Frameworks. The government has yet to respond to the public health consultations, but the initial NHS and Social Care Outcomes Frameworks have both been finalised. The outcome frameworks to deliver population health have therefore been agreed prior to consideration of wider issues, not only the determinants of health, but international and global priorities such as demographic change and health threats. One outcomes framework with associated responsibilities for implementation would be preferable.

25. The result of the Strategic Needs Assessment process that engages all relevant bodies should be a strategy that is owned by the local authority and its population. The strategy should describe the activity that is to be prioritised, the evidence for it and what it aims to achieve.

PUBLIC HEALTH INVOLVEMENT IN COMMISSIONING

Commissioning Plans

26. Several sets of commissioning plans will be needed to implement the strategy (GP commissioning, public health commissioning, social care commissioning, children's, employment and skills etc) and should reference each other. The HWB must coordinate the commissioning plans for consistency, efficiency and quality and should sign them off as the set of plans that will deliver for the Health and Wellbeing Strategy. HWBs should be able to hold GP consortia to account for public health outcomes.

27. Public health involvement in commissioning must be recognised at all levels from the National Commissioning Board to GP consortia, with a requirement for all commissioners to seek and take account of public health advice. The expertise of public health in commissioning of health services should be highlighted.

Commissioning Public Health programmes

28. Responsibility for Public Health commissioning should originate at local authority level through the DPH with regional or national commissioning only where local commissioning is inefficient. Anomalies such as the divide in children's commissioning must be resolved.

29. Public health funding proposals offer perverse incentives, literally in the case of the health premium. Premiums should be attracted to populations with the worst health and wellbeing without performance conditions. Evidence of collaborative use of premiums directed through the HWBs would be more appropriate.

PUBLIC HEALTH BUDGET

Ring fenced budget

30. The proposal for a ringfenced public health budget holds out the illusion of dedicated funding for population health activity but is a tenuous concept with no indication of what it might have to fund and who might be able to access it. If local authorities are to embrace their population health responsibilities, it must be clear that any ringfenced budget is funding the transition of a public health service, while core funding will be used to deliver outcomes. Public Health departments should be asked to list essential public health delivery functions for sustainable inclusion in local authority responsibilities, rather than list what a (possibly time limited) ringfenced budget should fund.

31. Directors of Public Health, through the JSNA and the Joint Health and Wellbeing Plan, should be able to direct resource to evidence based public health activity from all NHS and social care funded organisations, including NHS and Foundation Trusts. Economies and efficiencies are possible through training, commissioning and intelligence where the health economy works to the same objectives and there is recognition of public health priorities.

Partnership working

32. Considerable efforts have been made by health and wellbeing partnerships to maximise the impact of health inequalities funding such as Neighbourhood Renewal Fund and single budgets such as Area Based Grant on population health and wellbeing through public health delivery programmes. The 2010–11 in year savings requirements and abolition of Area Based Grant caused the loss of exactly those partnerships and integrated programmes that the Public Health White Paper exhorted public health to develop on its publication three

months later. It is concerning that the government appeared unable to recognise the impact withdrawal of Area Based Grant would have for health and wellbeing commissioners across the health economy.

June 2011

Written evidence from the Department of Public Health, Liverpool Primary Care Trust (PH 166)

SUMMARY

- Consideration of the integration of health care, social care and public health and necessary structures should have preceded proposals for the reform of the National Health Service.
- Excision of public health expertise from the NHS and dispersal into local authorities and Public Health England will tip the balance in a different direction rather than providing equality of resource.
- Health and Wellbeing Boards should have the power to sign off area commissioning plans that are based on the JSNA and have been developed to achieve the outcomes of the Joint Health and Wellbeing Strategy.
- The Director of Public Health should have executive director status within the local authority and report direct to the Chief Executive.

LINKS BETWEEN PUBLIC HEALTH AND NHS COMMISSIONING

1. In response to the call for evidence to be submitted to the inquiry into Public Health, we would wish to suggest that the scheduling of health and care reform as put forward by the Government has been incorrectly ordered, leading to confusion about the role of public health in the local authority, the role of the local authority in public health and the need to integrate NHS services, social care and public health. Proposals on the future of population health since April 2010 have lagged behind proposals on the intended form of healthcare structures.

2. The introduction of the health and social care bill after the government's response to Liberating the NHS but before a response to the Public Health White Paper has meant that public health staff have been working with a future NHS model that does not include public health, while the future relationship of population health with health and care services is still the subject of consultation. It was notable that the "Pause, Reflect, Listen, Improve" listening exercise was based on the future NHS model without public health and there was no reference to public health even under the "Advice and Leadership" topic.

3. The web channel on health and care changes on the Department of Health website is titled "Modernisation of health and care" rather than NHS reform, highlighting the barrier of regarding the NHS as a static entity dealing with "health" or "ill-health" rather than as part of a complex system. We would suggest that a return to the aims of improving health, care and wellbeing outcomes through modernisation may clarify possible relationships of health system elements and the role of public health as part of that system.

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PUBLIC HEALTH LEADERSHIP

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PUBLIC HEALTH WORKFORCE

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10. Taking public health staff out of the NHS in entirety would mean the loss of expertise developed since the function moved into the NHS, especially the positive advisory relationship with other health services and organisations that needs to be maintained and enhanced from local authorities.

Public Health Training

11. PHE having the role of public health staff employer would mitigate against fragmentation of the public health workforce and enable the continuance of the public health specialist training scheme to build necessary capacity. Public health training should be equivalent to that for other health professionals and delivered through Health Education England via the existing Deanery network.

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12. The public health workforce has been categorised as specialists, practitioners and the wider public health workforce who may not be working within public health teams.

13. Consideration of the future of the public health workforce has primarily been in terms of specialists, who have achieved or are working towards, registration by the GMC or UK Public Health Register according to Faculty of Public Health standards. Registration can be achieved through the Faculty training scheme, by conversion from another medical or dental specialty, or through voluntary registration by submission of a portfolio for those who have public health expertise but have not been on the training scheme.

14. Those public health professionals who are not clinically registered are not statutorily regulated and cannot be held to account. Statutory regulation of public health specialists will provide equity and public accountability.

15. Consideration needs to be given to registration for existing practitioners and future routes into such roles. Beyond these two categories it is possible that all NHS and local authority staff may be said to have public health aspects to their roles, and therefore to be available to DsPH as a resource to deliver on population health, but it is not clear whether only staff in specialist and practitioner roles would be designated as public health staff in local authorities. GP training and continuing professional development in public health should be strengthened and some form of accreditation considered.

ROLE OF THE DIRECTOR OF PUBLIC HEALTH

16. Directors of Public Health will oversee and direct work in all three areas of public health. The DPH role is that of the linchpin of the local NHS, social care and public health system, bringing structures together and making them stronger by their presence. In order to fulfil the “Vision of the role of the Director of Public Health” (Annex A Healthy Lives, Healthy People) the prime importance of the DPH role must be recognised and the following will need to be implemented:

- The DPH must be required to have specialist public health registration and be appointed through an equivalent formal Appointments process to that currently in place.
- Every first tier local authority must appoint a DPH with accountability to the Chief Executive, executive team membership and direct access to elected members and their executive group.
- The DPH must be able to express professional, independent views as the advocate for the health of the local population.
- The DPH will be the principal adviser to the Health and Wellbeing Board on health matters and all local authority functions and their impact on the health of the population.

- The DPH must have sufficient resources including professionally trained staff with the knowledge and skills to deliver strategic public health advice and plan and implement public health programmes across the three public health domains.

Function of Health and Wellbeing Boards

17. Health and Wellbeing Boards (HWBs) should be the driving force behind needs assessment, prioritisation and collaborative commissioning for local population health. They will work towards the integration of NHS services, social care and public health, with the aim of ensuring provision of seamless, person centred services. HWBs will oversee local commissioning for populations and for services to individuals. HWBs should take responsibility for ensuring health equity in all policy.

18. HWBs should aim to implement person centred elements of Liberating the NHS such as provision of appropriate information and involvement in decision making across all locally commissioned health, care and wellbeing services. HWBs will have the responsibility for Strategic Needs Assessment and Health and Wellbeing Strategies and should have the power to sign off commissioning plans that should deliver within the population health commissioning cycle.

- Health, care and wellbeing needs should be determined for local authority populations.
- Health, care and wellbeing outcomes should be agreed in accordance with the local authority responsibility for population health improvement, health protection and reduction of health inequalities, to be achieved within agreed time periods and performance measured by agreed instruments.
- A Health, Care and Wellbeing Strategy should set out how the outcomes are to be achieved.
- A set of commissioning plans should set out the specifications for the services to deliver the outcomes and how resources will be used.
- Activity should be performance managed, performance should be evaluated and population needs reassessed.

UNDERSTANDING NEEDS

Joint Strategic Needs Assessment

19. The Joint Strategic Needs Assessment process has been a joint responsibility of Local Authorities and Primary Care Trusts. Much of the input to JSNA will have been public health expertise, addressing all three of the domains of public health: health improvement, health protection and health services. The Strategic Needs Assessment process should not be “Joint” in name, but through the requirement on all parties to engage. The current proposal to share responsibility for ensuring the process is undertaken between GP Commissioners and Local Authorities with a lead role for the DPH needs to be underwritten with a requirement for any health and social care funded body to contribute information and expertise, and for Local Authorities to be able to require the same in relation to economic, social and environmental determinants of health. GP Consortia will need to be engaged in and provide leadership for the JSNA process as it will form the foundation of commissioning decisions. Public Health expertise will be invaluable in changing primary and secondary care culture to consider population need as part of the commissioning cycle and in designing care pathways.

Public Health Intelligence

20. Public health intelligence is needed at national, regional and local levels to specify what data is collected, and in what way, to analyse it and interpret it in context. Public health intelligence is the driver for evidence based commissioning for population health. Public health provides some of the strongest tools for assessment, such as asset based approaches, impact assessment and participatory research. Public health also takes a population view of consultation, engagement and involvement, recognising that health, care and wellbeing are whole population issues, rather than just the population accessing services.

21. The Public Health Intelligence workforce has always been a highly skilled but scarce resource that does not necessarily sit within NHS Public Health departments. Given the current lack of incentive for public health intelligence staff to define themselves as such, the reforms could precipitate the loss of this resource just as it comes under pressure to support the new roles of GP commissioners and the Health and Wellbeing Boards. Developing secure training routes for the public health intelligence workforce will be a priority as well as ensuring continuing professional development opportunities and support networks for this distributed workforce.

Public Health Outcomes

22. The Public Health Strategy for England and the Public Health Outcomes Framework were both issued for consultation some months after the proposals in Liberating the NHS and the NHS and Social Care Outcomes Frameworks. The government has yet to respond to the public health consultations, but the initial NHS and Social Care Outcomes Frameworks have both been finalised. The outcome frameworks to deliver population health have therefore been agreed prior to consideration of wider issues, not only the determinants of health,

but international and global priorities such as demographic change and health threats. One outcomes framework with associated responsibilities for implementation would be preferable.

23. The result of the Strategic Needs Assessment process that engages all relevant bodies should be a strategy that is owned by the local authority and its population. The strategy should describe the activity that is to be prioritised, the evidence for it and what it aims to achieve.

PUBLIC HEALTH INVOLVEMENT IN COMMISSIONING

Commissioning Plans

24. Several sets of commissioning plans will be needed to implement the strategy (GP commissioning, public health commissioning, social care commissioning, children's, employment and skills etc) and should reference each other. The HWB must coordinate the commissioning plans for consistency, efficiency and quality and should sign them off as the set of plans that will deliver for the Health and Wellbeing Strategy. HWBs should be able to hold GP consortia to account for public health outcomes.

25. Public health involvement in commissioning must be recognised at all levels from the National Commissioning Board to GP consortia, with a requirement for all commissioners to seek and take account of public health advice. The expertise of public health in commissioning of health services should be highlighted.

Commissioning Public Health programmes

26. Responsibility for Public Health commissioning should originate at local authority level through the DPH with regional or national commissioning only where local commissioning is inefficient. Anomalies such as the divide in children's commissioning must be resolved.

27. Public health funding proposals offer perverse incentives, literally in the case of the health premium. Premiums should be attracted to populations with the worst health and wellbeing without performance conditions. Evidence of collaborative use of premiums directed through the HWBs would be more appropriate.

PUBLIC HEALTH BUDGET

Ring fenced budget

28. The proposal for a ringfenced public health budget holds out the illusion of dedicated funding for population health activity but is a tenuous concept with no indication of what it might have to fund and who might be able to access it. If local authorities are to embrace their population health responsibilities, it must be clear that any ringfenced budget is funding the transition of a public health service, while core funding will be used to deliver outcomes. Public Health departments should be asked to list essential public health delivery functions for sustainable inclusion in local authority responsibilities, rather than list what a (possibly time limited) ringfenced budget should fund.

Partnership working

29. Considerable efforts have been made by health and wellbeing partnerships to maximise the impact of health inequalities funding such as Neighbourhood Renewal Fund and single budgets such as Area Based Grant on population health and wellbeing through public health delivery programmes. The 2010–11 in year savings requirements and abolition of Area Based Grant caused the loss of exactly those partnerships and integrated programmes that the Public Health White Paper exhorted public health to develop on its publication three months later. It is concerning that the government appeared unable to recognise the impact withdrawal of Area Based Grant would have for health and wellbeing commissioners across the health economy.

June 2011

Written evidence from County Councils Network (PH 167)

CCN

1. The County Councils Network (CCN) is a cross-party special interest group of the Local Government Association which speaks, develops policy and shares best practice for the County family of local authorities, whether unitary or upper tier. CCN's 38 member councils, with over 2,500 Councillors, serve 24 million people over 45 thousand square miles or 87% of England.

2. CCN works on an inclusive and all party basis, and recognises that member authorities must have the right to respond to their communities in different ways. We seek to make representations to government that can be supported by all member authorities.

INTRODUCTION

3. CCN welcomes the opportunity to submit evidence to the Health Select Committee on the issue of Public Health. In our response we highlight key issues for member councils arising from the proposals set out in the

Public Health White Paper and the Health and Social Care Bill. As a special interest group (SIG) of the LGA CCN firmly endorses the overall response submitted by the LGA.

4. CCN strongly supports the general direction of the proposals to return to councils a leading role in improving, promoting and protecting the health of their local communities. We welcome the commitment to move from a centralist approach focusing on processes to a more localist approach focused on achieving improved health outcomes. This transfer of responsibility for improving public health to local authorities is a welcome return to the historic role played by local government in the area of health improvement and health inequalities. There is considerable synergy between local authorities' current activities that already contribute to improving health outcomes (for example sustainable travel, promotion of cycling and walking, and healthy schools) and the responsibilities that will be transferred.

5. Whilst CCN welcomes the localist intentions we have concerns that details do not fully match the rhetoric. In a number of areas, from the functioning of Health and Well-being Boards (HWBs), to the roles of Public Health England (PHE), the NHS Commissioning Board and the Director's of Public Health (DsPH), and the ability for identifying and including local priorities and allocating resources at the local level, CCN believes that there needs to be a significant shift of power and resources to a more local level.

THE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

Health and Wellbeing Boards

6. CCN strongly supports the creation of Health and Wellbeing Boards (HWBs) and are pleased to see that the Government has put them on a statutory footing in the Bill. The HWBs must have clear and sufficient legal powers to provide local leadership and a strategic framework for the coordination of health improvement and addressing health inequalities in an area. It is important for Health and Wellbeing Boards to be able to identify their own locally appropriate outcomes through the development of a robust and inclusive Joint Strategic Needs Assessment (JSNA) process and to set out the direction of their plans through the Joint Health and Wellbeing Strategy (JHWS). We therefore very much welcome the government's commitment to place a duty on GP Consortia and HWBs to this effect and that there is a clear acknowledgement that the JSNA needs to be an integral part of the process.

7. However it is not clear how they will work with other commissioners to ensure the most co-ordinated commissioning of health and social care for communities. CCN believes that for this to happen HWBs need to have equality in statute with the National Commissioning Board and for the relationship between PHE and HWBs to be equally defined.

8. CCN calls on the Health Select Committee to recommend that, following the recent "Listening exercise", the role of the boards is not watered down, that they have sufficient teeth, are able to do the job effectively and that local decisions are not undermined by national priorities.

Public Health England

9. CCN have a number of concerns about the role and responsibilities of Public Health England (PHE) and its relationship with local authorities. It appears that the majority of public health services will be commissioned by PHE with very little being delegated to local government. The current proposals provide no satisfactory rationale for PHE to retain commissioning responsibility or for continuing to include them in the primary care contract for general practitioners (GPs). It is also not clear how PHE will make a significant impact on health improvement and health inequalities if it does not seek innovative ways of improving services. CCN is also concerned that whilst there are clear lines of accountability of PHE to the Secretary of State for Health there is little reference to accountability to councils or communities at the local level. CCN believes that the government should also more clearly define the relationship between PHE and HWBs and resolve issues of local accountability.

Directors of Public Health (DsPH)

10. Current proposals suggest that DsPH will be "strategic leaders for public health and health inequalities in local communities". This fundamentally misunderstands the role of elected members (particularly Cabinet) in providing strategic direction and also has the potential to miss opportunities to join up public health services with other related services in a locality. This will be even more important during the current period of deficit reduction and resulting reductions in public sector funding.

11. The majority of DsPH in CCN member councils are already jointly appointed by the PCT and local authority and therefore we welcome the formal transfer of this role to councils. However under the current proposals there are significant accountability issues—with the DPH being jointly appointed by PHE and local authority, professionally accountable to the Chief Medical Officer and able to be dismissed by both the local authority and the Secretary of State for Health. CCN firmly believes that the DPH should be locally accountable for their record on health improvement and health inequalities and that this is best achieved by being fully accountable to the local authority.

12. The transfer of public health responsibilities and staff to local authorities will also create a number of complex employment issues. It is in councils' interests that local government should have the flexibility to manage this effectively and we will be seeking clarification on this matter, as the employment implications are considerable—especially at the time when councils are seeking to maximise efficiencies.

Multi-tier Areas

13. CCN believes that in multi-tier areas District councils will have a complementary role to play in improving health outcomes given their statutory responsibilities for housing, planning, environmental health and leisure. CCN member councils in multi-tier areas are already engaging with District councils in their area and CCN strongly believes that it must be a matter for local areas to determine the best way for districts to be involved in the operation of Health and Wellbeing Boards (HWBs) and how they can contribute to this agenda.

Arrangements for the Funding of Public Health

14. The Secretary of State for Health has indicated that total public health funding will be “about £4 billion”. However it is not clear whether this is sufficient funding at the national level as there is a distinct lack of reliable data on current spending on public health and health improvement nationwide. The Department of Health admitted to the Health Select Committee that it “does not collect detailed information (on expenditure on public health and tackling health inequalities) because of local discretion on how funding is spent”.

15. There are also issues about how funding will be allocated between PHE and local government, and what evidence will be used to make this decision. The Audit Commission has indicated that the responsibilities to be taken on by PHE will cost more than £2 billion which could mean that less than half the funding allocated to public health will find its way to local authorities. CCN urges the government to ensure a fair share of funding for the delivery of this important agenda for which councils are going to be ultimately accountable.

16. Equally as important are significant questions about how funding will be distributed between upper-tier local authorities, either based on historic levels of funding or a new funding formula. Distributing funds based on historic levels of expenditure could be significantly hampered by the lack of reliable data at national and local levels. This could be compounded by the possibility that some PCTs may classify prevention spending differently and, following the announcements about a ring-fenced public health grant, offer misleadingly low estimates of their spending on public health. There is also considerable risk of “asset stripping” on the part of PCTs prior to the handover to local government in 2013. This could lead to councils receiving less funding to fulfil new public health responsibilities than is currently spent by the PCT. This will be difficult to track and is of significant concern to local government.

17. CCN believes it is essential that local authorities have sufficient financial resources so that they can take on these new functions and deliver real improvements in health for the communities to which they are responsible. Whilst we very much welcome the commitment that local authorities will receive additional resources, CCN has genuine concerns that the proposal for ring-fenced funding will limit the ability for local partners to pool resources at the local level, thereby constraining improved co-ordination and the design of effective and efficient services which really deliver improved health outcomes at the local level.

18. If the Government insists that public health funding is ring-fenced we would urge the Government to develop a funding formula and the level of allocations to individual councils in partnership with experts from CCN member councils, alongside wider local government representatives, including Directors of Children's and Adult Services and the Society of County Treasurers.

19. CCN also welcomes the Government's commitment to the “Health Premium” as a means of rewarding improved outcomes. However we would want to ensure that there was a balance between financial rewards and the resources to support communities with the greatest challenges in relation to health improvement.

20. There are many unanswered questions in relation to the “Health Premium” including whether rewards will relate to national or local outcomes, which authorities will be eligible and what will be the qualifying criteria. CCN urges the Department of Health to provide greater clarity on operation and funding allocation of the “Health Premium” and work with local authorities to ensure that it will be used to maximise improvements in health and wellbeing.

Public Health Outcomes Framework

21. CCN firmly supports the focus on improving health outcomes and addressing health inequalities and fully endorses the Government's support for the “life course” framework set out in Sir Michael Marmot's report which considers the wider determinants of public health encompassing both Starting Well—focusing on maternal and child health, and Developing Well—focusing on child and adolescent well-being. CCN agrees that significant improvements in public health can only be achieved through addressing the “causes of the causes” as expressed in the Marmot report.

22. In our Manifesto CCN set out our view that there should be an alignment of outcomes frameworks for public services in a locality. The current proposals introduce yet another separate outcomes framework and whilst the government has indicated the public health outcomes framework will be linked to separate NHS and

Social Care Outcomes Frameworks, CCN believes that this is a missed opportunity to align performance frameworks more closely and reduce the burden on local authorities.

23. Within the context of the current proposals CCN urges the government to ensure that the Public Health Outcomes Framework is not overly prescriptive, thereby limiting the ability of local councils to respond to the public health needs of a particular area which they are best placed to understand. The framework needs to leave room for Health and Wellbeing Boards to identify their own locally appropriate outcomes through the development of a robust and inclusive Joint Strategic Needs Assessment (JSNA) process and to set out the direction of their plans through the Joint Health and Wellbeing Strategy (JHWS). It is essential that these local priorities are not undermined or overridden by national imperatives set by PHE and/or the Secretary of State.

CONCLUSION

24. The Government's proposals represent a major restructuring over a number of years, not just of public health but also of councils' responsibilities in relation to health improvement, and coordination of health and social care.

25. CCN is fully committed to a localist agenda and reiterates our view that public health should be a local service, directed by local government and not simply a national public health service hosted by local government, and that without compelling evidence to the contrary decisions should be devolved to the local level.

26. However, as outlined in our response, we do have a number of concerns about resources, the role of local authorities and national agencies in relation to public health and the lack of joining up between the NHS, public health and adult social care.

27. We trust that the Health Select Committee will take account of our concerns and recommend that the Government addresses these issues as health and social care policy is further developed over the coming months.

28. We would welcome the opportunity to address the Committee as part of your important inquiry or provide further information on any aspect of our response.

June 2011

Written evidence from The Cheshire and Merseyside Directors of Public Health (PH 168)

1.0 INTRODUCTION

The Cheshire and Merseyside Directors of Public Health (C&M DsPH) operate as a federation to maximise their capacity to promote and protect health and reduce inequalities across Cheshire and Merseyside, via the Public Health Network (ChaMPs). The C&M DsPH work together in association with the Cheshire and Merseyside PCT CEO Board and as independent advocates for public health.

The C&M DsPH are the driving force behind the leading edge Public Health Network that was established in 2003 and serves the 2.4 million people of Cheshire and Merseyside. The C&M DsPH are the Network executive and collaborate with a multi-disciplinary Board that includes Local Authority, NHS, Health Protection and Academic representatives to oversee the delivery of a comprehensive public health programme outlined in an annual Business Plan, underpinned by a Five Year Strategy.

The C&M DsPH via Public Health Network has established robust partnerships and effective strategic working at all levels including the Merseyside and Cheshire footprints. There is a strong history of developing influential partnerships and collective lobbying for change when necessary including the successful collaboration on smokefree places. With the emergence of the Liverpool City Region—Safer Healthier Communities Board and the Cheshire and Warrington Commission—Health and Wellbeing Board the C&M DsPH, via the Network, provide both Boards with professional leadership and have influenced their strategic direction specifically relating to their current joint priority of alcohol. The unique position of the Network to serve two similar Local Authority led collaborations has meant shared learning and a powerful association between the two health focused Boards, welcomed by the lead Local Authority CEOs.

Following the White Paper *Equity and Excellence: Liberating the NHS* the C&M DsPH are developing a new managed system for public health across Cheshire and Merseyside. The system will build on the successful ChaMPs Public Health Network model with enhanced pooling of public health resource to achieve efficiency savings and maximise collaborative advantage.

2.0 OVERVIEW—CONCERNS FOR THE PUBLIC HEALTH SYSTEM

The C&M DsPH recognise that the proposed reforms raise opportunities for public health and welcome the increased formal role of Local Authorities (LAs) in the health agenda and integration of local DsPH into LAs. However, England needs an integrated system for delivery of public health outcomes, and we are concerned that there is a significant risk that the proposals could have adverse effects on fragmentation:

- of the public health workforce across a number of organisations;
- of commissioning and finance responsibility for public health programmes;
- and loss of clarity on accountability, particularly in the area of health protection; and
- of well-functioning national public health training scheme.

The C&M DsPH think that LAs should be accountable for improving and protecting the health of their population at all times (with support from Public Health England). However, in order to ensure a coherent system-wide approach to public health, the Health & Social Care Bill should place a statutory duty on all health and social care bodies (including NHS funded providers) to cooperate in efforts to improve and protect health and in responding to public health incidents and emergencies.

3.0 SPECIFIC ISSUES IDENTIFIED BY THE COMMITTEE

3.1 *The creation of Public Health England within the DH; the abolition of the HPA and the NTA for Substance Misuse*

Public Health England (PHE) can only effectively operate as a national public health service if it encompasses all three domains of public health:

- Health protection (infectious diseases, environmental hazards and emergency planning).
- Health improvement (lifestyles, inequalities and the wider social, economic and environmental influences on health).
- Health services (service planning, commissioning, audit, efficiency and evaluation.)

PHE should operate as a supporting organisation which can:

- provide independent scientific evidence-based advice to national and local government, the NHS and the public on all matters relating to the maintenance, improvement and protection of health;
- offer expertise to the National Commissioning Board (NCB) in support of its role in providing national leadership in commissioning for quality improvement, commissioning national and regional specialised services, and allocating NHS resources;
- provide effective, expert and adequately-resourced specialist PH capacity to support the work of local DsPH and their teams;
- provide independent scientific evidence-based advice and guidance to the devolved nations where they are unable to access this locally; and
- generate revenue from external consultancy and academic research funding.

It is unlikely that these aims can be achieved if PHE becomes a fully-integrated part of the Department of Health. It should be established as an NHS body which would:

- facilitate the employment of public health staff by PHE;
- enable pooling of scarce and specialist public health capacity;
- enable the continuance of external income streams that currently support national health protection activity; and
- facilitate the separation of science from policy and therefore re-enforce the independence of DsPH and health protection for the populations' health and protection.

The C&M DsPH are also concerned that:

- there is a lack of definition on the role and status of DsPH within PHE—this requires clarification, including in relation to the health protection functions of DsPH locally;
- clarity is required on the mechanisms for public health input to the NCB; and
- there must be clear lines of accountability, communication and access between PHE, commissioning consortia, NHS and DsPH working within local authorities.

Specialist public health capacity (including specialists working across the domains of health improvement, health protection, healthcare public health, and public health intelligence/analysis) should be consolidated into PHE. The specialist capacity can then be deployed to provide public health input to all parts of the health and social care system; Commissioning Consortia, LAs, NCB, and NHS-funded provider organisations.

3.1.1 Health Protection

The C&M DsPH feel that capacity for emergency preparedness and response must be maintained within the new structures—and robust interim arrangements to ensure a stable transition. Clarity is vital over which part of the system will lead responses to incidents at local and sub-national/supra local or regional levels.

The C&M DsPH also feel that there needs to be clear agreement on the roles and responsibilities for DsPH and local health protection units, including assurance that health protection work carried out in second tier local authorities is connected with coordination and planning mechanisms organised at the top tier of local government.

The C&M DsPH agree that PHE and the NHS will need to liaise closely with public health agencies in the devolved administrations to ensure that cross border support remains robust in relation to UK health protection issues.

3.2 *The public health role of the Secretary of State*

The C&M DsPH welcome proposed new duties on the Secretary of State (and NCB and commissioning consortia) to have regard to the need to reduce health inequalities. However these duties are narrowly drawn, only applying to the role of the NHS in providing services to patients. The duties should reflect the broader role of the NHS in promoting public health as a provider, commissioner and major employer.

There are also no equivalent duties on the Secretary of State or local authorities in respect of their roles in promoting public health.

3.3 *The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)*

The C&M DsPH agree that:

- DsPH are the frontline leaders of public health working across the three domains of health improvement, health protection, and health care service planning and commissioning. DsPH must be enabled—through primary legislation—to provide oversight and influence across all these determinants of health within local authorities, the NHS and primary care, and other appropriate sectors and agencies in order to secure the improving health of their population.
- Over the past year Local Authority funding and functions have been reduced dramatically and this contraction will continue over the next few years. Some Local Authorities are looking to defray their reductions and staff costs through public health funding. This brings a number of risks including diluting public health skills, downsizing programmes and potential loss of influence and effectiveness. The DsPH question whether this is the most appropriate time for Local Authorities to take on responsibility for the public health function without robust safeguards being in place.
- If the transfer of PH continues DsPH should be jointly appointed by LAs and PHE and should have a contractual relationship with both. However the supporting HR framework and clarification of terms/conditions and accountabilities are urgently needed.
- DsPH will need clearly defined responsibilities and powers and the professional status and enablement to express an independent view in order to provide advocacy for the health of the population. This is analogous to the requirement for local authorities to appoint a suitably qualified officer responsible for the proper administration of its financial affairs in section 151 of the Local Government Act 1972.
- DsPH will require a well-resourced, professional and co-located Public Health team providing the skills and experience to input to local service planning and commissioning, and to deliver Public Health programmes and advice across the health economy, supported by access to high quality local and national data and scientific evidence base.

The C&M DsPH strongly believe that:

- A DPH should be an individual trained, accredited, and registered in specialist public health.
- There should be a statutory requirement for top tier Local Authorities to appoint a DPH with the appropriate professional training and accreditation.
- The DPH should be recognised as the principal adviser on all health matters to the local authority, its elected members and officers, and its Health & Well Being Board, on the full range of local authority functions and their impact on the health of the local population as stated in Annex A of the PH White Paper.
- The DPH should work at corporate/strategic director (top team) level as a full executive member of the corporate leadership team with direct access to the local authority Cabinet and councillors— influencing and working alongside other Local Authority Executive Directors and normally reporting or accountable to the CEO or equivalent.
- The professional status of the DPH and ability to express an independent view in order to advocate for health improvement and reducing health inequalities within their local population and act for the protection of the local population—and the independent DPH annual report—must be protected.
- As the principal advisor to a Health & Well Being Board, a DPH should not relate to more than one Board. However, we recognise that where local arrangements lead to a shared Board, then it may be appropriate for one DPH to work to this Board.

- DsPH should:
 - (a) Either be appointed jointly by the local authority and PHE **or** through a single national organisation, through a statutory appointments process which mirrors the existing Faculty of Public Health process including the statutory establishment of an Advisory Appointments Committee.
 - (b) If a joint appointment with the Local Authority have a formal contractual relationship and role—which could be honorary—with PHE; if a single national organisation have a formal contractual relationship and role with the Local Authorities.
 - (c) If a joint appointment with the Local Authority has their employment terminated only with approval of both the local authority and the Secretary of State for Health.
- HR guidance to clarify employment/contractual issues—and professional accountability issues for DsPH and their teams—is urgently needed. There is an immediate and transitional risk of loss of PH professional staff and expertise through uncertainty and staff concerns over the implications of potential transfer out of NHS employment.
- Clarification of the resources that will support the DPH role in local authorities is urgently needed.
- Funding for DPH and PH team development will be crucial to support effective transformational change.

3.4 Health & Well Being Boards/JSNAs

The C&M DsPH feels that the powers granted to Health and Well Being Boards are weak and there is a risk that health and social care integration may be more difficult to achieve.

The Boards have not been granted sufficient powers to meet the expectation that they will join up commissioning between the NHS and local authorities. The interface between GP consortia and local authorities will be critical in ensuring that services meet the full range of local population health needs. However, while Consortia must consult Boards in drawing up their commissioning plans, there is no requirement for Consortia to have regard to the views of the Board.

Health and Wellbeing boards must have the power to sign-off local commissioning plans, ensuring that they are aligned with the joint strategic needs assessment and address the identified needs of the population.

In two tier authorities existing health and well-being partnerships should continue to work together. District Authorities should have specific roles and duties for the improvement and protection of health and the reduction of health inequalities.

The C&M DsPH strongly believe that the JSNA must:

- be asset-based, wide-ranging and thorough and include qualitative “citizen” views (not just service-user or patient views);
- include preventative and health protection issues; and
- be the basis for all local commissioning.

3.5 Arrangements for public health involvement in the commissioning of NHS services; arrangements for commissioning public health services

The C&M DsPH agree that public health oversight of and input to commissioning will be essential to achieve real improvements in health outcomes and the reduction of health inequalities.

The proposed reforms:

- lack clarity over who will be responsible for providing “local system leadership” and planning services across GP consortia boundaries following the abolition of SHAs/PCTs;
- include few requirements on the governance of consortia;
- do not require GP consortia to promote integration between health and social care—an omission that will be exacerbated by lack of co-terminosity between consortia and local authorities; and
- do not appear to place a duty on GP consortia to promote and protect the health of their local health population.

Locally, the DPH should provide oversight and the Public Health team input to GP consortia commissioning, supported by additional resources and expertise held within PHE. GP consortia should be required to work through and with DsPH to ensure consortia decision-making is underpinned by expert, professional public health advice. DsPH should have a formal relationship with GP consortia, and local commissioning plans should be signed-off by the Health and Well-being Board.

Specialists working in health services public health possess skills that are highly specialised. The essential role of this group in the commissioning of health services by commissioning consortia (and NCB) has not been grasped in the draft Health & Social Care Bill. The current position is that the Bill requires commissioners to

take advice only from those with “professional expertise relating to the physical or mental health of individuals”.

The requirement for commissioners to take advice should be extended to ensure that all organisations undertaking commissioning functions (at national or local level) should be required to consult and take cognisance of specialist public health advice in formulating their commissioning proposals. The board of each such organisation must include a specialist in public health as a full member.

GP Consortia (and NCB) should be responsible for improving inequalities of health outcome rather than just inequalities of access to health services. Clarity is required over where responsibility lies for ensuring GP consortia meet their responsibility for improving outcomes and how consortia are to be held to account for PH outcomes.

The population size of GP consortia should be based on evidence of effectiveness, as should decisions as to whether services are commissioned and delivered nationally, regionally or locally. Consortia should develop structures for stable joint commissioning where these would best serve their population.

GP consortium must be responsible for a defined geographical population which is coterminous with local authority boundaries.

In order to promote coherent response to emergencies, GP Consortia should assume similar responsibilities as category one responders under the Civil Contingency Act (that have previously applied to Primary Care Trusts) and be required to have a responsible officer for emergency response.

Commissioners should be required to demonstrate the use of a strategy covering high quality, universal services, targeted services for communities of interest at greater risk especially deprived communities and tailored services for people with multiple and complex needs. This should be underpinned by evidence base, public health intelligence and needs assessments.

There must be clear lines of accountability, communication and access between PHE, GP consortia, NHS and DsPH working within local authorities.

3.6 The future of the Public Health Observatories

The C&M DsPH think that the new system must ensure that all those working in public health have access to timely, comprehensive and appropriate data and analysis to inform their decisions and advice.

Reliable data and information are essential to the understanding of health needs, modelling of future scenarios and assessment of impact and efficacy. This is relevant both for service planning and design and for the recognition of and response to hazards and outbreaks.

The reforms could result in disruption of existing flows of data and the loss of analytical expertise. Arrangements for maintenance of the public health observatory function and for ensuring access to health service data at local and national levels need urgent clarification.

3.6.1 Public Health Intelligence

The C&M DsPH agree that public health intelligence is needed at national, regional and local levels to specify what data is collected, and in what way, to analyse it and interpret it in context. Public health intelligence is the driver for evidence based commissioning for population health. Public health provides some of the strongest tools for assessment, such as asset based approaches, impact assessment and participatory research. Public health also takes a population view of consultation, engagement and involvement, recognising that health, care and wellbeing are whole population issues, rather than just the population accessing services.

3.7 The structure and purpose of the Public Health Outcomes Framework

The C&M DsPH welcomes this focus on outcomes, and whilst recognising that many of the proposed indicators are process rather than outcome measures, we feel that this mix of process and outcome measures is appropriate given the long time frames which may be involved.

However the C&M DsPH feel there needs to be:

- greater emphasis should be put on ensuring that the Public Health framework is relevant to all sectors—with greater emphasis on linkage across the NHS, Social Care and Public Health outcomes frameworks;
- public health analytical capacity is essential to delivery of public health outcomes and current capacity must be preserved and enhanced; and
- investment will be needed in national surveys relating to health and wellbeing to ensure LA data can be assembled.

3.8 Arrangements for funding public health services (including the Health Premium)

3.8.1 The ring fenced budget

The C&M DsPH thinks that the scope of the ring-fenced budget must be defined clearly and the funds available in the ring-fenced budget must be sufficient to meet the needs for which that budget is intended.

PHE will require adequate resources to immediately and effectively fulfil its wide remit—and vitally to invest in the continuing development of public health expertise and the public health workforce.

In relation to the local ring-fenced public health budget the C&M DsPH agrees that:

- it should be explicit what will fall within this budget, and equally explicit that excluded activities with a bearing on public health will continue to be resourced from other / existing Local Authority and GP commissioning consortia budgets;
- within the LA these budgets should be deployed with flexibility for DsPH to direct resources to best meet the needs of the local population based on the JSNA and Health & Well Being strategy;
- it should be clarified as to how baseline budgets will be set. We are concerned that public health resources have already and will continue to be lost through the impact of local financial savings—any baseline must not be based on reduced resources.

Resources will also be required to support transition—including funding for DPH and PH team development to support effective transformational change, plus funding an awareness programme to ensure that politicians (national and local) fully understand the DPH role and all key PH functions.

3.8.2 Health Premium

The C&M DsPH feel that the health premium should:

- target need;
- reward **relative** improvement; and
- identify and reward “value added” activity/outcomes.

The C&M DsPH are concerned over potential unintended consequences and that the health premium may create greater health inequalities. The C&M DsPH feel that public health funding proposals offer perverse incentives, literally in the case of the health premium. Premiums should be attracted to populations with the worst health and wellbeing without performance conditions. Evidence of collaborative use of premiums directed through the HWBs would be more appropriate.

The extent of the health premium is unclear but may not provide significant additional resources. Learning and evidence from existing programmes (such as the Spearhead approach) may provide useful evidence/outcomes to inform development of the health premium. We recommend that a full assessment of Spearhead experience should inform the further development of the health premium concept.

3.9 The future of the public health workforce (including the regulation of public health professionals)

The C&M DsPH support the recommendations within Dr Scally’s Report on the Review of the Regulation of Public Health Professionals. The Faculty of Public Health is the standard setter for all public health practice in the UK. The C&M DsPH agree that the title “Specialist in Public Health” should be a protected title, required by statute to be registered.

The C&M DsPH believe that the statutory regulation of public health specialists is the best mechanism for providing effective protection of the public. The current requirement for statutory registration for public health specialists who are doctors or dentists should therefore be extended to cover those from all other backgrounds. All specialist public health staff (including DsPH) should be appropriately qualified, should be appointed through a statutory Appointments Advisory Committee and should have access to recognised continuing professional development. The training of public health specialists should be planned and delivered through Health Education England and should be consistent with arrangements for training other health professionals.

The independent PHE should act as the employing body for public health specialists, seconding them to other organisations as necessary, to ensure their primary responsibility is to the public. The use of honorary contracts can facilitate this model.

3.9.1 Public Health Training

The C&M DsPH feel that PHE having the role of public health staff employer would mitigate against fragmentation of the public health workforce and enable the continuance of the public health specialist training scheme to build necessary capacity. Public health training should be equivalent to that for other health professionals and delivered through Health Education England via the existing Deanery network. The C&M DsPH also feel that current arrangements for recruitment and training of public health consultant staff (mirroring the NHS consultant recruitment process) should be maintained as, otherwise, we will not be able to maintain the diversity of workforce and skills in the future.

3.10 *How the Government is responding to the Marmot Review on health inequalities*

The C&M DsPH feel that the current reorganisation of the NHS and Public Health significantly underestimate the role of the NHS in addressing health inequalities.

Marmot advocates “proportionate universalism”—ie that health will continue to be a universal service but be tailored to the level of need within communities so the more needy will get more, should be more widely promoted as it will help with targeting resources in a more structured way.

The C&M DsPH welcome new duties on the Secretary of State, NHS Commissioning Board and GP consortia to have regard to the need to reduce health inequalities. However these are narrowly drawn and do not reflect the broader role of the NHS in promoting public health as a provider, commissioner and major employer. There are also no equivalent duties on the Secretary of State or local authorities in respect of their roles in promoting public health.

The duties are unlikely to be sufficient to ensure that tackling health inequalities is prioritised in the health system. We strongly recommend that the NHS commissioning bodies should be held to account for reducing inequalities in health outcomes.

The proposed new system risks service fragmentation with detrimental impacts on the very areas the reforms seek to improve: quality of services, education and training, patient choice, efficiency and equity, and has the potential to exacerbate any existing postcode lottery in health services.

The “Nuffield Intervention Ladder” should be applied to the Responsibility Deal approach. Robust, time-limited monitoring and evaluation after 12 months will be crucial to assess the effectiveness of voluntary commitments.

4.0 ADDITIONAL ISSUES

4.1 *Provider and Regulatory organisations*

The C&M DsPH agree that protecting, maintaining and improving the public’s health require services to cooperate, addressing shared priorities to meet health needs, and making best use of all available resources. A requirement to promote competition will discourage integration and collaboration across the sectors, and should be removed from the draft Health & Social Care Bill. A duty of cooperation should be placed upon service providers and commissioners.

The C&M DsPH agree that public health influence within provider organisations should be extended to:

- a public health lead working within Trusts;
- provider trusts should work with LAs in improving the health of the population; and
- above a capped level of reserves, an annual proportion of Foundation Trust reserves to be spent on initiatives agreed locally as providing health gain for the population.

The C&M DsPH support the conclusions of a 2010 ADPH survey on *Transforming Community Services* that are:

- in any re-organisation the impact on public health services should be assessed—particularly true for emergency planning and response;
- where possible there should be a named public health lead in community services; and
- public health expertise should be readily available to provider services where no public health lead is in place.

The C&M DsPH agree that there should be clear lines of public health input into CQC and Monitor:

- public health expertise and input at a high level within the CQC to ensure a strong population perspective in quality regulation; and
- public health expertise and input into Monitor to ensure effective use of resources in support of the prevention agenda health improvement and a reduction in health inequalities.

4.2 *Partnership working*

The C&M DsPH highlight that considerable efforts have been made by health and wellbeing partnerships to maximise the impact of health inequalities funding such as Neighbourhood Renewal Fund and single budgets such as Area Based Grant on population health and wellbeing through public health delivery programmes. The 2010–11 in year savings requirements and abolition of Area Based Grant caused the loss of exactly those partnerships and integrated programmes that the Public Health White Paper exhorted public health to develop on its publication three months later. It is concerning that the government appeared unable to recognise the impact withdrawal of Area Based Grant would have for health and wellbeing commissioners across the health economy

The Cheshire and Merseyside Directors of Public Health welcome this opportunity to respond to the Health Select Committee inquiry into Public Health.

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June 2011

Written evidence from the Youth Justice Board for England and Wales (PH 169)

INTRODUCTION

1. The Youth Justice Board for England and Wales (YJB) welcomes the opportunity to provide a submission to the inquiry on Public Health. This submission provides brief background on the role of the YJB and the youth justice system and the links between health and offending and antisocial behaviour, before outlining some key issues related to public health. The YJB would be pleased to provide any further information that would be of assistance to the inquiry if required.

2. At national level it is vital that the work of Public Health England takes into account the specific issues relating to health and criminal justice, and at a local level there is potential for building closer relationships between Directors of Public Health, Health and Well Being Boards and the youth justice system. This will not only help ensure that the specific health needs of the young offender population are met, but also more effective delivery of community safety and early intervention/prevention strategies. The YJB sees the new Public Health Service having a key role to play in the prevention of health problems through:

- stronger linkages with preventative education;
- issuing guidelines to Health and Well Being Boards/GP consortia that highlight what is expected in terms of providing support and interventions;
- advising on commissioning and effective operation of population health services;
- ensuring needs assessments relating to young offenders feature adequately in JSNAs in order that adequate resources can be directed into youth justice and prevention services; and
- ensuring the provision of services for young offenders (as with all vulnerable/excluded groups) who often are not accessing health services.

BACKGROUND: THE YJB AND YOUTH JUSTICE SYSTEM

3. The role of the YJB is to oversee the youth justice system in England and Wales. It works to prevent offending and reoffending by children and young people under the age of 18, and to ensure that custody is safe, secure, and addresses the causes of their offending behaviour. The statutory responsibilities of the YJB include:

- advising Ministers on the operation of, and standards for, the youth justice system;
- monitoring the performance of the youth justice system;
- purchasing places for, and placing, children and young people remanded or sentenced to custody;
- identifying and promoting effective practice;
- making grants to local authorities and other bodies to support the development of effective practice; and
- commissioning research and publishing information.

4. While the YJB is responsible for overseeing the performance of youth justice services, including multi-agency Youth Offending Teams (YOTs), it does not directly manage these services. YOTs are made up of five statutory partners including health and are accountable to the local authority Chief Executive.

5. The main role of the YOT is to assess criminogenic risk, plan, review and supervise the sentences young people are serving (whether served in custody or the community) and to ensure they have access to mainstream services in order to reduce the risk factors related to their offending patterns. On that basis, the YJB has taken a holistic approach to identification and treatment of health, mental health and substance misuse (SMU) needs, including alcohol and illicit drugs.

6. Research has shown health, mental health and substance misuse problems significantly increase the risk of children and young people offending and reoffending. When a young person enters the youth justice system, the relevant bodies which make up the local statutory YOT partnerships (including health) have a responsibility to ensure that their health needs are taken into consideration and addressed effectively.

7. The YJB's approach to ensuring that adequate provision is made for young people in the youth justice system is based on the following underpinning principles:

- (a) Health and children's services locally should work in a collaborative way to ensure that children and families showing early signs of the risk factors that may lead to offending are given prompt access to preventive interventions.
- (b) A young person in contact with the youth justice system, whether in custody or in the community, should have the same access to a comprehensive health service as any other young person within the general population.
- (c) Health and emotional wellbeing are intrinsically linked, especially in children and young people, and should be viewed as such and result in the delivery of integrated assessment and treatment.
- (d) Entry into the youth justice system in many cases presents an opportunity to assess and deal with presenting health problems in a way that may not have occurred before in the life of the young person.
- (e) Local services delivered to young people who offend should be shaped and improved through the effective use of strategic information on needs, outcomes and the effectiveness of services delivered to this high risk group whether dealt with in custody or the community.

8. We support any changes which improve early assessment and interventions for high risk families where this will prevent children with emerging mental health, conduct disorder or learning disability/difficulty from becoming offenders.

9. There are specific considerations involved in the delivery of health services to young offenders. These have been well documented in the DoH strategy Healthy Children, Safer Communities published in 2009. It is vital that in the reconfiguration of health service commissioning and delivery systems the following considerations are taken into account:

- The need for effective commissioning and delivery of a range of health services to young people in custody, potentially located far from their home area.
- The importance of resourcing triage and diversion services to ensure that those young people with mental health and or learning disabilities who may come to the attention of youth justice services are diverted at the earliest opportunity into the relevant treatment as opposed to being processed through criminal justice.
- The ability of health services to input into multi-agency intervention programmes triggered when a young person's health needs are identified, perhaps for the first time, upon entry into the youth justice system.

10. Well informed commissioning is key to ensuring the appropriate services are delivered. Those commissioning services have a responsibility to know which programmes are having an impact on:

- reducing criminality; and
- substance misusers altering their lifestyles to such an extent that they gain employment or go back into education to improve their ability to improve the local economic climate.

THE EXTENT OF HEALTH NEEDS IN THE YOUTH JUSTICE SYSTEM

11. This section outlines the extent of the problems faced by young people in the youth justice system in five main areas:

- mental health;
- substance misuse;
- sexual health;
- physical well-being; and
- health and education.

MENTAL HEALTH

12. Young people in the youth justice system have three times the prevalence of mental health needs as the general population. The Healthy Children, Safer Communities strategy highlights over a third of young people in custody are diagnosed with a mental health disorder. This includes young people:

- experiencing problems with depression;
- suffering from anxiety;
- suffering from post-traumatic stress disorder (PTSD);
- having problems with hyperactivity; and
- displaying psychotic-like symptoms.

Additionally:

- a high proportion from BME groups, compared with others have post-traumatic stress disorder (community and custody); and
- a high proportion have experienced bereavement and loss through death and family breakdown (community and custody).

13. In a study of young women in young offender institutions (Female Health Needs in Young Offender Institutions, also available from the YJB website), 36% had self-harmed in the last month: the majority of these (92%) had cut themselves. The study also found that 71% of the young women surveyed had some level of psychiatric disturbance, which rose to 86% when factoring in longstanding disorders.

SUBSTANCE MISUSE

14. Research commissioned by the YJB shows that young people in the youth justice system are more likely to have used both legal and illegal drugs (including alcohol and tobacco). They are also more likely to suffer from substance misuse problems, even in comparison to other groups of vulnerable young people: for example, the use of Class A and Class B drugs is considerably higher among young people who offend than in other groups in the general population.

15. YJB research of young people in custody shows that:

- 90% of young people in custody had used an illegal drug at some point in their life.
- 72% used cannabis daily in the 12 months before their arrest.
- 74% of the sample drank alcohol more than once a week, with the majority regularly drinking more than six units each time.
- 51% used two or more drugs more than once a week.
- 37% said they would commit less crime if they stopped using drugs.
- 25% said they would commit less crime if they stopped using alcohol.

16. Young people who have offended and have problems with substance misuse are likely to have experienced difficult life events such as problems within the family, including bereavement and abuse. They are also likely to have low levels of psychological well-being, to have poor social skills and to experience difficulties with school.

17. Substance misuse can lead to additional problems—for instance, it is the second largest contributory factor to homelessness among young people who offend (after violence in the home). Unsurprisingly, these young people report using drugs and alcohol in order to cope—in one study, 69% of young people reported that they drank alcohol or used drugs in order to think less about their problems.

SEXUAL HEALTH

18. The Health of Children and Young People report (available from www.statistics.gov.uk) showed that adolescent sexually-transmitted infections have worsened since 1990. In a study into the health of young women in young offender institutions (Female Health Needs in Young Offender Institutions, available from the YJB website), although 26% of those surveyed reported three or more sexual partners in the last year, only 15% had always used condoms, 23% had been diagnosed with a sexually transmitted infection and 10% had been paid for sex.

PHYSICAL WELL-BEING

19. Many young people have physical health needs that only come to light through contact with YOTs. As highlighted in Healthy Children Safer Communities over a quarter of young men (and a third of young women) in custody report a long standing physical complaint.

20. Appropriate healthcare while young should help to reduce problems in adult life, but a quarter of these young people have never been to their GP, and many of those who use conventional GP services say they do not find them helpful. It follows that if they are not engaged with mainstream health and education provision, many young people will not have the information they need to make choices about healthy living. When YOT

and secure establishment health workers carry out physical health checks, multiple health needs are sometimes identified. Included in this would be dentistry and opticians.

HEALTH AND EDUCATION

21. Information gathered from YOT assessments of young people indicates that there are established links between health, educational inclusion and achievement and risk of offending and committing anti-social behaviour. The Healthy Children, Safer Communities report highlights that of young people in the youth justice system:

- over 75% have serious difficulties with literacy and numeracy (custody);
- over 75% have a history of temporary or permanent school exclusion (custody);
- over 50% have difficulties with speech, language and communication (custody); and
- over 25% have a learning disability (community and custody).

22. Furthermore, a study in the North East with the region's YOTs showed that over 40% of young offenders also have an identifiable learning disability or difficulties (2006).

23. It is also necessary to consider emerging emotional, behavioural and conduct disorders known to contribute to some young people's educational ability/achievement along with increasing their risk of committing anti-social behaviour and/or (re)offending. These "conditions" include:

- Attention Deficit Hyperactivity Disorder (ADHD).
- Autistic Spectrum Disorders.
- Aspergers Syndrome.
- Conduct Disorders.
- Traumatic Brain Injury (TBI)/Acquired Brain Injury (ABI).

KEY POINTS TO CONSIDER FOR THE YOUTH JUSTICE SYSTEM

24. If we do not address the holistic health needs (including mental health and substance misuse needs) of young people who offend, there is a strong possibility they will be excluded from the opportunity of improving and maintaining good health, and so from the ability to achieve their full potential in life. It is also more likely they will continue to offend in the longer term with all the contingent costs to society.

25. The YJB believes that all work with vulnerable young people in the youth justice system should be sensitive to their health needs and their possible substance misuse. Services should work together to respond effectively to young people's identified needs. It is critical that health provision in YOTs and the secure estate is fully supported by local health services, and that current effective practice in bringing health services to this group of vulnerable young people continues to improve.

26. Whilst the YOT client group is small in terms of numbers, it is this cohort that subsequently goes on to cost the "system" the most. YOTs are in a unique position to identify those individuals with complex health needs. Through early intervention it is possible to prevent, not only more expensive health related treatments being required in the future but also offending and reoffending, negative outcomes and the related costs to the state of being dependant on benefits (eg for long term unemployment).

27. As noted above, young people often present with multiple needs which taken individually may not be deemed problematic but when grouped together collectively result in complex needs leading to high risk of poor outcomes that require a collaborative, multi-agency response if they are to be resolved.

June 2011

Written evidence from Department of Health Equality, NHS Nottingham City (PH 170)

1. The creation of Public Health England within the Department of Health

1.1 We would suggest that creation of Public Health England as a part of a separate system to deliver "public health" carries some significant risks. To implement population level approaches, coordinated activity between many different organisations and agencies is required and cannot be delivered by a single agency. Creating a public health agency risks other agencies demurring from their important roles in delivering public health. As proposed there would be a considerable weakening of the relationship with the NHS which makes significant contributions to health improvement and reducing inequalities in health in the short and medium term.

1.2 However, assuming it is intended that the public health function be transferred to Local Authorities and some degree of sub-national level of organisation, it will be absolutely necessary to hold these functions in an organisation such as Public Health England. This will need to be an NHS body independent of the DH. Reasons for this include:

- Securing of independent highly skilled specialist workforce.

- Within an NHS contract framework, avoiding the significant contractual problems in transfer of staff.
- Reducing the inherent risk of transition to Local Authorities that have yet to grasp the importance of Public Health and without the capacity and governance arrangements to support it.
- Reduce the risk of erosion of influence of public health and the public health budget as it comes under pressure from other financial cuts.
- Enable continued close working with the NHS.
- To support health care commissioning.
- To support important functions not directly related to patient care such as mobilising resources to support the health protection function.
- To contribute important expertise to sub-national organisation of services such as health protection, screening programmes, regional networks, specialist centres (where planning is necessary to ensure access, efficiency and good outcomes).

1.3 Assuming that those working in public health (including those currently working at a local level in primary care trusts) are realigned into a national public health service, we would also see a number of roles for such a service at national level. Nationally it would:

- provide centralised independent evidence-based advice to the National and Local Government and the NHS;
- support the National Commissioning Board in commissioning for quality improvement and specialised services; and
- provide an umbrella for governance and training in public health.

1.4 To accomplish this it will be necessary for PHE to be an NHS body that:

- facilitates the employment and deployment of NHS public health staff (Specialists working across all three domains of health improvement, health protection, and healthcare public health, as well as public health intelligence/analysis) should be consolidated into PHE);
- enables pooling of scarce and specialist public health capacity (the specialist capacity could then be deployed to provide public health input to all parts of the health and social care system including Commissioning Consortia, Local Authorities, National Commissioning Board, and NHS-funded provider organisations);
- enables the continuance of external income streams that currently support national health protection activity; and
- facilitates the separation of science from government policy and therefore reinforces the independence of DsPH and health protection staff for the population's health and protection.

1.5 In a marketised system PHE could generate income from provision of services to other agencies—such as training, analysis and consultancy. However, marketisation may not be technically efficient where there are important statutory implications of the work involved (such as health protection) and where the majority of the work is for internal agencies.

2. *The abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse*

2.1 Delivery of Health Protection depends on a variety of organisations beyond the Health Protection Agency. Hithertofore, PCTs and other agencies have been key in mobilising support, services and response to local emergencies and outbreaks of communicable disease (as well as implementing important health protection measures such as immunisation). It should therefore be recognised that these important linkages are vital to the safety of the public in transition. We would agree that capacity for emergency preparedness and response must be maintained within the new structures—and robust interim arrangements to ensure a stable transition. We would also agree that clarity is vital over which part of the system will lead responses to incidents at local and sub-national/supra local or regional levels. Transition from regional to sub-national governance creates considerable risk to delivery of the health protection emergency response.

2.2 There needs to be clarity of where responsibilities lie in relation to the health protection of the local population between the Directors of Public Health and Public Health England. We would point out that present responsibilities are set out in the legal framework for PCTs and the HPA but are not clear in the future arrangements, creating a risk of fragmentation of emergency planning and response.

2.3 PHE and the NHS will need to liaise closely with public health agencies in the devolved administrations to ensure that cross border support remains robust in relation to UK health protection issues.

3. *The public health role of the Secretary of State*

3.1 We welcome proposed new duties on the Secretary of State (and NCB and commissioning consortia) to have regard to the need to reduce health inequalities. However these duties are narrowly drawn, only applying

to the role of the NHS in providing services to patients. The duties should reflect the broader role of the NHS in promoting public health as a provider, commissioner and major employer.

There are also no equivalent duties on the Secretary of State or local authorities in respect of their roles in promoting public health.

4. *The future role of local government in public health*

4.1 Arrangements for appointment of Directors of Public Health

4.1.1 DsPH are the frontline leaders of public health working across the three domains of health improvement, health protection, and health care service planning and commissioning. DsPH must be enabled—through primary legislation—to provide oversight and influence across all these determinants of health within local authorities, the NHS and primary care, and other appropriate sectors and agencies in order to secure the improving health of their population.

4.1.2 DsPH should be jointly appointed by Local Authorities and Public Health England and should have a contractual relationship with both. To retain staff and promote continuity within the public health profession DsPH contracts should remain with the NHS. The supporting HR framework and clarification of terms/conditions and accountabilities are urgently needed to retain highly skilled staff in the current uncertain climate. It will also help DsPH retain credibility within the NHS which will be important to effective functioning.

4.1.3 DsPH will need clearly defined responsibilities and powers and the professional status and enablement to express an independent view in order to provide advocacy for the health of the population. This is analogous to the requirement for local authorities to appoint a suitably qualified officer responsible for the proper administration of its financial affairs in section 151 of the Local Government Act 1972.

4.1.4 DsPH will require a well-resourced, professional and co-located Public Health team providing the skills and experience to input to local service planning and commissioning, and to deliver Public Health programmes and advice across the health economy, supported by access to high quality local and national data and scientific evidence base.

4.1.5 We would agree with the Association of Directors of Public Health that:

- A DPH should be an individual trained, accredited, and registered in specialist public health.
- There should be a statutory requirement for top tier Local Authorities to appoint a DPH with the appropriate professional training and accreditation.
- The DPH should be recognised as the principal adviser on all health matters to the local authority, its elected members and officers, and its Health & Well Being Board, on the full range of local authority functions and their impact on the health of the local population as stated in Annex A of the PH White Paper.
- The DPH should work at corporate/strategic director (top team) level as a full executive member of the corporate leadership team with direct access to the local authority Cabinet and councillors—influencing and working alongside other Local Authority Executive Directors and normally reporting or accountable to the CEO or equivalent.
- The professional status of the DPH and ability to express an independent view in order to advocate for health improvement and reducing health inequalities within their local population and act for the protection of the local population—and the independent DPH annual report—must be protected.
- As the principal advisor to a Health & Well Being Board, a DPH should not relate to more than one Board. However, we recognise that where local arrangements lead to a shared Board, then it may be appropriate for one DPH to work to this Board.
- DsPH should:
 - be appointed jointly by the local authority and PHE, through a statutory appointments process which mirrors the existing Advisory Appointments Committee process for DsPH and Consultants/Specialists in Public Health—and accredited by the Faculty of Public Health (as is currently the case);
 - have a formal contractual relationship and role—which could be honorary—with PHE; and
 - have their employment terminated only with approval of both the local authority and the Secretary of State for Health.
- HR guidance to clarify employment/contractual issues—and professional accountability issues for DsPH and their teams—is urgently needed. There is an immediate and transitional risk of loss of PH professional staff and expertise through uncertainty and staff concerns over the implications of potential transfer out of NHS employment.
- Clarification of the resources that will support the DPH role in local authorities is urgently needed.
- Funding for DPH and PH team development will be crucial to support effective transformational change.

4.2 The role of Health and Well Being Boards, Joint Strategic Needs Assessments, and Joint Health and Well Being Strategies

4.2.1 The proposed powers granted to Health and Well Being Boards are weak. While Consortia must consult Boards in drawing up their commissioning plans, there is no requirement for Consortia to have regard to the views of the Board. This will pose a serious challenge to Board's ability to hold partners to account. The aim of democratic accountability may be better achieved by making GP consortia boards democratically accountable.

4.2.2 As currently proposed there is a considerable risk that health and social care integration will be difficult to achieve. This may be compounded in times of relative austerity by contention over the middle ground where funding for services can come from health or social care depending on view point. There is also a gulf in organisational ethos between NHS commissioning organisations and Local Authorities that are predominantly providers. We think that the government could consider integrating commissioning of health and social care within NHS commissioning as an alternative arrangement.

4.2.3 Health and Well Being Boards need to serve the needs of the whole population and this is the Public Health perspective. We therefore believe that The DPH should act as a principal advisor to the Health and Well Being Board and appropriate authority to ensure plans are justified on population health grounds.

4.2.4 Under the current proposals it would appear that some DsPH will potentially relate to more than one Health and Well Being Board. This situation should be resolved so that no DPH relates to more than one board.

4.2.5 We welcome the central role of the Joint Strategic Needs Assessment and the delegation of responsibility for its production to the Local Authority and the GP Consortium. However, we would support strengthening of the requirements for these agencies to engage with public health to ensure the quality of such a document achieve its commissioning and population health aims.

5. Arrangements for public health involvement in the commissioning of NHS services

5.1 Public Health oversight of and input to commissioning will be essential to achieve real improvements in health outcomes and the reduction of health inequalities. The essential role of this group in the commissioning of health services by commissioning consortia (and NCB) has not been grasped in the draft Health & Social Care Bill. The current position is that the Bill requires commissioners to take advice only from those with "professional expertise relating to the physical or mental health of individuals".

5.2 Specialists working in health services public health possess skills that are highly specialised:

5.3 Public health specialists are trained to analyse a wide range of information in assessing population health needs, to critically appraise evidence to ensure health services are based on evidence of effectiveness and are cost effective, and in evaluating health services. These specialist skills are critical for "world class commissioning". Although GPs have a good understanding of individual patient health issues and are experts in diagnosis and treatment, they trained in the skills required for commissioning.

5.4 Public health specialists bring a population perspective that values the relative benefits of prevention alongside treatment, a key area better use of NHS resources and for control of NHS expenditure.

5.5 Public health specialists can provide a neutral unbiased perspective based on evidence and not subject to conflicted interests of service providers.

5.6 The proposed reforms:

- lack clarity over who will be responsible for providing "local system leadership" and planning services across GP consortia boundaries following the abolition of SHAs/PCTs;
- include few requirements on the governance of consortia;
- do not require GP consortia to promote integration between health and social care—an omission that will be exacerbated by lack of co-terminosity between consortia and local authorities; and
- do not appear to place a duty on GP consortia to promote health and prevent disease nor to protect the health of their local health population.

5.7 Locally, the DPH should provide oversight and the Public Health team input to GP consortia commissioning, supported by additional resources and expertise held within PHE. GP consortia should be required to work through and with DsPH to ensure consortia decision-making is underpinned by expert, professional public health advice. DsPH should have a formal relationship with GP consortia, and local commissioning plans should be signed-off by the Health and Well-being Board.

5.8 GP consortium must be responsible for a defined geographical population which is coterminous with local authority boundaries.

In order to promote coherent response to emergencies, GP Consortia should assume similar responsibilities as category one responders under the Civil Contingency Act (that have previously applied to Primary Care Trusts) and be required to have a responsible officer for emergency response.

6. *Arrangements for the commissioning of public health services*

6.1 There should be clarity about what is meant by public health services, as much of mainstream provision could be seen as public health services.

6.2 For Local Authority led commissioning, there needs to be a clear remit for a public health role where services have a clinical element (for example sexual health services).

6.3 There must be clear lines of accountability, communication and access between PHE, GP consortia, NHS and DsPH working within Local Authorities.

7. *The future of the Public Health Observatories*

7.1 The new system must ensure that all those working in public health have access to timely, comprehensive and appropriate data and analysis to inform their decisions and advice. Reliable data and information are essential to the understanding of health needs, modelling of future scenarios and assessment of impact and efficacy. This is relevant both for service planning and design and for the recognition of and response to hazards and outbreaks. The reforms are likely to result in disruption of existing flows of data and the loss of analytical expertise. Arrangements for maintenance of the public health observatory function and for ensuring access to health service data at local and national levels need urgent clarification.

8. *The structure and purpose of the Public Health Outcomes Framework*

8.1 We agree with a focus on outcomes, and whilst recognising that many of the proposed indicators are process rather than outcome measures, we feel that this mix of process and outcome measures is appropriate given the long time frames which may be involved.

8.2 However:

- greater emphasis should be put on ensuring that the Public Health framework is relevant to all sectors—with greater emphasis on linkage across the NHS, Social Care and Public Health outcomes frameworks;
- public health analytical capacity is essential to delivery of public health outcomes and current capacity must be preserved and enhanced; and
- investment will be needed in national surveys relating to health and wellbeing to ensure LA data can be assembled.

9. *Arrangements for funding public health services (including the Health Premium)*

9.1 The scope of the ring-fenced budget must be defined clearly and the funds available in the ring-fenced budget must be sufficient to meet the needs for which that budget is intended.

9.2 Resources will also be required to support transition of public health into Local Authorities. This would include support to transition commissioning arrangements around tendering, procurement, contract and performance monitoring and an awareness programme to ensure that politicians and councillors fully understand the role of public health and the DPH.

9.3 In relation to the local ring-fenced public health budget:

- it should be explicit what will fall within this budget, and equally explicit that excluded activities with a bearing on public health will continue to be resourced from other/existing Local Authority and GP commissioning consortia budgets;
- within the LA these budgets should be deployed with flexibility for DsPH to direct resources to best meet the needs of the local population based on the JSNA and Health & Well Being strategy;
- it should be clarified as to how baseline budgets will be set. We are concerned that public health resources have already and will continue to be lost through the impact of local financial savings—any baseline must not be based on reduced resources.

9.4 The health premium should:

- target need;
- reward **relative** improvement; and
- identify and reward “value added” activity/outcomes.

We are concerned over potential unintended consequences and that the health premium may create greater health inequalities.

9.5 The extent of the health premium is unclear but may not provide significant additional resources. Learning and evidence from existing programmes (such as the Spearhead approach) may provide useful evidence/outcomes to inform development of the health premium. We recommend that a full assessment of Spearhead experience should inform the further development of the health premium concept.

10. *The future of the public health workforce (including the regulation of public health professionals)*

10.1 We would agree with the recommendations within Dr Scally's Report on the Review of the Regulation of Public Health Professionals. The Faculty of Public Health is the standard setter for all public health practice in the UK.

10.2 The title "Specialist in Public Health" should be a protected title, required by statute to be registered.

10.3 Statutory regulation of public health specialists is the best mechanism for providing effective protection of the public. The current requirement for statutory registration for public health specialists who are doctors or dentists should therefore be extended to cover those from all other backgrounds. All specialist public health staff (including DsPH) should be appropriately qualified, should be appointed through a statutory Appointments Advisory Committee and should have access to recognised continuing professional development. The training of public health specialists should be planned and delivered through Health Education England and should be consistent with arrangements for training other health professionals.

10.4 The independent PHE should act as the employing body for public health specialists, seconding them to other organisations as necessary, to ensure their primary responsibility is to the public. The use of honorary contracts can facilitate this model.

11. *How the government is responding to the Marmot review on health inequalities*

11.1 We believe that the current reorganisation of the NHS and of Public Health significantly underestimates the role of the NHS in addressing health inequalities.

11.2 We welcome new duties on the Secretary of State, NHS Commissioning Board and GP consortia to have regard to the need to reduce health inequalities. However these are narrowly drawn and do not reflect the broader role of the NHS in promoting public health as a provider, commissioner and major employer. There are also no equivalent duties on the Secretary of State or local authorities in respect of their roles in promoting public health.

11.3 The duties are unlikely to be sufficient to ensure that tackling health inequalities is prioritised in the health system. We strongly recommend that the NHS commissioning bodies should be held to account for reducing inequalities in health outcomes.

The proposed new system risks service fragmentation with detrimental impacts on the very areas the reforms seek to improve: quality of services, education and training, patient choice, efficiency and equity, and has the potential to exacerbate any existing postcode lottery in health services.

June 2011

Written evidence from Asmat Nisa (PH 172)

Public health is an extremely important function, and there is concern that there is a lack of adequate input proposed from public health within the NHS Futures Forum and associated work streams. This places a risk for the health of the public which may be seen as a lower priority without adequate public health specialist knowledge and representation in key areas of NHS work.

The current public health system is robust and "fit for purpose". As public health professionals and leaders we are committed to improving the health and well being of people in the community, protecting their health and reducing inequalities through already established and well developed partnerships with local authorities, and other key stakeholders such as businesses, voluntary and community organisations. We need to be focussing on building and strengthening existing partnership work to deliver an excellent public health system. The proposed reforms would de-stabilise effective public health and undervalue the specialist trained public health workforce and undermine existing partnership work.

As part of the proposed reforms, we believe that the following should be an integral part of the reforms to create a meaningful public health function that is "fit for purpose" in future society.

- The three key areas of public health would function most effectively if they remain together within Public Health England ie health protection (communicable disease control, emergency preparedness and environmental hazards), health improvement (through lifestyle and addressing health inequalities) and health services (ie planning and commissioning of services, audit and evaluation).
- All specialist public health staff must be appropriately qualified in the field of public health. Qualifications must be recognised by the faculty of public health. Specialists should have access to recognised continuing professional development. There is a real risk of losing a highly qualified public health workforce, should people choose to remain in the NHS and apply for other roles in the new NHS structure. Being employed by a Local authority does not seem like an attractive option and people generally feel they may lose NHS pension benefits that they currently have.

- Public Health England must have some form of independence and should employ specialists in public health. Specialists could be seconded to other organisations.
- Ring fenced public health budgets should be defined clearly and remain indefinitely ring fenced, so that the public health function remains protected and is not at risk from future cuts. This will help to reduce the risk of public health becoming marginalised in the future.

This is a crucial time for the NHS in light of the proposed changes and it is important that the view of public health organisations, experts and leaders is fully recognised and taken on board for the effective development of public health in the future.

June 2011

Written evidence from the Transport and Health Study Group (PH 173)

1. The Transport and Health Study Group is a scientific society of health and transport professionals studying the relationship between health and transport and promoting consequential policies.

2. Founded over 20 years ago in the UK we are now expanding internationally with a European Committee alongside our UK-based Executive Committee.

3. We believe we are the only public health society constituted on an interdisciplinary basis for another discipline to study, together with public health, the health implications of the work of that partner discipline. In June a similar organisation is to be launched in spatial planning.

4. We give evidence since societies such as ours could play an important role.

5. There could be scope to establish similar bodies in fields like marketing, economics, food and agriculture, housing, welfare, crime and disorder, human relations, education, community development, youth work, culture and media, public finance and probably others.

6. In our evidence we

- explain the role of transport in health (scientific references can be found in our e-book *Health on the Move 2*);
- discuss how societies like ours could contribute and the implications for Public Health England and the role of the Secretary of State;
- support, in that context, the BMA proposal that each Government department should have a Public Health Director;
 - discuss the role of Parliament in public health, even though this is not within the specific scope of the enquiry;
 - discuss, from our own experience, the role of DH and the Attorney General's office in litigation to protect the public health;
- assert, using transport as a case study for local government involvement in the wider determinants of health, that;
 - DPHs must have status across the whole of the local authority and be professionally independent;
 - the Health and Well Being Strategy must influence other strategic documents (in our case the Local Transport Plan);
 - there is a role for district councils, supra-upper-tier authorities and parish councils;
- discuss the contribution societies such as ours can make to training and the way professionals from partner disciplines can form part of the public health workforce;
- discuss, using transport funding as a case study;
 - the problem of ring fencing only NHS public health funding; and
 - the scope for innovative financial approaches involving benefit-capture.

THE HEALTH IMPLICATIONS OF TRANSPORT

7. We have described the links between transport and health in our recently published e-book, *Health on the Move 2* available at www.transportandhealth.org.uk

8. Briefly they are as follows.

9. Obesity results from imbalance between food intake and energy output. Physical activity is important—the evidence that physical activity has declined during the epidemic is stronger than the evidence that calorie intake has increased. A major component is the decline in walking and cycling. As walking and cycling is easily incorporated into everyday life it forms a significant part of an obesity strategy. Healthy transport policy would promote walking for journeys under a mile, cycling for journeys of up to five miles and the train/cycle combination for longer journeys.

10. Powerful scientific evidence shows the importance of social networking to health, so much so that the Alameda County study found a three fold difference in all causes mortality between the least-supported and most-supported groups, and McKee found that areas where more than 46% of the population were members of clubs and societies escaped the ravages of the Eastern European alcohol epidemic resulting from the decline of the Soviet Union. Therefore the finding by Hart in Bristol, replicating earlier work by Appleyard & Lintell in San Francisco, that people have fewer friends if their streets are heavily trafficked raises far ranging questions about the role motor traffic has played in deteriorating community spirit. Healthy transport policy would restrict traffic flow in residential streets and give priority to community use.

11. Speed is important. Kinetic energy rises with the square of the speed. Healthy transport policy would reduce speed limits and require the fitting of speed governors.

12. Vehicle exhaust emissions contribute to asthma, cancers and climate change.

13. Other issues include transport for disabled people, transport crashes, access to health-promoting services (including the countryside, other opportunities for physically active recreation, and shops stocking cheap healthy food), encouragement of safer transport systems such as rail, the contribution of transport poverty to health, rural deprivation and traffic education.

PUBLIC HEALTH ENGLAND AND THE ROLE OF THE SECRETARY OF STATE

14. The Secretary of State should represent health across Government. The above issues should be high on the agenda for DH relations with DfT.

15. Societies such as ours should be invaluable eyes and ears for the Secretary of State and PHE should support them.

16. Some years ago we applied to DH for funding of administrative support to our group and received indirectly ongoing support of one day a week of an Agenda for Change band 5 worker. That's the only support we have ever received although we have repeatedly outlined services that we could provide if we were managed more substantially instead of being dependent on the time our members can squeeze into busy day jobs—or, more frequently, their own spare time. A Secretariat supporting various organisations like ours, promoting new ones and linking them to DH could contribute to central public health infrastructure.

17. DfT has shown more interest in transport and health than DH and includes it in briefing papers for the Local Transport Plans. Without an established mechanism to capitalise on that, DH misses many opportunities.

18. Things may change with the establishment of Public Health England. However the separation within DH structures of PHE, Policy and CMO suggests that the vision of a single public health body has already been undermined and the role of PHE as a civil service body does not command confidence in its role as a more open body. Indeed Public Health England seems to be much more limited in its scope than we had hoped, sometimes seeming to be little more than the taking in house of the HPA.

PUBLIC HEALTH DIRECTORS IN GOVERNMENT DEPARTMENTS

19. We support the BMA proposal for a Public Health Director in each Government department (using the term “Public Health Director” for posts which serve an agency and confining the term “Director of Public Health” to posts which serve a population.)

20. No Government department would function without a high level link to the Treasury. The same should be true for Health.

21. We congratulate DfT on attempting this through overhauling its own Chief Medical Officer post. This has been less successful than hoped because

- The post was too junior. Although the individual recruited was quite capable of working at a more senior level, the status of the post seems to have constrained its potential.
- It did not have professional support from CMO's office in DH.
- Civil service roles prevented an open professional dialogue with the public health specialty.
- Rigid tendering rules prevented full use of expertise in the field for important tasks.
- The agenda was set by DfT itself rather than by a public health needs assessment.

22. This pilot experience allows lessons to be learned in going forward. We believe that these posts should:

- exist in all departments;
- be appointed at Director or Director General level;
- be supported from PHE;
- be professionally led by the Chief Medical Officer who should approve their agendas;
- write an annual independent report on the contribution their department has made to the health of the people;

- be appointed on contracts, such as NHS consultant contracts, which permit participation in a free professional interchange of ideas; and
- be able to make use of, and engage in mutual support with, sources of expertise in the field.

THE ROLE OF PARLIAMENT

23. The promotion of walking and cycling is central to the response to obesity.

24. Which Select Committee is responsible—Transport because it is a transport policy or Health because it is health strategy? What actually happens is that it falls between two stools.

LITIGATION FOR PROTECTION OF PUBLIC HEALTH

25. We were involved in 2003 in litigation for judicial review of a railway closure decision, the Oldham Loop Line. The line was being closed for conversion to a tramway. The Directors of Public Health for Greater Manchester were co-claimants.

26. Replacing the stopping service on the line with trams was uncontentious. We had good working relationships with the Greater Manchester Passenger Transport Executive which initiated this plan and have excellent relationships still with their successor body Transport for Greater Manchester. The closure however was carried out by the National Rail Authority and it is here that the problem arose.

27. From our standpoint, we said the line should remain open for use by heavy rail trains to retain the fast train service. This was part of an ongoing policy of ours that the prohibition on mixing light and heavy rail on the same track was risk averse, and on balance damaging to health because of its restraining effect on rail development. We (and others) had succeeded a few years previously in persuading the Railways Inspectorate of this but the Minister was wrongly advised that the old policy still applied. We were deeply concerned that such a state of ignorance about railway operation could exist within the body responsible for rail franchising. The PTE had a good reason for not doing this (the cost of resignalling) but we didn't know that and it was never mentioned at any time in the closure process nor was it mentioned in response to our litigation.

28. From the standpoint of the DPHs the issue was that they had given public health advice that part of the line be converted in such a way that it could easily be turned into mixed use if demand developed for freight. This advice had been ignored on the technical grounds that only passenger services were relevant to railway closure proposals. The issue therefore was failure to include public health advice amongst the issues weighed in the balance.

29. DH and the Attorney General's office were unhelpful. The DPHs were officers of the Crown bringing the action in the public interest but Treasury Solicitors saw it as their role to defend the decision, by seeking to strike the case out on the grounds that the claimants were not juristic persons and also by threatening to incur substantial costs. We responded by applying for an order to limit costs. The DPHs proposed that as the dispute was between two emanations of the Crown the Attorney-General should arbitrate and we consented to withdraw from the action if this course of action was agreed between the two Crown parties but the proposal was ignored.

30. In the end common sense broke out in Greater Manchester. The PTE (which had not been involved in carrying out the closure process) agreed to receive and consider the public health advice and the case was discontinued. In the discussions which resulted the PTE accepted the advice about the northern part of the line and gave us the sensible and entirely acceptable explanation as to why mixed use was unviable.

31. A number of issues arise from these events but the following are relevant to your enquiry.

- There is no statutory duty on public bodies to take public health advice into account.
- There is no support for DPHs in processes of this kind. Whilst the pursuit of legal proceedings in the High Court would be highly unusual, participation in, for example, planning processes should be more routine. Some form of legal support is needed.
- The legal status of DPHs in such processes is in doubt. Since this point was raised the BMA (which provided almost half the funding of the case) has suggested that the office of Director of Public Health should statutorily be granted corporation sole status. In this capacity, which would be separate from its role as an officer of an authority, it should be an NHS body. Although initially advanced by the BMA only as a technical solution to this technical legal problem it could potentially have other benefits as well.
- The Attorney-General's office thinks issues of this kind lie outwith its remit. Actions taken by officers of the Crown in the public interest should be very much in its remit.

TRANSPORT AS A WIDER DETERMINANT OF HEALTH FOR LOCAL GOVERNMENT ACTION

The DPH Must Act Across the Council

32. In a local authority, the Director of Public Health will see walking and cycling provision as the highest priority for the highways budget but the Borough Engineer may see it as a much lower priority. How does that conflict play out?

33. This example from our own field will be matched by similar examples elsewhere—density of housing against protection of open space, quality of work against growth at all costs etc

34. Ultimately such judgments must be made by elected members. But whose voice is heard round the management table? Who has the right to put their view to elected members? Who has the right to place their view in the public domain?

35. Directors of Public Health must have access to the highest level of management, an acknowledged role in challenge, and a right to access to elected members or full Council. There are other officers of the Council who have this right enshrined in statute. It should be true of the DPH as well.

The Health and Well Being Strategy and other strategic documents

36. A survey has suggested most Health and Well Being Strategies will not address transport. We find it hard to understand how a strategy can discuss obesity (as it must) yet ignore active travel.

37. If it does address this issue, what is the relationship of the strategy to the Local Transport Plan?

38. If the strategy is written independently of other strategic documents and then takes second place to them, it will be at risk of being set at nought by decisions made in the commissioning strategies of GP consortia, the business plans of NHS providers and a number of local government strategies that impact upon health.

39. The Health and Well Being Board must have powers to require compliance with the strategy in the health and social care field and at the very least a high level of attention to it in other fields.

District Councils in Two Tier Areas

40. District councils in county council areas have important functions relevant to public health, not least housing and environmental health. They are close to local communities and are best placed to bring about cultural change, including change related to walking and cycling and the communal use of streets.

41. Each such council needs its own dedicated public health adviser with the same role that a DPH has in an upper tier authority. It could have

- its own DPH;
- a designated Deputy DPH seconded from the public health department of the County Council; or
- its Director of Environmental Health may take on an expanded role.

Supra-Upper-Tier Authorities

42. The Mayor of London, the Combined Authorities in city-regions, the Joint Boards of metropolitan counties and the police commissioners of large constabularies all have significant powers relevant to public health. These include the transport powers of the Mayor of London, the Combined Authorities and the metropolitan Passenger Transport Authorities.

43. They need public health advice, which could come from

- a Public Health Director appointed to a specific authority;
- a DPH appointed to serve the population of a metropolitan county or city-region or Greater London; and
- a lead DPH drawn from a collective of the DPHs of the county.

Parish Councils

44. Parish councils are close to local communities. They have responsibility for footpaths.

45. It would be silly to suggest that they should have their own public health specialist, but a local GP or health visitor could act as their health adviser.

Workforce

46. Issues like the health impact of transport and spatial planning must be included in the academic curriculum of public health training and of partner disciplines.

47. One way to provide public health trainees with experience of the wider determinants of health is to place them with organisations like ourselves.

48. Some of the members of our society from a transport background are well placed to contribute to the public health workforce.

49. There is a dilemma here. Retention of the medical specialty structure (albeit with non-medical entrants) and consultant status is essential for the standing of public health in the NHS and also for avoiding local authorities sidelining the public health challenge process by appointing unqualified people. Without registration of non-medical specialists there is a danger that local authorities would appoint doctors as the DPH (for their professional standing in the NHS) and then appoint non-medical people to other jobs, re-establishing the medical/nonmedical divide. On the other hand too rigid a structure would produce a divide between the specialist and non-specialist workforce, would be severely unfair to some individuals and would block career advance for much of the present workforce.

50. The solution is to retain the specialty structure but to develop flexible pathways to specialist status.

Funding

51. Only the NHS contribution to public health funding will enjoy the protection of NHS status in the public spending plans or be ring fenced in the local authority. Some extremely important public health programmes lie outside that protection. Walking and cycling is an example.

52. *Health on the Move 2* advocates substantial infrastructure investment including new international high speed rail networks, new integrated public transport networks, new walking and cycling networks and new high speed broadband investment. Section 20.7 of the book discusses the scope for innovative financial approaches involving benefit-capture. This is an approach which may have wider potential eg in financing alcohol preventive programmes that are ultimately funded by NHS savings.

June 2011

Written evidence from the Queen's Nursing Institute (PH 174)

INTRODUCTION

1. The Queen's Nursing Institute (QNI) is the national charity concerned with the quality of nursing care patients receive in their own homes. We aim to improve care by funding nurse-led improvement projects, and inspiring nurses through the example of our Queen's Nurses. We also aim to influence policies that impact on the quality of care patients receive. The QNI does not have a membership base: this response reflects the expertise from our community nurse forum—which has more than 1,000 members.

2. The QNI welcomes the opportunity to respond to the Health Committee's inquiry on the Public Health reforms. Our submission addresses the questions most relevant to community nursing, and also showcasing examples of public health innovation led by community nurses. The QNI would of course be very pleased to meet with members of the Committee to discuss these issues further.

WORKFORCE, EDUCATION AND TRAINING

3. Improving the public's health is a key role for all community nurses. Working closely with GPs, local social services and health promotion teams, community nurses share health information to encourage healthy lifestyles, help to deliver preventative services to help young people stop smoking, assist hard-to-reach groups access outreach services, and support falls prevention programme for older people.

4. The QNI believes that the delivery of the vision in the Public Health White Paper, of a service which empowers people to makes changes that will make a difference to their lives, is dependent on the skills, knowledge and engagement of community nurses, midwives, health visitors and AHPs, in addition to new, targeted, flexible programmes. There is no alternative workforce to deliver these services and programmes.

5. Disappointingly, the framework for healthcare workforce education and training lacks focus on improving the capabilities in public health. We are relatively clear about the direction of structural reforms, but the framework has failed to convince us of the future reform direction of the competencies of healthcare professionals in a public health setting. Public health needs to be better taught to all nurses so that they understand the complexity i.e. it's not just about epidemiology or social marketing. We believe there is a huge opportunity to use nurses, health visitors and midwives to improve the health of the population if the workforce issues are addressed early on.

HEALTH EDUCATION—THE IMPORTANCE OF SCHOOL NURSES

6. Health education should be part of the national school curriculum. The National PSHE continuing professional development (CPD) programme should be the foundation going forward. Currently the programme provides community nurses and teachers with the opportunity to gain recognition and accreditation of their

experience in teaching personal, social and health education (PSHE) and to develop their knowledge, understanding and teaching and learning skills in the delivery of PSHE in schools and other settings. It has been running for six years and around 10,000 teachers, community nurses and other professionals have undertaken the programme. The programme is an important area of the curriculum that helps children and young people grow and develop as individuals and as members of families and communities.

7. The health perspective within the education curriculum needs to be supported by skilled health professionals. Specifically, School Nurses are essential within the school health team and have the capacity to increase the access to healthcare for children and young people both within educational settings and outside traditional settings. Examples of further refinement to the current programme include:

- Sexual Health, using the “building backwards” approach to personal hygiene in younger years and valuing self, gives structure to sexual and relationship education and should include the importance of using inclusive language thereby supporting a sensitive approach.
- Emotional Health including short term psycho-social interventions will help address prevention of mental health problems identified in Healthy Lives, Healthy People.
- Preventing uptake of smoking and the health risks of drug and alcohol are also necessary discussion areas.
- A critical success factor in progressing health education will be partnership working. The opportunity for health education to be situated within the Public Health Service will give greater opportunities for integration with education and social services for children and families which encompass the wider determinants of a school child’s health.

COMMISSIONING NURSE LED SERVICES—HEALTH PROMOTION AND PUBLIC HEALTH

8. Modern healthcare services are increasingly nurse-led in response to changing healthcare needs. Since 1990, the QNI has funded hundreds of projects led by community nurses, midwives or health visitors, which set up new services or improved ways of working. The following examples illustrate the ability of community nurses to influence behaviour change and that their achievements in public health have a visible and measurable impact at individual and community levels.

9. *Health Literacy Project for Travellers (Pregnancy)—Hackney London*—This project engaged with the Traveller and Gypsy community to improve their experience of accessing and using maternity and health services during pregnancy, ante-natal care and childbirth. The project, through consultation, with the Traveller community identified the issues and concerns Travellers have about accessing mainstream health services, particularly for pregnancy and childbirth services. As a result materials were developed to increase knowledge, confidence and health literacy. As this group has the highest rate of maternal and baby deaths in the country, such initiatives can ultimately save lives.

10. *“What if” Project—Cornwall*—“What If” is a life survival skills project, aimed at young people, their parents/carers and the community. The project brought together education, health and police agencies to tackle “real life” issues that affect every member of society through six life skills workshop days covering domestic abuse, sexual health, substance misuse, emotional wellbeing and healthy eating. The project also developed an interactive resource which included comprehensive lesson plans and a DVD for professionals which enabled the life skills programme to be delivered in other environments. This project showed that equipping young people with the skills to help keep themselves and others stay safe makes real differences to their lives and also the wider community. The success of this project has spread across the region with the teaching package and DVD made available to all the schools in Cornwall with strong interest for national dissemination.

11. *Smoke Free Homes Project—Kirklees*—This project set up a support service for parents of infants and children with breathing problems to help the parents to stop smoking in the home. The parents often express an interest to stop smoking but were unable to access the support for a variety of reasons. This project brought together the services of respiratory nurses and the Stop Smoking Service and succeeded in reducing the number of children admitted to hospital. More and more families are being referred to the service by other health professionals.

12. *Stop That Shake, Babies Break—West Midlands*—This was an innovative project equipping young people with vital life skills, via an audio visual teaching experience, on the cause, consequences, risks and prevention factors around “Shaken Baby Syndrome”. The project team took the teaching tool out to a variety of educational establishments within the Tamworth locality. Students viewed the experience as extremely valuable improving their understanding around “Shaken Baby Syndrome, specifically: how it affects infants physically, mentally and developmentally; the circumstances which could lead to shaken baby attack; the types of coping mechanisms that need to be employed as a prevention behaviour; and the support networks available for further support in positive parenting. The DVD has already been adopted by Heart of Birmingham PHSE training department and is being adopted into school curriculum for 6th Form pupils. The project was presented in Atlanta Georgia USA at the Eleventh International Conference on Shaken Baby Syndrome/Abusive Head Trauma. The project has also been submitted to National Foundation for Educational Research as best practice evidence.

13. *Parenting In Pictures—Hasting*—This project supported the development of positive parenting skills for young parents especially those at risk of social exclusion. A photographic resource called “Parenting in Pictures” was produced using the young people themselves as actors. These scenarios covered preparing for a baby, managing money, breast feeding and dealing with emotional or relationship changes. The resource is now being used by multiple agencies such as education, social services and health as well as young Peer Educators within school sexual health programmes and parenting awareness sessions.

14. In summary, the QNI believes that nurses, midwives and health visitors are a ready-made workforce capable of having a positive impact on public health—there is no other workforce to rely on. We also believe that more attention needs to be paid to the inclusion of public health teaching in all nursing courses, if new generations of nurses are to have these competencies.

June 2011

Written evidence from the British Association for Sexual Health and HIV (PH 175)

EXECUTIVE SUMMARY/KEY POINTS

- In recent years, sexual health has been recognised as a public health priority, and with centrally funded support, sexual health services have become an NHS success story. Services have embraced significant changes in work practices and developed new and innovative approaches to patient care. It is vital that the commissioning infrastructure builds on these successes and continues to enable high quality sexual health services that are not only efficient, but put patients first and deliver real and tangible health outcomes. However, continued success depends on continued investment. Historical experience shows that under budgetary pressures, sexual health services are often the first to get cut and therefore, robust measures must be put in place to ensure that the ring fenced public health budget remains truly ring fenced.
- BASHH welcomes the inclusion of “open access” sexual health services within the remit of the public health ring fenced budget as it demonstrates a proactive move to improve sexual health and reduce health inequalities through a unified public health approach.
- Whilst BASHH welcomes “outcomes” as far as they promote improvements in public health, we are concerned about adverse consequences related to the wholesale removal of process targets, including the 48-hour access target for sexual health. Unlike other areas of public health, STIs and HIV are transmissible, but also avoidable, and therefore *rapid open access* to sexual health services is vital for early detection, reduction in onward transmission, reduction in adverse consequences related to late diagnosis and for delivering cost savings associated with the delivery of high quality sexual health care. Requirements must be put in place to ensure all services are *rapid open access*.
- BASHH is concerned that increased competition between providers may lead to a “race to the bottom” competition on price rather than quality, and this concern is exacerbated by the fact that according to the health reforms, that national tariff will not apply to public health services. Tariffs for sexual health are a vital element of the QIPP agenda, ensuring that services provide value for money, are affordable, do not destabilise services/providers or PCTs, are in the best interest of patients and public health, and promote the integration of services. The London Sexual health Programme has developed an integrated tariff for sexual health: BASHH recommends that this tariff applied across all sexual health services as part of the QIPP agenda.
- Under increased competition, BASHH welcomes the principle of the “any *qualified* provider” rather than the “any *willing* provider” approach to commissioning in so far as it ensures that only sexual health services which are underpinned by nationally recognised quality, clinical and training standards, are commissioned. This will ensure the delivery of high quality care, which is clinically effective, safe, and cost efficient.
- BASHH is concerned that Local Authorities may not have the correct skills or expertise to commission specialist clinical services such as those for sexual health. It is only by ensuring that commissioning service specifications are underpinned by nationally recognised clinical and quality standards, commissioning decisions are based on comprehensive public health data and evidence, and that sexual health clinicians are engaged in the commissioning process that the highest quality of sexual health care will be provided.
- Whilst BASHH welcomes the commitment to health protection through the proposed continuation of the functions of the HPA, and hopes the new service may encourage further opportunities for research and data analysis, BASHH is concerned that the move may threaten the independence, credibility and trust of the service, and recommends that measures are put in place to ensure any credibility is not lost.

- The UK has one of the worst rates of STIs in Western Europe, and therefore, excellent leadership in sexual health is vital to ensure that we meet the challenges that face the health services both now and in the future, and to ensure that there are recognised clinical and training standards in place to enable the delivery high quality sexual healthcare at the local level. BASHH is concerned that, unless incentivised, non NHS providers will not provide training in sexual health, which could lead to a reduction in quality of patient care. It is vital that non NHS providers are subject to the same requirements with regards to education, training, as those working in the NHS, and that such training meets nationally recognised standards.

ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

1. BASHH welcomes the inclusion of open access sexual health services provided by sexual health services within the public health service. Open access sexual health services are available to all regardless of PCT of residence and, therefore, ensuring their continuation under the new public health service demonstrates a proactive move to improve the sexual health of our population through a unified public health approach.

2. Investing in high quality, rapid open access sexual health services produces longer-term savings as early detection and treatment of STIs, along with partner notification, reduces onward transmission and reduces adverse consequences such as ectopic pregnancy and infertility. An emphasis on increased HIV testing will also help identify the one in four people who are unaware of their condition and one in two who present with a late diagnosis. Poor sexual health is more common amongst people who already experience inequality associated with their age, gender, ethnicity, sexuality or economic status, and poor sexual health also affects a significant number of people who have other public health needs, in particular alcohol and drug misuse and violence. It is often these most deprived and marginalised communities that find it hard to access health services. Therefore, for the social, health and economic benefits it brings, ring-fenced funding of sexual health services and sexual health promotion via Public Health England is an “invest to save” concept.

3. Commissioning sexual health services as part of the ring fenced public health budget will help ensure that fully comprehensive, rapid open access sexual health services are delivered across a range of health and community settings, and in particular, reach communities vulnerable to or at risk of poor sexual health, therefore delivering the best possible outcomes for the local population as a whole. Commissioning through the local authority will also facilitate the integration of sexual health services, encourage linkages between services addressing related public health issues such as alcohol and drug misuse, reduce duplication of effort, and ensure that patients receive a seamless model of care. Such combined approaches are more effective and offer better value for money from public health budgets so should be encouraged.

4. However, whilst BASHH welcomes the commitment to public health through the ring fenced public health budget, we are concerned that the funds may not be sufficient to support the range of services needed in order to, improve health outcomes, reduce health inequalities, and avoid the higher costs of managing ill-health. Furthermore, with local authorities facing increasing budgetary pressure, BASHH is concerned that public health funds may be diverted to support non public health activities: historical experience (IAGSH 2006 report) shows that under financial pressure, sexual health services are often the first to get cut and funds are often diverted away from front line services. BASHH recommends that robust measures, such as regular audits, are put in place to ensure that the ring fenced funds remain truly ring fenced, and reach those frontline services the funding is allocated for.

5. In recent years, commissioners and providers of sexual health services have worked together to improve access to services, increase patient choice, improve the availability of testing and treatment for STIs, and put patients at the centre of their care. As a result, sexual health care is now provided by a variety of different sexual health providers, in a variety of settings, from HE colleges, and pharmacies, to GUM clinics providing fully comprehensive testing and treatment and more specialist case management. This approach has allowed areas to tailor their service provision to suit differing local needs.

6. However, BASHH is concerned that this increase in providers, alongside increased competition, may lead to a “race to the bottom” competition on price rather than quality. With commissioners facing ever increasing budgetary pressure, BASHH is concerned that “cheaper” services, which are less comprehensive, will be commissioned in place of fully comprehensive services: for example, clearly, a service which provides training and complex case management is more expensive than one which is limited to providing high volume, low cost STI screening.

7. In light of such concerns, BASHH advocates the principle of the “any *qualified* provider” rather than the “any *willing* provider” tender basis for public health service commissioning, in so far as this approach ensures that commissioners commission only those sexual health services that;

- (a) Are underpinned by a national tariff system of pricing which is a true reflection of the services provided by sexual health services, and which will ensure a fair and level playing field.
- (b) Provide rapid, open access to sexual health services.
- (c) Are underpinned by BASHH standards for the management of STIs, which is endorsed by the Department of Health
- (d) Are delivered by staff educated and trained to nationally recognised standards.

- (e) Are commissioned as part of a consultant led community network.
- (f) Are required to provide local data relating to prevalence of STIs and HIV and notify all disease outbreaks.
- (g) Include in every locality comprehensive (i.e. including level 3), sexual health services which offer testing and treatment of STIs, opportunistic Chlamydia screening, and high quality partner notification, to all people regardless of residence.

8. Through proper enforcement, this approach should ensure the delivery of high quality, clinically effective, safe, and cost efficient services.

9. Looking at proposals for sexual health commissioning, BASHH is concerned that local authorities may not have relevant or sufficient experience of commissioning specialist clinical services such as GUM. Successful commissioning for public health services depends on a number of different factors relating to;

- (a) The availability and use of public health data and the skills to interpret this.
- (b) The availability of best practice public health guidance which sets standards and expectations, and
- (c) The development of appropriate clinical partnerships to both share and draw upon expertise.

10. In the past NHS commissioning of sexual health services has been of variable quality. Experience has indicated that commissioners must be equipped with relevant knowledge and skills relating to sexual health, and that clinicians must be engaged in the commissioning process to help ensure both improved patient related outcomes and to help deliver service efficiencies. Mechanisms should be put in place to ensure that clinicians are able to feed in to the commissioning process for public health.

11. Commissioning service specifications should also insist that national clinical and quality standards, such as those produced by medical Royal Colleges, medical specialties, and NICE, are adhered to. Such guidance is vital to ensure both consistency and quality across all services provided for public health, and levers of accountability should be put in place to ensure this guidance is followed. BASHH has produced national guidelines for sexual health, which have recently been accredited by NHS Evidence, and therefore, as the representative body for sexual health, these guidelines should be used to provide the framework for commissioning of high quality sexual health services.

ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES (INCLUDING THE HEALTH PREMIUM)

12. As outlined above, BASHH is concerned that increased competition in the NHS will lead to a decline in the quality of sexual health care provided. This is exacerbated by the fact that the national tariff system for the NHS will not apply to the new public health service, under which sexual health service fall.

13. The London Sexual Health Programme has put a huge amount of work into developing an integrated sexual health tariff, which will allow for the development of prices that are setting-independent and could be used by a variety of providers. The work of the London Sexual Health tariff project is vital to ensuring that in the future SH services are appropriately remunerated for the important public health work that they do, and they are intended to drive good practice and increase access to sexual health services, including for HIV.

14. The tariff prices which have been developed:

- (a) Are in the best interest of patients and public health ensuring open access is maintained.
- (b) Promote the integration of services (SRH/GUM).
- (c) Provide value for money and are affordable.
- (d) Do not destabilise services/providers or PCTs.
- (e) Provide tariffs for SRH & integrated services that are robust.

15. International evidence suggests that without a fixed tariff system in place, the resulting situation will be a “race to the bottom” to provide the lowest cost services at the most competitive prices. Whilst this may be desirable for commissioners facing ever diminishing budgets, “cheaper” less comprehensive services can often be achieved at the expense of quality. BASHH, is concerned that any compromise on quality could lead to rapidly worsening rates of sexual ill health, increased spread of disease and ultimately, poorer health outcomes.

THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

16. BASHH advocates outcomes in so far as they promote improvements in health and reduction in inequalities. For sexual health, which is linked to a number of different public health issues, outcomes should encourage collaboration of effort across the public health service, to improve quality and efficiency, reduce duplication of effort and ultimately help improve the health of the local population.

17. Whilst outcomes will be important for delivering health improvements, BASHH is concerned about the wholesale removal of all process targets. Unlike many other areas of public health, STIs and HIV are transmittable, but also avoidable. Therefore, for sexual health, as treatment forms a vital component of the prevention function, *prompt* access to sexual health services can bring about significant public health benefits:

- (a) *Early diagnosis* of STIs reduce risk of costly complications and of onward transmission

- (b) *Earlier diagnosis* and treatment of STIs, can prevent the development of long term and life threatening complications, including cancers and infertility
- (c) Undiagnosed HIV increases the risk of passing on HIV: The NHS cost of providing lifetime treatment for people with HIV is increasing by £1 billion each year, whilst each time a person is prevented from acquiring HIV the NHS saves over £350,000.

18. Clearly, the realisation of better outcomes in sexual health is dependent on *timely access to sexual health services*. The 48 hour access target, which has underpinned sexual health services in recent years, is not a politically driven target, but one based on sound clinical rationale, with the result of improving clinical outcomes and delivering:

- (a) Earlier access to STI testing, diagnostics, and treatment;
- (b) A break in the onward chain of transmission; and
- (c) Rapid public health benefits to the NHS, the individual, and the population.

19. Ten years ago, as rates of STIs increased, sexual health services were struggling to cope with demand, with median waiting times of around 10–12 days. The 48 hour access target was introduced to ensure people received prompt access to diagnosis and treatment. It is vital that all sexual health services, which are open access by nature, are commissioned as *rapid open access* services. BASHH is concerned about the impact that the removal of the rapid access requirement may have on the quality of services provided and the health of the nation.

The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)

20. Sexual health is inextricably linked with a number of areas of public health, and with such a variety of providers operating within localities, Local Health and Wellbeing Boards (LHWBs) will need to play a central role in ensuring that communication and collaboration is facilitated between different service providers to;

- (a) Help build effective partnerships.
- (b) Ensure that efforts are not duplicated.
- (c) Help the further integration of services.
- (d) Ensure that local prevention initiatives are mutually reinforcing and/or complementary to each other.
- (e) Ensure clinical and quality standards are being met across all providers so that the care delivered is both clinically effective and consistent.

21. BASHH recently launched “Standards for the management of STIs” which are endorsed by the Department of Health, and which represent current best practice in sexual health service provision. The standards were drawn up to facilitate the commissioning of services within a clinical network framework, and to enable healthcare professionals in different settings to work together to deliver quality care across providers.

22. Joint Strategic Needs Assessments will be crucial for the development of proposed Local Joint Health and Wellbeing Strategies. It is vital that sexual health services are included as a key component in this strategy, and that sexual health clinicians, as local leaders in their field, are involved in the development of these documents.

THE ABOLITION OF THE HEALTH PROTECTION AGENCY

23. The HPA is the current provider of epidemiological information on sexual health in the UK. Its data collection and analysis methodology has been refined over many years and there are systems in place to ensure that the data is robust, avoids duplication and that there is widespread dissemination of analysis both on their website and in peer reviewed journals.

24. According to the proposals, Public Health England (PHE) will encompass all the current functions of the HPA. Whilst BASHH welcomes the commitment to health protection and hopes this may encourage further research and data analysis in the field of sexual health, BSHH is concerned that the proposals may have a negative impact on the provision of robust monitoring and surveillance data.

25. There is already a great deal of useful data that is supplied to the HPA which is not currently analysed as other key data is prioritised, and there is a concern that any reduction in personnel or resources may lead to a reduction in key epidemiological analysis and a reduction in the ability to respond quickly to requests for data analysis in outbreak situations.

26. Furthermore, there are some additional concerns about the potential loss of independence, credibility and trust that could arise out of the proposed move. Independence of the functions of the HPA is critical in terms of retaining credibility and the trust and confidence of the public, health professionals and others working in the field of health protection—locally, nationally and internationally: steps must be taken to preserve its independence.

THE FUTURE OF THE PUBLIC HEALTH WORKFORCE (INCLUDING THE REGULATION OF PUBLIC HEALTH PROFESSIONALS)

27. The UK has one of the worst rates of STIs in Western Europe, and therefore, excellent leadership in sexual health is vital to ensure that we meet the challenges that face the health services both now and in the future. Medical Royal Colleges Professional Medical Associations are the custodians of the postgraduate specialty medical curricula, and through leadership, develop training programmes that are underpinned by national clinical and quality standards, and which are set within overarching governance frameworks.

28. Effective training and ongoing education is essential to achieving high quality and safe care, which ultimately delivers cost savings for the NHS. BASHH is concerned that, unless incentivised, non NHS providers will not provide appropriate development opportunities and training in sexual health. A proliferation of non training services would have an adverse effect on education, training and research opportunities and ultimately, could lead to a reduction in the quality of patient care delivered.

29. BASHH *Standards for the management of STIs* set out a number of recommendations relating to training which are relevant for all providers of STI care. Recommendations include:

- (a) People at risk of STI should have their care managed by an appropriately skilled health professional. Individual practitioners are responsible for maintaining their own competence but should be supported in this by their employing organisation.
- (b) Agreed mechanisms should be in place for the assessment of clinical competence. These should be standardised and common across all professional groups.
- (c) Services should be able to provide assurance that all professionals delivering care for the management of STIs can demonstrate that they are competent and remain competent to do so.

30. In line with the concerns about the proposed structures, BASHH further recommends that:

- (a) Non NHS providers are subject to the same requirements with regards to the provision of education, training and continuing professional development as those working in the NHS.
- (b) Such training and education meets nationally recognised standards.
- (c) All services providing training are appropriately reimbursed.
- (d) Royal Medical Colleges and professional bodies are actively involved in advising and approving education and training provided by all service providers.

ABOUT BASHH

The British Association for Sexual Health and HIV—BASHH—was formed in 2003 through the merger of the Medical Society for the Study of Venereal Diseases (MSSVD; established 1922) and the Association for Genitourinary Medicine (AGUM; established 1992).

The objectives of BASHH are:

- To promote, encourage and improved the study and practice of the art and science of diagnosing and treating sexually transmitted diseases including all sexually transmitted infections, HIV and other sexual health problems.
- To advance public health so far as it is affected by sexually transmitted diseases and to promote and encourage the study of the public aspects of sexually transmitted diseases including all sexually transmitted infections, HIV and other sexual health problems.
- To advance the education of the public in all matters concerning the medical specialty of Genitourinary Medicine (hereinafter referred to as “the Specialty”), to include the management of HIV infections and the broader aspects of sexual health.
- To promote a high standard in the medical specialty of Genitourinary Medicine to include the management of HIV infections and the broader aspects of sexual health.

There are currently over 700 members of the BASHH, over 70 of whom are overseas members. The Association membership includes medical practitioners, scientists in the field of medicine and other healthcare workers who have shown a commitment to the specialty, who have been duly elected Fellows, Members and Honorary Fellows. Criteria for commitment to the specialty are that the applicant should be currently working in or have contributed to the specialty or an allied field. Honorary Life Fellowship may be conferred on persons, including those not medically qualified, who have given distinguished service to the Society.

Written evidence from Roche Products Ltd (PH 176)

1. ABOUT ROCHE

Roche is a leading manufacturer of innovative medicines, including in oncology, rheumatology and virology. We closely work with organisations to improve the quality and efficiency of NHS services, including the Department of Health, NICE, patient and professional organisations, NHS commissioners and providers of care.

Roche aims to improve people's health and quality of life with innovative products and services for the early detection, prevention, diagnosis and treatment of disease. Part of one of the world's leading healthcare groups, Roche in the UK employs nearly 2,000 people in pharmaceuticals and diagnostics. Globally Roche is the leader in diagnostics, and a major supplier of medicines for the treatment of cancer, transplantation, virology, bone and rheumatology, obesity and renal anaemia.

Roche has a heritage in working with NHS organisations to translate information about health service delivery into intelligence on how services can be improved, and on into action to improve the quality of care provided to patients.

2. THE CREATION OF PUBLIC HEALTH ENGLAND WITHIN THE DEPARTMENT OF HEALTH

2.1 Roche supports the establishment of Public Health England within the Department of Health. This national body should ensure that there is sufficient oversight of public health issues and a means to ensure joint working across the NHS, public health and social care services.

2.2 Public Health England should play a role in ensuring that a proportion of the public health budget is spent by local authorities on information campaigns such as those on bowel, breast and lung cancer which are currently being piloted.⁴⁸⁸ It should also provide advice on the type of awareness campaigns that could be undertaken in areas of high prevalence of a condition such as hepatitis C.

2.3 Public Health England will also be responsible for screening programmes. It should take a lead in improving participation in existing programmes and ensure that screening hubs are able to implement new programmes as soon as evidence supports it. This should include technologies such as flexible sigmoidoscopy for bowel cancer for which the evidence exists and lung cancer screening if the pilot shows that this system is proven to work.

2.4 Roche welcomes the proposal to publish data on public health outcomes by Public Health England—this will allow benchmarking between providers and a mechanism to drive up performance. Roche has a history of collecting and analysing data on areas relevant to our markets and we would welcome the opportunity to share this data to encourage public health providers to improve their performance and target areas where people are being disadvantaged with poorer public health outcomes.

3. THE ABOLITION OF THE HEALTH PROTECTION AGENCY AND THE NATIONAL TREATMENT AGENCY FOR SUBSTANCE MISUSE

3.1 Roche is concerned that the abolition of the Health Protection Agency may impact negatively on the collection and analysis of data on key public health areas such as pandemic influenza and hepatitis C. Measures should be taken to ensure the transfer of data and responsibilities is smooth and that no expertise is lost.

4. THE PUBLIC HEALTH ROLE OF THE SECRETARY OF STATE

4.1 It is welcome that the Secretary of State has a specific role to protect the health of the nation. His specific responsibilities should include:

- 4.1.1 Ensuring that the ring-fenced public health budget is used on measures that are linked to clear health improvements such as awareness campaigns for bowel cancer, hepatitis C and rheumatoid arthritis and targeted screening programmes for cancer and hepatitis C.
- 4.1.2 Ensuring that the activities of Public Health England, the NHS and social care are effectively coordinated so that services that span the three services such as cancer, hepatitis C and rheumatoid arthritis are streamlined and deliver the best outcomes for patients
- 4.1.3 Ensuring that measures in the Public Health Outcomes Framework are coordinated with the NHS and social care outcomes frameworks and focused on real health outcomes such as the proportion of patients diagnosed at Stage 1 or Stage 2 cancer and a reduction in mortality from liver disease

5. THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH (INCLUDING ARRANGEMENTS FOR THE APPOINTMENT OF DIRECTORS OF PUBLIC HEALTH; AND THE ROLE OF HEALTH AND WELLBEING BOARDS, JOINT STRATEGIC NEEDS ASSESSMENTS AND JOINT HEALTH AND WELLBEING STRATEGIES)

5.1 Alignment across Public Health, adult social care and the NHS is vital if we are to improve outcomes across the health service. Directors of Public Health should take a lead in ensuring that local government focuses on measures that have a tangible public health impact.

⁴⁸⁸ Department of Health, *Improving Outcomes: A Strategy for Cancer*, January 2011.

5.2 Health and wellbeing boards will be very important to ensuring that services are joined up. These boards should include input from experts in the delivery of services such as cancer networks, the voluntary sector and patients.

5.3 Where necessary, there should be joint performance measurement across the NHS, public health and social care as some of these interventions will require high quality commissioning from more than one commissioner. For example, early diagnosis may involve awareness (public health), screening (public health), primary care diagnostics (NHS) and secondary care investigation (NHS). Therefore it will be important to develop joint commissioning outcome indicators which can be shared at a local level.

5.4 National outcomes strategies such as the Liver Strategy, which is currently in development, provide a real opportunity to ensure joint working as they will set out how the different parts of the health service should work together. This has already been demonstrated in *Improving outcomes: a strategy for cancer* which underlined the importance of joint-working between the NHS, public health and social care services in improving outcomes. The Department of Health should also prioritise the development of an outcomes strategy for musculoskeletal conditions to ensure seamless delivery of these services.

5.5 Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies should take into account the needs of the local population in order that services can be directed in an appropriate manner. Some areas of the country have a higher prevalence of hepatitis C for example. In these instances, there should be some kind of measurement available that will ensure that these strategies focus on measures that will offer real public health benefit such as targeted awareness and screening campaigns. It is vital that resources are appropriately directed and not spent on more general areas of local authority funding streams.

6. ARRANGEMENTS FOR PUBLIC HEALTH INVOLVEMENT IN THE COMMISSIONING OF NHS SERVICES

6.1 Health and wellbeing boards should work to ensure that specific public health expertise within a local area are consulted on. On issues relevant to bowel cancer, the cancer networks should be included in discussions around commissioning. The voluntary sector should also be consulted as they have a wealth of information about the needs of the people that they represent.

6.2 Health and wellbeing boards should also consult people in the local area that run services relevant to public health. This could include pharmacies that have the capability of supporting testing for hepatitis C and signposting patients to their GP if they display symptoms of more serious conditions. It could also include drug treatment programme managers that may have expertise in identifying patients at risk of contracting blood borne viruses such as hepatitis C.

7. ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

7.1 Coordination will be key to commissioning effective public health services. Some public health interventions will require high quality commissioning from more than one commissioner. For example, early diagnosis may involve awareness (public health), screening (public health), primary care diagnostics (NHS) and secondary care investigation (NHS).

7.2 Early diagnosis is vital across all disease areas and should be the aim of every provider and commissioner. This includes cancer where Cancer Director Professor Sir Mike Richards has pointed to England's poor diagnosis rates for cancer as one of the reasons that England lags behind its European counterparts on cancer survival. For conditions such as hepatitis C, diagnosing the condition not only allows patients to be offered effective remedial treatment but it also means that these patients can be given advice on how to avoid the spread of the virus.

7.3 Joint working is vital to ensure that capacity planning is accurate—there is no point undertaking an awareness campaign for hepatitis C if there is no capacity in the NHS to undertake testing and to instigate treatment.

7.4 Cancer networks should play a key role in coordinating the commissioning of cancer services to ensure seamless care for the patient. This will also ensure that appropriate expertise is available to inform commissioning. It is welcome that future funding for cancer networks has been secured to support the implementation of the reforms to the NHS and public health service. Other clinical networks should be introduced in areas where they will help to ensure that services are integrated and coordinated across public health, NHS and social care—this could include cardiovascular disease and musculoskeletal conditions.

7.5 Where necessary, guidance should be given by Public Health England on the commissioning of public health services. This should help to ensure that local authorities commission services which have a tangible public health benefit. In times when budgets are tight, there is a danger that local authorities will commission initiatives that can be broadly defined as “public health” measures but which will not necessarily lead to improvements in the health of the local population.

8. THE FUTURE OF THE PUBLIC HEALTH OBSERVATORIES

8.1 Public Health England and local authorities will be responsible for the functions of Public Health Observatories and cancer registries. This change in responsibility should allow time for reflection in the timeliness of data collection around cancer.

8.2 Roche has a strong heritage in using data to drive improvements in outcomes—Public Health England should introduce measures that will speed up the publication of data on public health issues. This will support healthcare providers and commissioners to make informed choices about where to target resources and improve outcomes accordingly. In some instances, it may be necessary to develop proxies for outcomes to drive improvements in areas where the public health benefit may not immediately be seen. For example, it may be advisable to record and report on the percentage of patients diagnosed with hepatitis C being offered treatment. These early interventions will ensure that more complex and expensive treatments for chronic disease will be avoided.

8.3 Data on cancer survival, mortality and incidence is reported with a time lag of around four years—this kind of gap should not be acceptable in the age of the *Information Revolution*. Data collection systems should be streamlined to ensure that data are collected, verified and published as quickly as possible. Local authorities and the local NHS providers, with the support of Public Health England, in conjunction with local authorities, should take a lead in making this happen.

9. THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

9.1 Roche is broadly supportive of the Public Health Outcomes Framework. Measures within the framework should be directly linked to health improvement. Local authority budgets are being reduced and there is a risk that many activities that may be cut could be covered by a public health budget. This will ensure that the Outcomes Framework, Local Authority Public Health allocation, and the health premium contribute fully to health inequality reduction and advancing equality.

9.2 The Outcomes Framework should also encourage partnership working across the NHS and public health. The inclusion of measures that span across both the NHS and public health should support these—these measures include that in Domain 4 patients diagnosed at stage 1 or 2 as a proportion of cancers diagnosed and those in Domain 5 on mortality rate from cancer and mortality rate from chronic liver disease.

9.3 For a condition like hepatitis C, measures that span across the NHS and public health are important as screening and awareness may be the responsibility of the public health service but the treatment and testing will take place in the NHS—coordination will ensure that patients that are identified by the public health service are given the support they need in the NHS to be successfully treated.

9.3.1 The Liver Strategy is currently in development and it is important that the measures within the Public Health Outcomes Framework, including the data collected, reflect the aims of the strategy. This trend has already been seen in *Improving outcomes: a strategy for cancer*.

9.4 The inclusion of a measure on work sickness absence rate in domain 4 of the Public Health Outcomes Framework is welcome. This should ensure that local authorities take into account the wider implications on the economy of measures such as awareness campaigns for RA.

9.5 It is important that the lack of data is not used as an excuse not to focus on an important issue. In these instances, it may be necessary to collect data that have not been previously gathered. This is particularly relevant to hepatitis C where reporting and collection of data is poor.

9.6 Data should be collected at GP consortia level so that it supports local decision making and the NHS Outcomes Framework. In the development of data parameters, it should be borne in mind that all data is potentially comparable and they should be collected in a way that allows this. All information should be disaggregated according to age, gender, at-risk group so that it is possible to focus on specific population levels.

9.7 It is important that the time lag before the long-term benefits of public health measures are seen is considered in relation to indicators within the Framework. For example, for those investing in hepatitis C testing, the benefits on liver mortality may not be seen for a number of years. In the interim period, local authorities may decide to redirect spending in the search for fast results, thus there should be a clear focus on screening or diagnosis rates for hepatitis C within domain 4 as set out above to make sure that the longer-term benefits are achieved.

10. ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES (INCLUDING THE HEALTH PREMIUM)

10.1 Local authority budgets are being cut and there is a chance that activities under threat could be covered by a public health budget. It is important that the funding for public health services is directed at evidence-based interventions that are directly linked to health improvement such as hepatitis C testing among at-risk groups, national bowel cancer screening and awareness programmes for conditions such as cancer, hepatitis C and rheumatoid arthritis.

10.2 In order to maintain a focus on reducing inequalities, there should be measures focused on at-risk groups—for example those with an increased chance of contracting hepatitis C or developing bowel cancer.

11. THE FUTURE OF THE PUBLIC HEALTH WORKFORCE (INCLUDING THE REGULATION OF PUBLIC HEALTH PROFESSIONALS)

11.1 The public health workforce should be encouraged to be flexible and spread across wide areas of the community including the use of health in the workplace schemes, forging new partnerships across primary care and supporting the implementation of national awareness programmes.

12. HOW THE GOVERNMENT IS RESPONDING TO THE MARMOT REVIEW ON HEALTH INEQUALITIES

12.1 A greater emphasis should be placed on addressing inequalities—within the public health white paper, there was patchy information on the equality impact assessment for the measures set out in the plans. This suggests that steps to take on board the recommendations from the Marmot Review on health inequalities had not been properly taken on board.

12.2 Initiatives such as the National Cancer Equalities Portal should be encouraged for other disease areas as means to assess data that can identify inequalities in health outcomes. This information should be used to identify areas that require improvement. This portal is an early example of how the principle of the Information Revolution can be applied to a specific disease area. For example, the commitment in *Improving outcomes: a strategy for cancer* to examine survival, mortality and incidence data by geographical area and to publish one-year survival data is welcome as it will support identification of groups that are more likely to present late.

12.3 Equalities data should be used to support the public health service in introducing targeted campaigns aimed at particular equality groups within their area.

June 2011

Written evidence from Jean Gross, Communication Champion (PH 177)

1. Executive Summary

1.1 I welcome the Health Select Committee's inquiry into the future of public health. I urge that the Committee support proposals to transfer responsibility for public health to local authorities. I further urge that the Committee emphasises the vital public health role of services which address children's early development, following the Marmot recommendations that "giving every child the best start in life is crucial to reducing health inequalities across the life course. What happens during the early years has lifelong effects on many aspects of health and well-being—from obesity, heart disease and mental health, to educational achievement and economic status. To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences".

1.2 I ask that the committee recognises the centrality of positive early experiences that promote good social, emotional and language development to improved life chances and health outcomes, and notes the positive work that has been done in many areas of the country in this respect.

1.3 I suggest that public health work aimed at improving development and wellbeing outcomes for children is likely to be given a lower priority by health and wellbeing boards than issues relating to adults. Health and wellbeing boards should, therefore, be required to have a children's sub-board.

1.4 I note that there is a risk that the proposed new health premium will incentivise cost-ineffective activities aimed at adults rather than longer-haul but more cost-effective activities aimed at children and young people. The formula developed for the health premium should therefore include experts in early childhood development and wellbeing.

1.5 I suggest that the outcomes framework for public health use children's communication and language, physical and personal, social and emotional development levels at age two and five as key indicators of success, since these are factors which best predict later health outcomes as well as later educational achievement and employment opportunities.

1.6 I commend the Healthy Child Programme to the committee as a prime public health strategy, but note that when this was commissioned by Primary Care Trusts it was given a low priority and not fully implemented in an estimated 40% of local areas. I ask the committee to recommend that the health visitors who lead the programme for 0–5 year olds are in the long term commissioned by local authority public health directors, rather than by GP consortia.

1.7 I recommend that government and Public Health England include the vital public health role of speech and language therapists in the Healthy Child Programme, and in guidance on the use of public health funding under the proposed transfer of commissioning from Primary Care Trusts to local authorities.

2. About the Communication Champion

2.1 The post of Communication Champion, for children and young people aged 0–19 in England, was created by Government in response to the 2008 Bercow Report on services for children and young people with speech, language and communication needs. A key role for the Champion, who is appointed by but independent

of Government, is to assist commissioners and providers to develop services that improve outcomes for children with poor communication skills, including through spreading good practice.

2.2 In this role I have now visited 93 of 152 local authority/Primary Care Trust pairings, to discuss local practice within the Healthy Child Programme, children's community health services and local authority services for under fives and for older children with disabilities or who live in poverty.

3. *Where is the best point to intervene in order to improve public health?*

3.1 Effective interventions to improve adult health begin in early childhood. As the Marmot Review has shown, poor health in adulthood is strongly related to poverty and to factors in early childhood that affect development. Marmot found that "giving every child the best start in life is crucial to reducing health inequalities across the life course. What happens during the early years has lifelong effects on many aspects of health and well-being—from obesity, heart disease and mental health, to educational achievement and economic status. To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences." Marmot identified as a priority objective reducing inequalities in the early development of physical and emotional health, and cognitive, linguistic and social skills—and put giving every child the best start in life as the review's highest priority recommendation.

4. *Why are children's speech, language and communication skills a public health issue?*

4.1 Research evidence shows that of all areas of early childhood development, early language skills are particularly powerful predictors of later life chances. After controlling for a range of other factors that might have played a part (mother's educational level, overcrowding, low birth weight, parent a poor reader, etc), children who had normal non-verbal skills but a poor vocabulary at age five are at age 34 one and a half times more likely to have mental health problems and more than twice as likely to be unemployed than children who had normally developing language at age five (Law *et al.*, 2010)

4.2 As well as being an independent predictor of adult outcomes, language skills are a critical factor in social disadvantage and in the intergenerational cycles that perpetuate poverty. Poor language skills are the key reason why, by the age of 22 months, a more able child from a low income home will begin to be overtaken in their developmental levels by an initially less able child from a high-income home—and why by the age of five, the gap has widened still more.

4.3 Research in the USA found that on average a toddler from a family on welfare will hear around 600 words per hour, with a ratio of two prohibitions ("stop that", "get down off there") to one encouraging comment. A child from a professional family will hear over 2,000 words per hour, with a ratio of six encouraging comments to one negative (Hart and Risley, 2003).

4.4 Low income children lag their high income counterparts at school entry by sixteen months in vocabulary. The gap in language is very much larger than gaps in other cognitive skills (Waldfoegel and Washbrook, 2010).

4.5 Vocabulary at age five has been found to be the best predictor (from a range of measures at age five and 10) of whether children who experienced social deprivation in childhood were able to "buck the trend" and escape poverty in later adult life (Blanden, 2006).

5. *Examples of existing public health action and its impact*

5.1 A number of Primary Care Trusts and local authorities have recognised the predictive power of early language and communication development and have taken action to tackle the issue, aligning the work of speech and language therapists with the Healthy Child Programme and SureStart Children's Centres.

5.2 *Stoke Speaks Out*, for example, is a primary prevention initiative set up in 2004 to tackle the high incidence of speech and language difficulties in the city. It aims to support attachment, parenting and speech and language issues through training, support and advice.

5.3 The programme has developed a multi-agency training framework for all practitioners working in the city with children from birth to seven years, or their families. The training has five levels, ranging from awareness-raising to detailed theoretical levels, and was jointly written by the project team of speech and language therapists, a psychologist, a midwife, play workers, teachers and a bilingual worker. All levels have an expectation that the practitioner will create change in their working environment. In addition the initiative has developed resources for parents, including a model for toddler groups to follow which enhances language development, and a website offering practical information for parents to help with children's language development. "Talking walk-ins" provide drop in sessions at Children's Centres where parents can get advice from speech and language therapists.

5.4 Outcomes have been impressive. In 2004 64% of three year olds in the city had significantly delayed language skills. Now, as a result of the initiative, that figure is down to 39%.

5.5 Nottinghamshire has developed a Language for Life strategy, stemming from a decade of speech and language therapy work in SureStart Local programmes. In the most disadvantaged areas the therapy service provides training for all Early Years practitioners, support for practitioners to run listening and narrative groups

for children with language delay, and leaflets, posters and charts for parents, such as a Talking Tree height wall chart which includes speech and language milestones. The speech and language therapy Children's Centre core offer includes support for harder to reach families with 0–3 year olds through a 'Home Talk' home visiting programme. The Healthy Child Programme two-year development check includes a parent-interview language screen, with a 'traffic light' alert system which triggers use of relevant advice leaflets or access to the Home Talk programme, which has lifted 60% of two year olds supported out of language delay, with the remaining 40% referred early for speech and language therapy.

5.6 In Derby there is a team of speech and language therapists, therapy assistants and Family Visitors, who work from Children's Centres in one of Derby's localities. All two year olds are assessed on their language and development by Health Visiting team nursery nurses, or Family Visitors. Where the screening shows language delay, children are signposted to parent/child interaction groups, or home visits by the speech and language therapist or Family Visitor, to carry out a 4–6 week programme with the family.

5.7 In Herefordshire, local teams have maintained a Healthy Child developmental check at nine months, two years and three years. All members of the Health Visiting team (Health Visitors and community nurses) receive at minimum a two day course on children's speech, language and communication development delivered by speech and language therapists. The community nurses follow an in-depth ten-week course, so that they are able to contribute to the developmental checks and provide follow up support to families where the check indicates a need. All early years consultants receive the in-depth training so that they can provide advice and support to early years practitioners and signpost them to appropriate training. This means that where children are identified as having difficulties, the first line of support can be delivered in the early years setting the child attends. Highly trained speech and language therapy assistants model for early years practitioners how to run group interventions for children.

5.8 I ask that the committee note positive work of the type described here, and its contribution to improved life chances and health outcomes.

6. *Current risks*

6.1 Under current proposals for commissioning of children's community health services, GP consortia will hold the budget for speech and language therapy services. It is unlikely that they will commission therapy services to provide the kind of universal prevention work described above. They would rightly see this as falling within the public health remit.

6.2 Currently, government's public health proposals and consultation documents do not mention the importance of primary prevention work to tackle children's poor communication skills, particularly in areas of high social deprivation. Nor do they mention the public health role of speech and language therapists.

6.3 For these reasons there is a high risk that no-one will commission therapy services to undertake this work, unless there is a strong steer from government that it should be part of the local authority's public health spend.

6.4 Similar issues are likely to affect the promotion of resilience and good mental health in childhood, where again there is a risk that specialist CAMHs staff who play a key role at the universal level may no longer be commissioned to work in this area.

6.5 Another issue is that that public health work aimed at improving development and wellbeing outcomes for children is likely to be given a lower priority by health and wellbeing boards than issues relating to adults. Health and wellbeing boards should, therefore, be required to have a children's sub-board.

6.6 There is also a risk that the proposed new health premium will incentivise cost-ineffective activities aimed at adults rather than longer-haul but more cost-effective activities aimed at children and young people. The formula developed for the health premium should therefore include experts in early childhood development and wellbeing.

6.7 I suggest that the outcomes framework for public health use children's communication and language, physical and personal, social and emotional development levels at age two and five as key indicators of success, since these are factors which best predict later health outcomes as well as later educational achievement and employment opportunities.

7. *Who should commission public health services?*

7.1 My visits to local areas suggest that it is very difficult for NHS commissioners of services for children to think beyond obesity, immunisation and breastfeeding. The agenda they ought to share with local authorities—one of improving development and wellbeing outcomes for children, as highlighted by Marmot as being key to tackling health inequalities in adulthood—escapes them. For this reason I believe that public health services should be commissioned by local authorities, whose accountabilities already lie in these child development and wellbeing outcomes.

7.2 As the examples above demonstrate, the Healthy Child Programme is potentially a prime public health strategy. My visits to local areas to date, however, suggest that four out of ten Primary Care Trusts have not

implemented the programme universally. It has often been given a low priority. Commissioning the Healthy Child Programme from 0–5 needs to sit with local authorities, as it does from 5–19. This is necessary in order to make cost-effective integrated arrangements to provide the universal Healthy Child Programme, and targeted support for families, including health visitors working in partnership with children’s centres and early years providers. I therefore ask the committee to recommend that the health visitors who lead the programme for 0–5 year olds are in the long term commissioned by local authority Public Health directors, rather than by GP consortia.

June 2011

Written evidence from the Royal College of Speech and Language Therapists (PH 178)

1. SUMMARY OF MAIN POINTS

1.1 The RCSLT welcomes the opportunity to submit evidence and information to the Health Select Committee inquiry into public health. We would welcome the opportunity to present oral evidence to the Committee to provide additional information around communication difficulties.

1.2 The RCSLT is concerned that government policy contains no mention of the public health role of speech and language therapists or the importance of primary prevention work to tackle children’s poor communication skills, particularly in areas of high social deprivation.

1.3 Speech, language and communication needs have a serious impact on the quality of life of individuals and their family and lead to poor educational achievement and underdevelopment of key skills that are essential for a high performing economy. Nearly 20% of the population may experience communication difficulties at some point in their lives. It is essential that the importance of communication as a public health issue is recognised.

1.4 The ability to communicate is the key life skill. Evidence demonstrates that it is vital to intervene early as possible in a child’s life to identify delayed speech and language development and to provide appropriate support to improve their life chances.

1.5 We are content for any part of this evidence to be made public or included in the Committee’s report.

2. THE ROYAL COLLEGE OF SPEECH AND LANGUAGE THERAPISTS

2.1 Formed in 1945, the Royal College of Speech and Language Therapists (RCSLT) is the professional body for speech and language therapists, students and support workers working in the UK. The RCSLT represents over 15,000 members, including nearly 95% of the speech and language therapists (SLTs) working in the UK.

3. SPEECH AND LANGUAGE THERAPIST’S CONTRIBUTION TO PUBLIC HEALTH

3.1 For children’s services, the public health role of the work of SLTs is an intrinsic part of the intervention role. For children’s services the best models of commissioning are those with strong joint commissioning between health and local authorities. Many local authorities are taking the lead in commissioning the universal (public health) element of speech and language therapy services for all children through SureStart and Children’s Centres and by working in partnership with their health colleagues to secure a “whole systems approach” to care pathways.

3.2 For adult services: SLTs have a key role in public health, particularly through early intervention, the treatment and rehabilitation of long term conditions and through the promotion of activity to improve mental health, independence and quality of life amongst vulnerable adults. This includes involvement in the treatment and rehabilitation of chronic and long term conditions to support adults with speech, language and communication needs to go back to work, to maintain good health and wellbeing and quality of life.

4. PREVALENCE OF SPEECH LANGUAGE AND COMMUNICATION NEEDS (SLCN)

- Communication disorder is the most common disability seen in childhood, affecting up to 10% of children in society. 7% and 10% of five year olds entering school have significant speech, language and communication needs that require ongoing support. 1% of children have severe, specific and long term speech language and communication needs (SLCN).
- Up to 55% of children in areas of high deprivation entering school have delayed speech, language and communication skills which prevent them from learning to read and write.
- Unless children with SLCN are identified and supported at the earliest stage they are at risk of being unable to form relationships, express themselves emotionally, access education or contribute towards society.
- Evidence shows the link between delayed speech and language development and offending behaviour. 70% of young offenders have SLCN.
- 90% of the 1.5 million people in the UK with a learning disability have SLCN.

- Stroke is the most common cause of disability in adults in England and 50,000 people who have a stroke every year have ongoing communication difficulties.
- 700,000 people with dementia have SLCN and the figure rises each year.

5. THE CREATION OF PUBLIC HEALTH ENGLAND WITHIN THE DEPARTMENT OF HEALTH

5.1 The creation of Public Health England will provide vital input to the overall well being of the nation. It is recommended that Public Health England learn from best practice on the commissioning and delivery of speech and language therapy services to secure seamless care pathways for children and adults with speech, language and communication needs. It is recommended that guidance should be produced on the use of public health funding for local authorities and this should include the vital public health role of speech and language therapists.

6. THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

6.1 Communication must be recognised as a public health issue and ways are found to improve the communication skills of children and adults. If communication is not recognised as a fundamental life skill within public health guidance then there is a high risk that no-one will commission speech and language therapy services to some of the most vulnerable people in society.

6.2 The Health and Social Care Bill and the Government policy on public health has no mention of the public health role of speech and language therapists and the importance of primary prevention work to tackle children's poor communication skills, particularly in areas of high social deprivation.

6.3 Speech, language and communication needs are the most common disability experienced by children or adults. However as an "invisible" condition there is little understanding of its significance and it is often overlooked. Speech, language and communication is now recognised as the foundation life skill and the single most significant factor in determining a child's life chances—it is the means by which we form relationships, make choices and access education, employment and society. A delay in developing speech and language skills is a key factor in predicting future disadvantage and the single greatest barrier to social mobility. Educational underachievement affects the performance of the UK economy. Our economy has become increasingly dependent on communication-based employment; the fitness of the person of the 21st century will be defined increasingly in terms of his or her ability to communicate effectively. The economic impact on society of people whose communication disability renders them unemployable is significant and growing year on year. One study showed that 88% of unemployed young men had a language difficulty. The UK has between 10 and 25% lower output per hour than France, Germany and the US. Much of this can be attributed to a poorer level of skills and a shortfall of capital investment.

6.4 The RCSLT seeks urgent reassurance regarding the funding of speech and language therapy services in the new commissioning and public health arrangements. The RCSLT is concerned that local commissioners may lack understanding of therapy services, such as speech and language therapy and as a result it will fall between public health and health responsibilities.

6.5 It is vital that when public health, currently undertaken by the NHS, is transferred to local authorities, it does not become separated from the work of the NHS, resulting in fragmentation in service commissioning. Speech and language therapy services are currently delivered through a set of commissioning and funding arrangements particular to each locality (often isolated or led by one agency) and lack integration into mainstream service provision. Therefore the reforms could further destabilise the fragile arrangements that persist in some areas.

6.6 The RCSLT is concerned that services may become disjointed under the new plans. For example early years services will continue to be funded from local authorities under public health funding however this has an overlap with health care intervention. Programmes such as screening programmes need to be commissioned as a whole programme without a potential separation of the screening element or universal public health services from the assessment and intervention elements, including rehabilitation (often health, education and social care). The transfer of public health funding to local authorities needs to emphasise universal work including speech and language therapy. Public health guidance should emphasise the need for local authorities to work with commissioning consortia (via the health and wellbeing board). The vital public health role of speech and language therapists should be included in guidance on the use of public health funding under to local authorities.

6.7 It is important that, whilst public health is focused on prevention, the link to intervention services is clear. It should be highlighted to local authorities that many services, whilst not supporting prevention or cure, are based on rehabilitation and increasing quality of life for example stroke services.

6.8 The public health work of speech and language therapists should be funded by a reallocation of priorities within existing public health spend, towards the early intervention/life course approach now recommended by DH, which will yield greater health benefits than much current provision.

7. THE ROLE OF HEALTH AND WELLBEING BOARDS

7.1 To ensure that Health and Wellbeing boards achieve coordination across health, education and social care services it is essential that Health and Wellbeing Boards have input from appropriate clinicians to support and inform their commissioning function.

7.2 *The RCSLT calls for a speech and language therapist or an allied health professional to be guaranteed a place on every health and wellbeing board.* SLTs and AHPs are in a unique position as the only clinical professions able to combine knowledge and skills from all areas of health, social care and education. Their involvement in commissioning provides innovative ideas for redesigning services, integrating teams and sectors and delivering the QIPP agenda.

7.3 *Health and wellbeing boards must not be created separately from the work of the NHS; their role is integral to health promotion.* Health and Wellbeing Boards need to consider wider determinants of health. A lack of health representatives will prevent close health scrutiny and result in further fragmentation of services and patient pathway delivery.

7.4 It is essential that the establishment of new commissioning bodies results in greater coordination and more robust scrutiny of speech and language therapy provision in order to safeguard access to speech and language therapy for vulnerable groups.

8. THE ROLE OF JOINT STRATEGIC NEEDS ASSESSMENTS

8.1 As it stands there is little to encourage local authorities or partner commissioning consortia to consult with appropriate individuals. Given the importance of ensuring integrated working, particularly with regard to services for children or vulnerable adults, there should be a duty to consult with appropriate health professionals who work across sectors such as education, health and public health and who have expertise with regard to children and vulnerable adults.

8.2 *Speech and language therapists should be included in all public health commissioning decisions and be named as part of the workforce to contribute to the JSNA.* SLTs are woven into the fabric of public health in this country. They are in the vanguard of creating a service based on people being healthy rather than a service based on fixing ill-health.

8.3 Children are a key population group for the JSNA and academic progress is identified as a measure for children in terms of outcomes—SLT has a role to play. It is essential that the JSNA addresses inequalities and identifies levels of SLCN. Vulnerable people with communication needs require timely identification and provision of services to improve their life chances and reduce burdens on other services as their needs deteriorate. SLTs hold data on population groups of children with SLCN which would be invaluable for the JSNA. Failure to actually capture the communication needs of children will result in a substandard assessment which will in turn have a detrimental affect upon the consequential joint health and wellbeing strategy.

9. THE ROLE OF JOINT HEALTH AND WELLBEING STRATEGIES

9.1 In developing the Joint Health and Wellbeing Strategies the workforce should include speech and language therapists or allied health professionals. SLTs and AHPs work autonomously with patients, they are not support staff. Their involvement and input is crucial to all commissioning decisions.

9.2 At local levels much can be achieved by speech and language therapists contributing to the development of the local Health and Wellbeing Strategies, agreeing priorities and delivery mechanisms designed to deliver best outcomes for communities. This joined up approach across health and local government will help to align priorities and services according to patient need.

10. ARRANGEMENTS FOR PUBLIC HEALTH INVOLVEMENT IN THE COMMISSIONING OF NHS SERVICES

10.1 There is an assumption that GPs have a good understanding of public health. Building the capacity to address public health commitments should be a priority for consortia.

10.2 Under current proposals for commissioning of children's community health services, commissioning consortia will hold the budget for speech and language therapy services. There are concerns that the *commissioning consortia will not commission speech and language therapy services* to provide the universal preventative work required for all vulnerable children as they may see this as falling within the public health remit. Therefore there is a mandate for close working between commissioning consortia and local authorities to provide seamless packages of care along patient pathways.

10.3 GPs can have a substantial impact on the public health agenda. However this will require a rethink about how the delivery of public health outcomes is incentivised, how GPs and GP practices become part of the wider public health delivery system and how contracts by the NHS Commissioning Board are designed. The primary influence on GPs will be through these contracts with the NHS Commissioning Board, therefore delivery of the wider public health agenda needs to be a fundamental part of these contracts. This will ensure that the public health agenda will have a firm foundation.

10.4 It is unclear how services will be commissioned for vulnerable patient groups who have conditions such as people with dementia or people with learning disabilities but do not require acute health intervention to lead an independent life.

11. THE FUTURE OF THE PUBLIC HEALTH WORKFORCE (INCLUDING THE REGULATION OF PUBLIC HEALTH PROFESSIONALS)

11.1 The future of the public health workforce is at risk by a lack of understanding of professional roles by commissioners, by fragmentation of education and training and by localised workforce decisions which could marginalise smaller professional groups.

11.2 We are concerned that this model may destroy the pipeline of future clinicians so that the model fails in five to ten years. How will the longer term implications of potential damage to the education and training of future clinicians be addressed and resolved?

11.3 The RCSLT supports any process that ensures the development of regulated professional expertise leading to enhanced clinical outcomes, experience and safety for patients. Public health professionals should be determined by their ability, knowledge and professional skills.

12. HOW THE GOVERNMENT IS RESPONDING TO THE MARMOT REVIEW ON HEALTH INEQUALITIES

12.1 The Marmot review "*Fair Society, Healthy Lives*" highlighted that health inequalities result from social inequalities and that there is a need for action to tackle the social determinants of health inequalities.

12.2 The Marmot Review showed that poor health in adulthood is strongly related to poverty and to factors in early childhood that affect development. What happens during the early years has lifelong effects on many aspects of health and well-being—from obesity, heart disease and mental health, to educational achievement and economic status. Marmot identified as a priority objective reducing inequalities in the early development of physical and emotional health, and *cognitive, linguistic and social skills*—and put giving every child the best start in life as the review's highest priority recommendation.

12.3 Commissioning must address inequalities in access to services for children and adults with SLCN. Research has found that adults with SLCN have less access to primary care interventions for medical conditions as the interaction between themselves and the primary care team is affected as a result of their SLCN. This in turn exacerbates health inequalities.

12.4 There is a concern about ensuring that health inequalities are not increased. The Frank Field review on Poverty and Life Chances and the Graham Allen review on early intervention all highlighted the importance of early identification and early intervention—communication is a key area. The RCSLT carried out a survey of our members and the results show that universal services are being hardest cut especially in areas of deprivation where up to 55% of children have speech, language and communication needs. The risk is that unidentified and unmet need costs the economy more and there is a clear link between educational failure and criminal behaviour, with up to 70% of young offenders having communication problems.

13. THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

13.1 There is an assumption that GPs and GP practices have a good understanding of public health. Building the capacity to address public health commitments should be a priority for consortia. The RCSLT supports the proposal that incentives and drivers for GP activity should be specifically designed with public health concerns in mind, and that a proportion of the current value of QOF be devoted to evidence based public health and primary prevention indicators.

13.2 Given the future role of GPs as commissioners, the RCSLT recommends healthcare outcomes which relate to:

- Early identification and intervention.
- Facilitating and enhancing development in children.
- Prevention of emotional and behavioural difficulties.
- The speech and language needs of youth offenders.
- Children with specific speech language and communication needs.

Written evidence from Sanofi Pasteur MSD (PH 179)

INTRODUCTION

About Sanofi Pasteur MSD

Sanofi Pasteur MSD (SPMSD) is the only company in the UK totally dedicated to vaccines. It was founded in 1994 as a joint venture between Sanofi Pasteur and Merck & Co Inc. We have a heritage that includes pioneers in vaccination, such as Louis Pasteur (rabies vaccine) and Maurice Hilleman (measles vaccine), and have grown to become a leading supplier of vaccines. Using a combination of research and manufacturing expertise, our purpose is to bring innovative vaccines to the UK, protecting health and preserving quality of life for people of all ages.

Our main way of achieving this goal is to develop and make available innovative vaccines against a wide spectrum of diseases. We are also dedicated to increasing the understanding of the value of vaccines and vaccination by providing relevant and accurate information on their efficacy, quality and safety.

1. THE CREATION OF PUBLIC HEALTH ENGLAND WITHIN THE DEPARTMENT OF HEALTH

Sanofi Pasteur MSD welcomes the Government's focus on public health and the emphasis on preventing ill health and encouraging healthy ageing. We look forward to the creation of Public Health England and believe it will enable greater emphasis being placed on tackling the underlying causes of ill-health, something that vaccination can help to achieve.

However, Sanofi Pasteur MSD believes that management and coordination are key to ensuring effective immunisation programmes. Fragmentation of delivery via different providers (GPs, Local Authorities, NHS and other providers) may have a negative impact on uptake rates. Different providers may also result in a fragmentation of record keeping with the associated potential for missed opportunities for vaccinating susceptible individuals. Immunisation delivery will need to continue to be well coordinated with a clearly identified lead who is responsible for immunisation across the various providers. Sanofi Pasteur MSD believes that this should include an identified lead within Public Health England, as well as at a local level.

2. THE ABOLITION OF THE HEALTH PROTECTION AGENCY AND THE NATIONAL TREATMENT AGENCY FOR SUBSTANCE MISUSE

Sanofi Pasteur MSD does not believe that the Health Protection Agency should be abolished. The Health Protection Agency provides an essential service, including the collection of data, surveillance of disease at a local and national level and modelling. The Health Protection Agency currently provides an extremely high level of expertise on a wide range of issues and provides independent advice.

The Health Protection Agency's disease surveillance on a local level is integral to effective disease management. Given concerns about the rise of some infectious diseases, such as the H1N1 Pandemic flu in 2010, Sanofi Pasteur MSD believes that it would not be prudent to disband the Health Protection Agency, particularly just before the London Olympics in 2012, given the low levels of immunisation in some European countries, in particular the recent outbreak of measles.

Currently the Health Protection Agency leads the monitoring of disease epidemiology and vaccine uptake through a network of local organisations and systems that report centrally. Steps must be taken to ensure that the functions and information provision role of the Health Protection Agency are not diluted or lost if it becomes part of Public Health England.

Another critical consideration when accounting for the role of the Health Protection Agency is that of its modelling unit, which in the current system has the important responsibility for undertaking cost-effectiveness analyses and economic modelling which is used to inform decisions by the Department of Health and the Joint Committee on Vaccination and Immunisation for UK vaccination policy. This is by no means a trivial set of responsibilities and therefore, something the Government must consider as part of any reform to the current structure of the Health Protection Agency. This is particularly important given the Government's stated commitment to public health of which vaccination is a seminal component.

Under the new proposals for the Health Protection Agency to become part of Public Health England it will cease to be an independent organisation—something critical to the credibility of health protection both here in the UK and internationally.

Sanofi Pasteur MSD believes the Department of Health should actively consider making the Health Protection Agency an "executive agency", instead of making it part of Public Health England, so as to ensure its critical functions are not lost.

3. THE PUBLIC HEALTH ROLE OF THE SECRETARY OF STATE

Sanofi Pasteur MSD believes that strong leadership is essential to ensuring public health remains a priority and key focus of government health policy. Without strong national leadership for immunisation programmes there is a risk of fragmentation under the current proposed funding arrangements. This may impact on our

ability to maintain high uptake levels, to respond effectively to disease outbreaks or vaccine confidence issues, and may have a detrimental impact on uptake of new vaccines.

As the UK Vaccine Industry Group (UVIG) stated “the evidence and experience shows that national leadership for vaccination programmes works well. This leadership must also include central co-ordination and national direction to respond to changes in disease epidemiology, to any fall in uptake rates and generally manage the UK wide situation.”

The Secretary of State for Health through Public Health England, should set out a clear national strategy for vaccination from which programmes can be structured and implemented. It is extremely important that the Secretary of State for Health indicates vaccine priorities to ensure the vaccine industry can successfully plan to meet these. In addition to this, strong public health indicators are necessary in regards to vaccination to ensure that uptake rates are high.

4. THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH (INCLUDING ARRANGEMENTS FOR THE APPOINTMENT OF DIRECTORS OF PUBLIC HEALTH, AND THE ROLE OF HEALTH AND WELLBEING BOARDS, JOINT STRATEGIC NEEDS ASSESSMENTS AND JOINT HEALTH AND WELLBEING STRATEGIES)

Sanofi Pasteur MSD recognises the challenges involved in bringing health and social care together, however Sanofi Pasteur MSD welcomes the integration of public health into local government., It is vital that professionals from public health, the NHS, social care professionals and other providers all collaborate and share information where possible, to ensure they maximise vaccine uptake rates and coordinate and capture immunisation data and records.

Sanofi Pasteur MSD welcomes the introduction of Joint Strategic Needs Assessments, but believes that in relation to public health they should have a broader focus than the traditional “life-style” focus of public health.

Sanofi Pasteur MSD believes that Health and Wellbeing boards will provide an important forum to ensure that all agencies take a life course and co-ordinated approach to the delivery and implementation of immunisation programmes. Directors of Public Health should have an executive position and should be members of the cabinet to ensure immunisation policies are incorporated into the function of Health and Wellbeing Boards and their Joint Strategic Needs Assessments.

5. ARRANGEMENTS FOR PUBLIC HEALTH INVOLVEMENT IN THE COMMISSIONING OF NHS SERVICES

AND

6. ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

Sanofi Pasteur MSD is concerned that there is a serious risk of fragmentation and poor uptake rates for vaccination if Local Authorities are responsible for commissioning certain immunisation programmes. The system would need to be coordinated and managed to ensure that there was not an adverse affect on uptake rates. It is also essential that provision be made for the inclusion of new immunisation programmes in the future.

Both the NHS and Local Authorities should have a duty to commission or provide vaccination services for health and social care professionals. Local Authorities’ performance in this area should be subject to audit, as should the performance of the NHS.^{489, 490}

Sanofi Pasteur MSD is concerned that commissioning for infectious diseases may be problematic as they do not respect geographical boundaries. If the UK is to continue to deliver exceptional outcomes in immunisation, the new Public Health England must have overall leadership for programme development and take on responsibility for co-ordination and implementation of all aspects of the immunisation programmes. Failure to do so will lead to fragmentation, a drop in uptake rates of vaccines and poor infectious disease control in the population, communities and individuals.

7. THE FUTURE OF THE PUBLIC HEALTH OBSERVATORIES

N/a.

8. THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

Sanofi Pasteur MSD welcomes the renewed focus on prevention rather than cure in the public health outcomes framework and supports the overarching focus of the 5 domains and specifically the inclusion of vaccines and immunisation in domains 1 and 5. For the first time specific goals of the national immunisation programme are being reflected in measures of health outcomes. However, there are some concerns that the framework misses the opportunity to identify areas of immunisation policy where achieving consistently high uptake rates is historically challenging.

⁴⁸⁹ Department of Health: The Health and Social Care Act 2008; Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. January 2009.

⁴⁹⁰ Chief Medical Officer, The Seasonal Flu Immunisation Programme 2011/12, http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefmedicalofficerletters/DH_127048, May 2011

The outcomes framework needs to be explicit about the overall public health objectives as well as the specific goals and target rates for vaccination uptake. This will require robust systems to be in place to ensure a good flow of information, and clarity as to responsibilities. This should enable effective local implementation and monitoring, and ensure that individuals are clear as to their respective roles in the process.

Domain 1 must include specific reference to existing vaccination programme populations, in order for it to be an effective measure of outcomes and to support the implementation of immunisation programmes. This level of detail will support front line staff in focussing information campaigns and structuring services to maximise the benefit of the immunisation programme at a local level.

Explicit detail listed in domain 1 should also include uptake of occupational vaccines amongst healthcare professionals eg seasonal flu and hepatitis B, and uptake of vaccines in areas of socio economic deprivation.

9. ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES (INCLUDING THE HEALTH PREMIUM)

Sanofi Pasteur MSD believes that Public Health England should be responsible for funding all immunisation programmes and the proposed health premium should be applied to improving vaccine uptake rates in areas of low uptake and deprivation.

However, a concern is that the 4% ring-fenced budget allocated for public health may not be sufficient to achieve real results.

10. THE FUTURE OF THE PUBLIC HEALTH WORKFORCE (INCLUDING THE REGULATION OF PUBLIC HEALTH PROFESSIONALS)

N/a.

11. HOW THE GOVERNMENT IS RESPONDING TO THE MARMOT REVIEW ON HEALTH INEQUALITIES

N/a.

June 2011

Written evidence from the Royal College of Physicians (PH 180)

1. ABOUT THE ROYAL COLLEGE OF PHYSICIANS

1.1 The Royal College of Physicians (RCP) has been at the forefront of improving healthcare and public health since its formation in 1518. The RCP plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. As an independent body representing over 25,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

1.2 The RCP continues to play a leadership and advocacy role in relation to public health. As well as delivering seminal reports on public health-related issues, such as tobacco, the RCP coordinates the Alcohol Health Alliance UK. The RCP is currently undertaking a range of public health-related activity, including on the social determinants of health, obesity, sexual health and alcohol.

2. INTRODUCTION

2.1 The future viability of the National Health Service (NHS) depends on an effective approach to public health, nationally and locally. Only through long-term strategies, investment and integrated action across all three domains of public health (health improvement, health protection and healthcare) can we reduce the burden of disease, disability and dependence caused by health inequalities, non-communicable diseases caused by smoking, obesity and alcohol misuse, and morbidity levels in an ageing population.

2.2 Health is everybody's business. Tackling health inequalities, improving health and wellbeing, and protecting communities and individuals from harm rely on a coherent long-term vision and coordinated action across organisations, from central government and councils to hospitals and charities. This means adopting a joined up approach to health improvement, protection and healthcare, and to the planning and provision of primary, secondary and tertiary care and local authority functions, including social care, housing and planning.

2.3 Secondary care specialists and public health doctors are crucial, providing specialist knowledge and expertise on clinical issues and population health.

2.4 Individuals have a responsibility for their own health, supported by health and other professionals who can empower them to change unhealthy behaviours through targeted interventions. Education and health promotion targeted at individuals must be complemented by a broader population view and national leadership and action, including the introduction of legislation where appropriate.

2.5 The RCP welcomes this opportunity to submit evidence to the Health Select Committee on this important issue.

SUMMARY OF THE RCP'S WRITTEN EVIDENCE

All levers must be used to improve and protect health and reduce health inequalities

- Government must seize the opportunity to reduce health inequalities and address the social determinants of health, and ensure the new health system reflects these goals.
- The contribution of healthcare public health and the medical profession must be recognised and promoted when councils assume greater public health responsibility.
- Government must use the full suite of public health interventions available, including regulation, and coordinate action across departments and partners.

Integration and collaboration must be embedded across the health service, local and national government, and in all commissioning and service planning arrangements

- Secondary care specialists and public health doctors must be embedded at the highest level of decision-making throughout the system, ie in clinical commissioning groups, Health and Wellbeing Boards (HWBs), Public Health England (PHE) and the NHS Commissioning Board.

There must be an independent public health voice, nationally and locally

- The RCP supports the establishment of Public Health England. PHE must be independent and authoritative, and capable of holding government to account. We welcome government's commitment to establish PHE as an executive agency of the Department of Health.
- Locally, Directors of Public Health (DPH) must be independent, expert and influential, acting as a voice of challenge and representing their communities, including vulnerable people and children.
- The DPH's independent annual report on the health of their population should include an analysis of *health needs*, together with an analysis of whether these are being met or not.

There must be sufficient funding to provide effective and sustainable public health services

- The ring-fenced budget of circa £4 billion underestimates the resources required to achieve the government's wide-ranging vision for public health and should be recalculated.
- Health Premiums should be introduced only when a complex formula that does not act as a perverse incentive has been developed.

There must be solid evidence and research to support public health knowledge, policy and practice

- Evidence and data analysis capacity must be retained, with the Public Health Observatories working closely with PHE to provide comprehensive information on needs and performance.
- Our reputation for epidemiological research should not be threatened by a fragmented system, and our 'practice' research capacity should be developed.

The development of the public health profession must be supported

- Public health specialists, including the DPH, should be trained and registered to specialist level in public health.
- Public health training should continue to be organised and provided alongside other medical specialities with similar arrangements for recruitment, standard setting and quality assurance.

3. APPROACH TO PUBLIC HEALTH

All levers must be used to improve and protect health and reduce health inequalities

3.1 Health inequalities

3.1.1 The RCP welcomes the focus on the social determinants of health in the *Healthy lives, healthy people*, its emphasis on the importance of adopting a life-course approach, and the explicit references to reducing in health inequalities in the Health and Social Care Bill (including the duty placed on the Secretary of State). This commitment should be backed up in all structures and financial arrangements.

3.1.2 The Marmot report, *Fair society, health lives (2010)*, proposes major economic, educational and environmental interventions to address the wider social determinants of health. The RCP is disappointed that the current strategy and proposals for public health do not present a clearer, pan-departmental vision for addressing some of these issues, particularly when pitched against a backdrop of economic austerity and public sector spending cuts.

3.1.3 We must ensure that our record on equity of access to health services is protected. This must not be affected by the removal of practice boundaries or potential loss of public health expertise during the transition from Primary Care Trusts (PCTs) to councils.

3.2 Healthcare Public Health

3.2.1 Ensuring the health and wellbeing of people, protecting their health, and reducing health inequalities is dependent on an effective and robust public health system that integrates each of the three domains of public health: health improvement, health protection and healthcare. There is currently little reference to healthcare public health, or the contribution of the medical profession, in the public health white paper.

3.2.2 There is a risk, particularly with greater public health responsibility being given to local government, that there will be a dislocation of “medical” and “public” health. To avoid this, it is vital that the knowledge and ability of hospital clinicians and others to influence good public health and to improve public health planning is not lost in this reorganisation.

3.2.3 Hospital doctors have the expertise in their own specialties to work with GPs and other colleagues to promote:

- Quality, integrated care for patients, including those with rarer/complex conditions and co-morbidities.
- Effective use of service, clinical and research data to identify need, clinical effectiveness, capacity and potential efficiencies.

3.2.4 Public health expertise is needed to assess risks to health and trends in ill health—for example, assessing the risks of alcohol to young people, trends in common cancers and addiction, and recognising the benefits of new drugs. Public health expertise has devised new risk stratification for the treatment of heart disease and identification of people at highest risk from diabetes, alcohol problems or frequent admission to hospital.

3.3 Individual responsibility and national action

3.3.1 To improve the nation’s health, we must use all available tools and take action at all levels. Devolving to local level the responsibility for improving people’s health and wellbeing and reducing inequalities does not replace the need for action and leadership from the centre. Although there should be flexibility to tailor programmes to suit the needs of local populations, there is still a need for national programmes, service frameworks and coordination, eg for alcohol consumption and smoking.

3.3.2 Central government must assume responsibility for taking a population approach to public health interventions and programmes, and use the full suite of interventions available, including regulation. At present, many of the public policy measures that have been announced rely on personal enablement and individual responsibility for healthy choices. We welcome the recognition of the importance of these factors, but regulation and legislation also have an important role and can be key to ensuring that change happens quickly—from legislation on clean air and smoke-free spaces, to seat belts and drink driving.

3.3.3 With any public health plan as many levers as possible must be pulled simultaneously, as, for example, with smoking prevention (see extract from UK Centre for Tobacco Control Studies submission for illustration).⁴⁹¹ The uptake of local services by individuals, and their success, is dependent on their motivation to quit, which is driven by both national and local policies.

3.3.4 Central government also has a responsibility to maintain and develop health protection services at national and local level. Protecting the public from infectious diseases and major chemical and biological incidents must be paramount.

3.3.5 Action must be coordinated across government departments. Options for ensuring this happens should be explored, such as mandating that each government department has a senior public health advisor.

3.4 Responsibility deal

3.4.1 The RCP agrees that all sectors—including government, health, industry and the voluntary sector—have an important role to play in improving the nation’s health. However, public health policy must be independently set and measured. Any involvement of industry in public health action must be open and transparent, and accompanied by independent monitoring and evaluation (of both compliance with voluntary measures and their impact on public health outcomes) and by a spectrum of other public actions, including the introduction of regulatory measures.

3.4.2 At present, the RCP is not a signatory of the public health Responsibility Deal due to concerns that the criteria outlined in paragraph 3.4.1 are not currently being met, particularly for alcohol. We wish to see a clear presentation of the steps that will be taken if the voluntary objectives set for the alcohol industry are not met (see: RCP’s position on the Responsibility Deal for more information).

⁴⁹¹ Ev w34 Para 7

4. INTEGRATION AND CO-ORDINATION

Integration and collaboration must be embedded across the health service, local and national government, and in all commissioning and service planning arrangements.

4.1 To ensure an integrated approach to the public's health, secondary care specialists and public health doctors must be integral to commissioning and service planning arrangements at a national and local level. Locally, specialist doctors will bring their experience and knowledge of secondary care and the hospital environment to the table, working with GPs to challenge existing practice where it does not deliver good outcomes for patients, and to promote innovation and high quality joined up services across primary and secondary care.

4.1.1 *Clinical commissioning groups*

Secondary care specialists should have a place at the highest governance level of local commissioning groups, with access to wider networks of clinical expertise. The RCP is pleased government recognised this in their announcement of 14 June 2011. Public health specialists should also be involved at the highest level.

4.1.2 *Health and Wellbeing Boards*

Hospital clinicians (as well as the Director of Public Health) should have a mandatory role on HWBs, with other specialists called upon to advise as appropriate (eg via clinical senates and networks). Specialists should be involved in:

- analysing and interpreting data;
- preparing Joint Strategic Needs Assessments;
- setting local priorities via the Health and Wellbeing Strategy; and
- assessing if commissioning groups reflect local priorities in commissioning plans.

4.1.3 *Public Health England*

Clinicians of all types should be advisors to Public Health England.

4.1.4 *NHS Commissioning Board*

Primary care and services for rare conditions will be commissioned by the Board. Specialist doctors and public health specialists must be integral to national commissioning decisions. Specialist services must be part of a total integrated pathway of care and not allowed to operate in isolation.

4.1.5 *Foundation and NHS Trusts*

The RCP also recommends that there are cross-representation appointments within providers, with GPs on trust boards and public health consultants across the system.

4.1.6 The RCP welcomes the government's move (announced 14 June) to promote the co-terminosity of commissioning group and local authority boundaries.

4.1.7 Proper consideration should be given to the commissioning arrangements for "uncommon conditions". Access, and equity of access, to such services are a core component of an effective public health service. Facilities such as a trauma centres, and conditions such as immunodeficiency, require a critical mass to be cost effective and should be commissioned on a sub-national basis.

5. INDEPENDENT, EXPERT AND AUTHORITATIVE PUBLIC HEALTH VOICE

There must be an independent public health voice, nationally and locally.

5.1 Public Health England

5.1.1 The RCP supports the proposal to establish a national body, Public Health England (PHE), focused on coordinating and supporting public health. PHE must be accountable for its own performance and an independent and authoritative body capable of providing expert advice and holding government to account across departments. It should also act as a network for Directors of Public Health, supporting them to challenge local performance and utilising their knowledge of the local situation to identify where action is needed at a national level (such as by introducing new national initiatives, legislation, etc), and challenge central government when this does not happen.

5.1.2 We welcome the government's new commitment to establish PHE as an executive agency of the Department of Health (DH). Creating PHE as an executive agency at arm's-length from DH will help to establish it as an independent, authoritative source of public health expertise, whilst still providing the Secretary of State with a clear line-of-sight.

5.1.3 PHE should make use of the existing public health specialist workforce currently working in Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) so that valuable expertise is not lost. Expert PHE staff could be seconded to local authorities and clinical commissioning groups.

5.2 Local responsibility and accountability

5.2.1 Councils will often be best placed to design services and deliver programmes that best meet the needs of communities. However, steps must be taken to ensure that localism and the devolution of health budgets

does not lead to unnecessary costs and bureaucracy, unjustifiable variation, piecemeal and fragmented service provision, an absence of quality evaluation metrics, and a lack of information sharing and best practice. We believe an expert, influential and independent Director of Public Health—supported by robust data analysis and outcome monitoring systems—is essential.

5.2.2 Responsibility for public protection, including health protection, must be clear across the system. Councils should be given responsibility for—and be accountable for—all aspects of public protection at a local level.

5.3 Directors of Public Health

5.3.1 The independent public health voice should be replicated at a local level through the Directors of Public Health (DPH). The DPH must be expert and influential, and be able to act as the “voice” of the local community, including disadvantaged groups and children. The DPH must have influence across all aspects of local authority work and throughout the local health economy. To achieve this, the DPH must have direct access to the council’s cabinet, councillors, chief executive and directors, and manage the ring-fenced public health budget.

5.3.2 The DPH must be seen as the strategic leader for public health in their area providing, through their annual report, independent analysis of local needs and performance. The Health and Social Care Bill’s requirement that the DPH produces an annual report on the health of their population should be expanded to require the DPH to describe *health needs*, with an independent analysis of whether needs are being met.

5.3.3 The DPH must have the skills and experience needed for this expert and specialised job. The DPH should be recruited through a statutory appointments process. To ensure the Secretary of State as a “direct line-of-sight” to specialist public health expertise at the local level, the DPH should be jointly appointed by PHE and the LA.

5.3.4 The movement into local authorities must not result in the DPH losing access to valuable data and resources (eg NHS data systems). Likewise, links with local health service structures and the workforce must be retained or, indeed, strengthened. The DPH will need to ensure robust arrangements for seeking input and advice from colleagues working in primary, secondary and tertiary care.

6. FUNDING

There must be sufficient funding to provide effective and sustainable public health services.

6.1 Ring-fenced budget

6.1.1 Government has allocated 4% of the total NHS budget to public health, which it estimates at approximately £4 billion. It is important in these times of austerity that public health initiatives and interventions that will save money in the longer-term receive proper investment now. We therefore welcome the protection afforded to the public health budget.

6.1.2 However, the RCP believes the £4 billion figure underestimates the resources needed to achieve the government’s wide-ranging vision for public health, and represents a significant cut to funding. The figure does not take into account a range of costs (eg overheads, on costs, etc) and money will be deducted for various activities (eg Health Protection Agency, public health and GP screening) before it reaches councils.

6.1.3 There must be clarification of exactly what services are intended to be funded from the ring-fenced budget, and how funding will be split between the various public health functions, including PHE, the NHS and councils. These functions must be clearly defined to enable a robust assessment of the ring-fenced budget, calculated from a realistic baseline that considers activities across all three domains of public health. There must be sufficient funds to support the transition of public health teams and DPHs to councils, and projects that have not yet been rolled out, such as health checks.

6.1.4 It is vital that the ring-fenced budget is not seen as the only budget for public health. It must be clear that the ring-fenced money is intended only as a *core* budget intended to protect a clearly defined set of core services.

6.2 Health premium

6.2.1 The RCP appreciates the desire to incentivise public health action and reward good performance. However, to be effective and not a perverse incentive, a complex formula will need to be developed. The health premium should not be introduced until a formula is developed that: does not penalise those areas with the greater incidence of entrenched disadvantage, resulting in a cycle of increasing health inequalities; does not encourage “easier” public health wins over more difficult long-term gains; takes account of the impact of broader factors, such as funding cuts, the economic downturn and the impact of population change; and does not increase inequalities between already disadvantaged groups through the incentivisation of a limited range of specific indicators

6.2.2 This will take time and investment.

7. DATA, EVIDENCE AND RESEARCH

There must be solid evidence and research to support public health knowledge, policy and practice.

7.1 The new system must ensure that there is access to timely, reliable, appropriate and relevant public health information and intelligence to inform decision-making and service planning. Understanding the health and wellbeing needs of local communities requires in-depth analysis and assessment.

7.2 Public Health Observatories (PHOs) are vital in providing this important function. A reduction to the capacity of PHOs will have serious implications for the collation, assessment, analysis and provision of essential public health intelligence. Public health observatories should be retained and, working closely with PHE, could play a crucial role in:

- Gathering reliable information essential to the understanding of health needs.
- Undertaking modelling of future scenarios and assessment of impact and efficacy.
- Evaluating the effectiveness of local initiatives with different delivery methods.
- Gathering and disseminating examples of good practice.
- Providing a comprehensive and detailed understanding of their local population, across all three domains of public health.
- Coordinating longitudinal studies.

7.3 High quality public health teaching and research, addressing all three public health domains, are crucial to the success of public health. Our reputation for epidemiological research should not be threatened by a fragmented system (councils, in particular, do not have a strong research tradition), and our “practice” research capacity should be developed. Appropriate funding will be required to ensure that the evaluation of evidence and research in public health is not sidelined during the current financial climate.

8. PUBLIC HEALTH PROFESSION

The development of the public health profession must be supported.

8.1 It is essential that public health specialists, including each DPH, are trained and registered to specialist level in public health. This should be a requirement in the Health and Social Care Bill.

8.2 Robust mechanisms must be in place for ensuring that public health competence is obtained and maintained by staff in all areas, including universities and research. There is concern, for example, that councils do not have the training structures or workforce plans in place to support development of public health competencies.

8.3 To ensure public and profession confidence, public health training should continue to be organised and provided alongside that for other medical specialities with similar arrangements for recruitment, standard setting and quality assurance. This should be considered in the government’s planned restructuring of the way the healthcare workforce are trained and educated set out in *Developing the healthcare workforce* (see: RCP’s response to the workforce consultation for further information).

8.4 It is important that public health continues as a specialty that is attractive to doctors. It is also vital that in the new system specialty registrars undertaking public health training have access to the full breadth of experience and settings (such as local health protection units, provider trusts, local authorities) in order fully to develop their specialist public health competencies.

June 2011

Written evidence from the Faculty of Sexual and Reproductive Healthcare (PH 182)

EXECUTIVE SUMMARY/KEY POINTS

- The Faculty of Sexual & Reproductive Healthcare (The Faculty) is a faculty of the Royal College of Obstetricians and Gynaecologists. The Faculty has a membership of over 14,000, with the majority of its members being general practitioners, the remainder being doctors working in the community in Sexual & Reproductive Healthcare. In early 2010 the Government created the new medical specialty of “Community Sexual and Reproductive Health”, to formalise the training of community based specialists in women’s health with a leadership role and relevant of public health training. The Faculty sets National clinical and service standards and awards competency based qualifications to specialists and GPs in the field of Sexual & Reproductive healthcare (SRH) which includes contraception, basic management of sexually transmitted infections, community gynaecological care.
- Good sexual and reproductive healthcare is a public health challenge which has the potential to deliver significant public health savings, and therefore, should be a priority for both public health and the NHS, not least for the social and economic benefits it delivers.

- The Faculty welcomes the proposal that community contraception and termination of pregnancy services will be funded as part of the ring fenced public health budget. Good sexual and reproductive healthcare is a public health challenge which has the potential to deliver significant public health savings, and therefore, should be a priority for both public health and the NHS, not least for the social and economic benefits it delivers.
- The Faculty is concerned that the proposed division of *commissioning* pathways for SRH will lead to fragmented service provision for women’s health services which should be provided in a “continuum of care”.
- The Faculty welcomes the principle of the “any *qualified* provider” tender basis for service provision in response to proposals for increased competition. This will ensure that services meet nationally recognised standards, are underpinned by a national tariff system of pricing, are delivered by staff educated and trained to nationally recognised standards, and are commissioned as part of a consultant led community network.
- Commissioning in the past has been variable. The Faculty recommends that commissioning should be underpinned by nationally recognised commissioning guidance, quality standards and clinical guidelines. Sexual & Reproductive Health specialists should be involved in the commissioning process to help deliver improved patient related outcomes and service efficiencies.
- Sexual ill health is not restricted by geographical boundaries, and therefore, commissioning must be equitable and consistent across coterminous local authority borders. This is particularly important in areas which are densely populated, and consist of multiple local authorities (eg London). Public Health England has a vital role to play in ensuring that this collaborative working is facilitated.
- Sexual and Reproductive Health is linked to a number of public health areas, and therefore, Health and Wellbeing Boards must facilitate the development of local partnerships between providers to ensure that; efforts are not being reproduced or duplicated, local initiatives are mutually reinforcing and/or complementary to each other, seamless models of patient care are provided, and clinical and quality standards are being met across all providers.
- Joint Strategic Needs Assessments will be crucial for the development of Local Joint Health and Wellbeing Strategies. It is vital that SRH services are included as key component in strategies, and that clinical leads working across sexual health services are involved in the development of these documents.

ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

1. The Faculty welcomes the proposal that community contraception and termination of pregnancy services will be included as part of those services being commissioned and funded by the ring fenced public health budget.

2. Commissioning SRH services as part of the ring fenced public health budget managed by local authorities, will help ensure that fully comprehensive, sexual and reproductive health services are delivered across a range of health and community settings, and in particular, reach communities vulnerable to or at risk of poor sexual health, delivering the best possible outcomes for the local population as a whole. The centralisation of public health commissioning should also facilitate linkages between services for related public health issues. Around the country, many SRH services are forging links with related public health services such as those for alcohol, drug misuse, and social care, which are often linked to risky behaviour, unplanned pregnancy and poor sexual health (STIs). These combined approaches are more effective, help reduce duplication of effort, and offer better value for money for public health budgets.

3. Whilst the Faculty welcomes the proposal that SRH will be *funded* by the public health budget, there are concerns that the proposed commissioning structure may lead to fragmented service provision. As outlined in *Healthy Lives, Healthy People*, commissioning for community contraceptive services will sit with local authorities, whilst commissioning for primary care services provided in general practice will be carried out by the National Commissioning Board (NCB) via the GP contract. The Faculty is concerned that this division will lead to fragmentation of service provision with other women’s health services, which should be provided as a “continuum of care”.

4. The public health White Paper sets out that the process for NHS commissioning of public health funded activity will be “*mediated by via a relationship between Public Health England (PHE) and the NHS Commissioning Board*”. For SRH services, the Faculty recommends that there is a robust mechanism in place to ensure that effective, transparent dialogue is taking place between the NCB and PHE. Only then will we be sure that public health requirements are met, that negotiations take into account both clinical and public health expertise, and that services are not duplicated.

5. The public health White paper sets out plans to increase the range of providers for public health services. The Faculty is concerned about the impact that such increased competition may have on quality of service provision, and therefore, welcomes the principle of the “any *qualified* provider” rather than the “any *willing* provider” tender basis for community sexual health service provision, on the basis that this approach ensures that commissioners only commission those sexual and reproductive health services that:

- Are underpinned by a national tariff system of pricing which is a true reflection of the services provided by sexual health services, and which will ensure a fair and level playing field.
- Are underpinned by Faculty clinical and quality standards.
- Are delivered by staff educated and trained to nationally recognised standards.
- Are commissioned as part of a consultant led community network.
- Are required to train in the medical specialty of Community Sexual and Reproductive healthcare (CSRH).

6. Commissioning of sexual health services has in the past been of variable quality. A 2008 Faculty Report on SRH services indicated that commissioners did not fully understand the services provided by community sexual and reproductive health clinics, the benefits they bring to the local population and the value for money they represent. It also found that in many cases, commissioners were not equipped with relevant knowledge and skills relating to sexual health. It is essential that clinical experts in the field of SRH are actively engaged in the commissioning process to help ensure both improved patient related outcomes and to help deliver service efficiencies.

7. Commissioning service specifications should also insist that national clinical and quality standards, such as those produced by medical Royal Colleges, medical specialties, and NICE, are adhered to. Such guidance is vital to ensure both consistency and quality across all services provided for public health purposes, and levers of accountability should be put in place to ensure this guidance is followed. There is a clear role for guidance and standards produced by the Royal Medical Colleges, Faculties and membership organisations to be utilised here.

8. Sexual ill health is not restricted by geographical boundaries, and therefore, commissioning must be equitable and consistent across coterminous local authority borders. This is particularly important in areas which are densely populated, and consist of multiple local authorities (eg London). Public Health England has a vital role to play in ensuring that this collaborative working is facilitated.

ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES (INCLUDING THE HEALTH PREMIUM)

9. The Faculty supports competition that drives the standards of care up, however, it is concerned that increased competition could lead to a reduction in the quality of care provided. Whilst the *any qualified* provider approach may ensure that standards are met, the Faculty is concerned that potential new providers may ‘cherry pick’ the most lucrative services, and may not decide to provide training in order to keep costs down.

10. International evidence suggests that without a fixed tariff system in place, the resulting situation will be a “race to the bottom” to provide the lowest cost services at the most competitive prices, but potentially at the expense of quality of service provision. Clearly any compromise on quality could lead to rapidly worsening rates of sexual ill health, increased rates of unplanned conceptions, increased inequalities and ultimately, poorer health outcomes.

11. Recognising the inadequacies of the “block contract”, the London Sexual Health Programme has developed an integrated sexual health tariff. The publication of a national tariff system for sexual health, based on the work of the London Sexual Health Programme, which includes the core principles of patient safety, service quality, sustainability, cost-effectiveness, patient choice and open access, will ensure a level playing field for those bidding for contracts and will ensure that fully comprehensive SRH services, including those which provide training and development opportunities, are commissioned. It is also vital to ensure that in the future SRH services are adequately funded for the important public health work that they do.

THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

12. The Faculty welcomes the underlying scope of the outcomes framework which is to reduce health inequalities. Teenage pregnancy is directly related to social deprivation, reinforces health inequalities, and is associated with significant avoidable premature mortality and ill health. The Faculty therefore believes that the proposed indicator relating to unplanned teenage conceptions will be instrumental in improving health inequalities. It will also be a vital tool in ensuring that all agencies involved in the prevention of teenage conceptions work strategically, in partnership and in collaboration, to achieve a joint goal.

13. However, the Faculty is concerned that the outcome approach may lead to a skewed allocation of scarce resources. Women of all ages need access to good sexual & reproductive health services, and there are other age groups which currently experience disproportionate levels of poor sexual and reproductive health: The UK faces the highest rate of abortion in Europe, and in 2009 17.5 in every 1,000 women aged 15 to 44, had an abortion, whilst 33 per 1,000, women aged 19, 20 & 21 had an abortion (Abortion statistics, England and Wales, 2009, DH).

14. Abortion is not only costly to the NHS, but research indicates that it is directly linked to deprivation. In Scotland, the abortion rate in the most deprived areas is double that of the rate in the least deprived areas (ISD Scotland Abortion Statistics (2010)). Reducing the number of unplanned pregnancies will have a direct impact on both deprivation and health inequalities. Whilst it is important that tackling teenage conceptions is a public

health priority due to its relationship with health inequalities, it is vital that good, high quality sexual and reproductive health services are provided for all women of all ages.

ARRANGEMENTS FOR PUBLIC HEALTH INVOLVEMENT IN THE COMMISSIONING OF NHS SERVICES

15. Successful commissioning for public health services depends on a number of different factors relating to the availability and use of public health data and the skills to interpret it, the availability of best practice public health guidance which sets standards and expectations, and the development of clinical partnerships to share and draw upon expertise.

16. NHS commissioning for public health interventions should be underpinned by strong epidemiological research and needs-assessment evidence base. In 2008 a Faculty Report on SRH services highlighted that many PCT's lacked detailed information about both the availability of Long Acting Reversible Contraception (LARC) provision in their area, and the availability of trained clinical professionals correctly trained to deliver LARC. This lack of data consequently led to a shortage of LARC trained clinicians across the country.

17. The Faculty recommends that in addition to taking public health advice from Local Directors of Public Health in local authorities, and from Public Health England, clinicians from different public health related specialties, such as SRH, should be invited to feed in to the NHS in the commissioning process for public health, to help ensure that the services being commissioned are both appropriate and of a high quality standard. This is particularly important for SRH, 80 per cent of which is provided in Primary Care General Practice.

18. NHS commissioning of public health services must also reflect other sources of guidance, such as those produced by the National Institute for Health and Clinical Excellence (NICE) for public health issues, future NICE Quality Standards, and for SRH more specifically, standards produced by the Faculty of Sexual & Reproductive Healthcare. Such guidance is vital to ensure consistency and quality of care, and levers of accountability should be put in place to ensure such guidance is followed.

THE FUTURE OF THE PUBLIC HEALTH WORKFORCE (INCLUDING THE REGULATION OF PUBLIC HEALTH PROFESSIONALS)

19. Medical Royal Colleges and Faculties are the gate keepers of postgraduate specialty curricula, and develop training programmes that are underpinned by national clinical and quality standards, and set within overarching governance frameworks. The Faculty has developed national standards and training programmes, in sexual and reproductive health, which are recognised as the Gold Standard.

20. In early 2010 the Government created the new medical specialty of "Community Sexual and Reproductive Health", to formalise the training of community based specialists in women's health with a leadership role and relevant of public health training.

21. Training and ongoing education is essential to achieving high quality and safe care which ultimately delivers cost savings for the NHS. For SRH, such cost savings lie in ensuring that a full choice for contraception is offered to all women. Many contraceptive devices, such as LARCs, require specific training to be able to fit them. Evidence shows that without properly trained clinicians to fit, follow-up, and reassure women about their contraceptive method, women often do not continue with their contraceptive method for long enough for the NHS to realise savings associated with them. Furthermore, incorrectly implanted LARCs can result in complications and premature discontinuation of use.

22. The Faculty is concerned that providers will not offer appropriate development opportunities and training unless mandated and funded to. Clearly, a service which trains is more expensive than one which is limited to service delivery and, in a competitive market, will be attractive to commissioners looking to control budgets. A proliferation of non training service providers will lead to a reduction in the quality of education, professional expertise, and the standard of patient care delivered. Provisions must be put in place to ensure the protection of good quality education, training and research and to ensure that all providers are subject to the same requirements.

23. "*Developing the healthcare workforce*" set out proposals to replace deaneries and professional advisory bodies for training, with an overseeing board called Health Education England (HEE). The current system of postgraduate medical training under the umbrella of the Deanery structure is highly effective, and therefore, the Faculty is concerned about the lack of clarity on how the HEE will undertake its responsibilities and who will perform the work currently carried out by deaneries.

24. Meanwhile, the training functions provided by Strategic Health Authorities (SHAs), which are currently responsible for the majority of training and education commissioning, will be replaced by new local skills networks. Further clarity is needed about the constitution of the proposed local skills networks, and the advice and input that they will receive from medical specialties.

25. Effective workforce planning is dependent on the provision of consistent, high quality workforce information. In the past, there has been a lack of robust SRH workforce data to highlight skills shortages and training needs. Robust reporting mechanisms must be put in place to ensure the collection of comprehensive workforce and needs assessment data which will help ensure that we have a workforce capable of meeting the future challenges of the NHS.

26. Healthcare providers will also need support in understanding their training needs, and HEE along with local skills networks will have a significant role to play in providing this. However, the extent of HEEs powers, and its relationship with skills networks, are currently unclear and require further clarification.

THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH (INCLUDING ARRANGEMENTS FOR THE APPOINTMENT OF DIRECTORS OF PUBLIC HEALTH; AND THE ROLE OF HEALTH AND WELLBEING BOARDS, JOINT STRATEGIC NEEDS ASSESSMENTS AND JOINT HEALTH AND WELLBEING STRATEGIES)

27. Joint working and communication, is fundamental for the delivery of sexual health care that is comprehensive, avoids duplication, meets high standards, is clinically safe, and cost effective. SRH, which is provided across a range of settings (primary care, community, schools etc) and by a variety of providers, is also inextricably linked with a number of areas of public health such as alcohol and social care. Moreover, the new “Early Intervention Grant”, which will be allocated to local authorities, will also play an important role in funding a variety of initiatives to support a reduction in teenage conceptions.

28. With so many different groups, stakeholders, commissioners, funding streams and agencies working to achieve similar goals, it is vital that effective and transparent dialogue is facilitated to help build effective partnerships across localities, to ensure that efforts are not being reproduced or duplicated, that different initiatives are mutually reinforcing and/or complementary to each other, that seamless models of patient care are provided, and to ensure that clinical and quality standards are being met across all providers.

29. Joint Strategic Needs Assessments will be crucial for the development of Local Joint Health and Wellbeing Strategies. It is vital that sexual and reproductive health services are included as key component in local strategies, and that clinical leads working across sexual and reproductive health services, as local leaders in their field, are involved in the development of these documents.

30. Sexual ill health is not restricted by geographical boundaries, and therefore, commissioning must be equitable and consistent across coterminous local authority borders. This is particularly important in areas which are densely populated, and consist of multiple local authorities (eg London) consideration must be made of the appropriate level at which public health decision making operates.

*The Faculty of Sexual and Reproductive Healthcare*⁴⁹² is a faculty of the Royal College of Obstetricians and Gynaecologists. The Faculty awards qualifications in sexual and reproductive health care and oversees specialty training in Community Sexual & Reproductive Healthcare. As a body it promotes conferences and lectures, provides a clinical advisory service and publishes the Journal of Family Planning and Reproductive Health Care. It has a membership of over 14,000, the majority of whom are general practitioners and includes consultants in the speciality of Community Sexual and Reproductive Healthcare and nurses working in SRH.

June 2011

Written evidence from Northgate Public Services (PH 183)

INTRODUCTION

1. Northgate Public Services warmly welcomes the opportunity to submit evidence to the Health Select Committee’s inquiry in to public health. Ensuring good health is a key aspect of creating a more equal society and ensuring that the life chances of all citizens are improved.

2. Our submission builds on the previous responses we have made to the Healthy Communities, Healthy Lives consultations and focuses on the areas where we believe that the Government’s approach to public health requires further development.

GENERAL COMMENT

3. We firmly believe that, if we are to improve and support wellbeing in our communities, local government and active local communities should be at the heart of a new approach to public health. Local authorities are well placed to take a view on the health of their communities and understand local need, we therefore welcome an extension of their role.

4. However, the level of resources available to local authorities for their new responsibilities is still unclear. The Government has accepted in its consultation on commissioning that the figure of £4 billion is subject to substantial revision. We believe that there is a strong need for greater clarity about the weighting on the public health allocations for local authorities.

5. We also welcome the creation of Public Health England with its focus on empowering local communities to improve health while also maintaining a national view. If it is to do so effectively, it is important for this new body to foster a close relationship with the National Health Service at a national level and also with local authorities at a local level. Yet, we believe that there remain a number of unresolved issues around the proposed approach to partnership working at both a national and local level. We discuss these issues in more detail below.

⁴⁹² <http://www.fsrh.org/>

6. The Government says that it wants to reach out to address the root causes of poor health and wellbeing. To achieve this, we believe that a reduction of health inequalities must be the central driver behind the Government's approach. We have previously called on the Government to make a reduction of health inequality a key focus of the Health and Social Care Bill by focusing on the social determinants of health. Without such an approach, we fear many of the Government's plans around health may be blunted by the persistent root causes of poor health in our communities. To tackle this will require a holistic approach to health improvement which considers the wider social determinants of health by joining up services in the locality such as education, employment and housing.

7. Information also has a major role to play in the new approach to public health. High quality information will give people and professionals more control over the direction of healthcare and help shift the central emphasis to one of well-being and improving the health of our communities. Information will also be key to promoting an active citizen approach whereby individuals become fully involved in the decision making process around their own healthcare.

8. We discuss all of these issues in more detail below and make a number of recommendations which, we believe, will help to enhance the Government's public health vision and make it a reality.

SPECIFIC COMMENT

Local Authorities

9. As we have already identified, we warmly welcome an extended role for local authorities in public health, however, we believe that the transfer of public health responsibilities to local government will be restricted by the proposed ring-fencing of the budget.

10. The Government has not yet confirmed what conditions it should impose on local authorities and what level of resources will be available. It is important that the Government provides greater clarity around this issue so that local authorities can prepare for their new responsibilities.

PARTNERSHIP WORKING

11. As we have mentioned already, if public health is to be improved, there will need to be close partnership working between Public Health England and the NHS at a national level, and between local authorities, Directors of Public Health and GP consortia at a local level.

12. We have previously outlined some concerns about a lack of clarity around partnership working. The Government is proposing to split public health functions between Tier 1 local and Public Health England. It is essential that there is a clear duty for Tier 1 authorities to work in effective coordination with Tier 2 local authorities who have responsibility for health protection work to ensure more joined up working.

13. There also needs to be greater clarity of the relationship between the Secretary of State and local authorities. While the Government wishes to establish greater localism, it also proposes new powers and duties for the Secretary of State, in effect, greater centralisation of powers.

14. Clause 14 of the Health and Social Care Bill provides for the Secretary of State to specify the particular public health services, facilities or other steps that one, several or all upper tier local authorities must provide or take. While this regulation would be subject to Parliamentary approval, it does appear to be at odds with a localism agenda. It would be useful, in our view, for the Bill to clarify in what circumstances such provisions may apply and to consider whether this is in fact necessary.

15. Similarly, Clause 26 of the Bill provides that the Secretary of State may require an upper tier local authority to take certain action where they consider that a Director of Public Health, to be transferred to the employ of the local authority under the new arrangements, has failed or may be failing to carry out certain aspects of their responsibilities. We believe that this clause as currently drafted is at odds with the localism agenda that the Government wishes to pursue.

16. In developing public health strategies it is critical that health and social care strategies are aligned along with broader strategies addressing the wider social determinants of health. We welcome the proposals for minimum membership of the boards, but we think that it is essential that community organisations and the not for profit sector are also brought into the process. This would help to maximise the opportunities for developing an active citizen approach by ensuring that organisations which closely represent the interests of local citizens are able to influence the process.

HEALTH INEQUALITY

18. We firmly believe that the best investment in public health will be that which addresses inequality as its central concern and focuses on outcomes. This approach should maximise the opportunities and life chances for disadvantaged individuals and communities, thereby minimising cost.

19. Sir Michael Marmot's review *Fair Society, Healthy Lives* shows that dramatic health inequalities remain a dominant part of our lives. For example, in the wealthiest part of London—a ward in Kensington and

Chelsea—a man can expect to live to 88 years of age, while a few kilometres away in Tottenham Green—one of the capital's poorer wards—male life expectancy is 71. Such inequalities are apparent across all regions.

20. The review also highlights the costs that such inequalities can cause. It estimates that health inequalities cost the economy £31–33 billion every year through loss of productivity, £20–32 billion in lost taxes and higher welfare payments, and £5.5 billion through additional costs to the NHS, economy and society.

21. Health inequalities are not inevitable and can be significantly reduced through coordinated national and local action involving communities. They stem from avoidable inequalities in society such as income, education, employment and neighbourhood circumstances. We therefore believe that any local approach must be one that involves and includes local people in the design and delivery of services, and in their assessment.

22. In order to tackle health inequalities effectively, there must also be closer integration of services. This should involve health and social care, but also wider services in the locality such as education, employment and housing so that the wider social determinants of health can be addressed. Without such an approach, we fear that many of the Government's proposals may be blunted by the persistent root causes of poor health.

THE INFORMATION REVOLUTION

23. Information has an integral part to play, not only in supporting and improving performance and choice, but also in transforming our approach to healthcare. The use of high quality information would help to give people and professionals more control over the direction of healthcare and shift the central emphasis to one of well-being and improving the health of our communities.

24. If the Government's information revolution is to be successful, it is also essential that individuals are able to access the information that will empower them to be active citizens, taking more responsibility for their own wellbeing and that of their families.

25. In developing the right approach to information on public health, we believe that it is critical for social care and health care information to be closely integrated. At the same time, if the overall health of society is to be improved, it is essential that information on public health is linked to as many as possible of the external factors influencing health (such as educational attainment, benefit claims, crime and access to healthy food choices). There should also be coordination between the information collected at a local authority level so that public health information more accurately informs data about the population's health. This will ensure that the social determinants of health are taken into account by commissioners and enable individuals to assess the risks associated with their lifestyle choice and community more generally.

26. It is for this reason that we believe local authorities, given their public health responsibility and wider view of local issues, are ideally placed to take a leading role on the provision of information relating to the health of their local communities. We take the view, however, that Government has a central role in setting the applicable framework for public health and for coordinating an effective evidence base at a national level. The Information Centre has previously had a role to play in ensuring the quality and standard of data and we believe that its experience in doing so should be key to informing the Government's approach in the future.

CONCLUSION

27. We welcome the Government's overall vision of public health, however, there are a number of areas where we believe further development is required if the new approach is to be a success.

28. Particularly, we believe that more clarity must be provided about the role of local authorities and the nature of partnership working at both a national and local level. This is to ensure that all parties are fully prepared to take on their new duties.

29. At the same time, it is essential that the key driver behind the new approach to public health is a focus on the reduction in health inequalities. Without this, many of the Government's wider plans around healthy may be blunted in implementation by the persistent root causes of poor health.

30. Finally, we believe that information has a key role to play in directing the new public health agenda and also in encouraging active citizens who become fully involved in the decisions and management of their own health.

Written evidence from the Royal College of General Practitioners (PH 184)

Please note: this response was drafted before the outcome of the listening exercise and subsequent Government response

SUMMARY

- The Health and Social Care Bill brings an immense opportunity for GPs, both as commissioners and providers, to improve public health outcomes. As providers of holistic care, GPs understand the context in which the patient operates and are well placed to take on this role.
- Consortia will need to be equipped to take on responsibilities for population health through sharing of best practice; a more sophisticated usage of population health data; and more explicit terms of cooperation with public health staff.
- There will need to be tight controls on the types of projects applicable for public health funding, and rigorous oversight from Public Health England.
- The Public Health Outcomes Framework will need to be tested and evidence-based to avoid restricting the flexibility of local Health and Wellbeing Boards to plan services according to local needs.

The Health Premium must target incentivised outcomes at those groups which are particularly disadvantaged.

1. The Royal College of General Practitioners is the largest membership organisation in the UK solely for GPs. Founded in 1952, it has over 42,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care.

2. The RCGP is at the forefront of developing general practice to address the health needs of the wider population. The College's curriculum and associated statements, the first of their kind for general practice in the UK, includes the curriculum statement *Healthy People: promoting health and preventing disease*, and was developed in partnership with the Faculty of Public Health. It sets out how GPs should meet the curriculum requirements of promoting health and preventing disease in a range of settings.

3. The College's *Centre for Commissioning*—a virtual service that equips GPs, practices and consortia with the skills, competencies and expertise required to deliver effective healthcare commissioning—is undertaking joint work with the Faculty of Public Health and has produced a memorandum of understanding on how both organisations can work better together. Outcomes from this memorandum include College Members working with their public health colleagues to develop support materials for a variety of settings.

4. The work of the RCGP Research and Surveillance Centre (RSC), currently funded by the Health Protection Agency, is regarded as leading the world in this area—it has data and baselines extending back for 50 years—this is unparalleled. RSC data is even recognised by media and public in respect of flu outbreaks and there is great confidence in this data. The unit and its work are relatively cheap and cannot be easily displaced (it is possible to collect routinely obtained data from general practice quite easily, but without the baselines and context, it is relatively meaningless).

GENERAL COMMENT

5. The College holds the belief that GPs and their practices can play a key role in many aspects of the public health agenda. The advent of clinical commissioning brings with it opportunities for new models of care and means that GPs can play an even wider part in improving the health of the nation.

6. GPs, on the whole, are enthusiastic to take on increased public health responsibilities. To be able to realise their full potential and achieve the best outcomes for patients they will need the right tools: the appropriate skills and knowledge, supported by the right information and usage of data.

7. The RCGP welcomes the attention given to public health issues in the White Paper *Healthy Lives, Healthy People* and its subsidiary consultation papers. However, it is regrettable that public health has been dealt with separately to the wider health reforms and we believe this has missed opportunities for greater integration.

8. In relation to the wider health reforms, we are reassured that things are moving in the right direction; the emphasis on preserving the principles of the NHS and keeping it free at the point of need; freeing the NHS from political interference; clinical commissioning of local services; and the real focus on reducing health inequalities are to be welcomed. However, we still have a number of outstanding concerns about the potential risks and unexpected consequences of the proposals. We need the Government to reassure us that GPs will be given the freedom and autonomy to lead the decision-making and design of future integrated health systems drawing on the support of other health, social care and third sector services. We support clinician-led commissioning but continue to believe that GPs are best placed to lead this process.

SPECIFIC QUESTIONS

- Arrangements for public health involvement in the commissioning of NHS services.
- Arrangements for commissioning public health services.

CONSORTIA LEVEL

9. We welcome the proposal that commissioning consortia will have responsibility for the whole population in their area and that Public Health England, the NHS Commissioning Board and local Health and Wellbeing Boards will be expected to coordinate with consortia in planning and implementing public health strategies.

10. We welcome the Prime Minister's recent announcement that Monitor will have a responsibility to integrate services and believe this has to be enshrined in the Health and Social Care Bill.

11. We are concerned that, in some cases, consortia and local authorities will be non-coterminous, with the potential for overlapping boundaries, making cooperation unnecessarily complicated. This could result in these consortia being required to commission in line with the strategies of multiple Health and Wellbeing Boards and multiple Joint Strategic Needs Assessments. If the public health needs of the population are to be truly addressed, the Government must look at aligning consortia with local authority boundaries.

12. As well as this, the proposed abolition of practice boundaries and resultant greater flexibility for patients to choose their GP practice, is likely to result in practices having a number of patients outside of the territorial area of their consortium, making it even harder for them to commit resources to community-level initiatives. The decision to abolish practice boundaries, with potentially huge implications for patient safety, home visiting and practice stability, must be reconsidered.

13. Effective accountabilities for Public Health England, Local Authorities and Health and Wellbeing Boards need to be in place in order for the right cooperation to take place. This must be supported by the Health Premium and outcomes frameworks that are targeted and incentivising in the right way.

14. For public health expertise to be properly embedded in commissioning, there will need to be more explicit terms of cooperation between consortia and public health staff. A major concern for GPs and GP commissioners is the removal of public health staff into local authorities which could reduce rather than facilitate the capacity for public health intelligence to inform NHS planning and commissioning. Our members have commented that they make considerable use of public health epidemiological and data assessment skills, and envisage these becoming more useful under GP commissioning, particularly for analysis of sociodemographic variations in outputs of service.

15. Crucial to the maintenance and success of the commissioning relationships between local authorities and the NHS will be the assembly, analysis and sharing of examples of best practice as well as the availability of public health information. Consortia must be enabled to use this data in more sophisticated ways than is currently possible.

16. In terms of data, there is a wealth of information already kept in general practice and this is an untapped resource. Computer systems that can be inter-linked across organisational boundaries could facilitate the collation and utilisation of this data, which would make a real impact in improving population health.

PRACTICE LEVEL

17. Many GPs see their role as at the front line of meeting the public health needs of their populations and are enthusiastic about taking this forward.

18. However, some are sceptical of their potential to manage population health needs and feel that there is a tension between health promotion at a population level and their primary role of meeting individual patients' needs and that this may, in fact, in some cases damage the relationship with an individual patient. Recurrent challenges to patients about lifestyle can be seen as personal criticism and undermining of the struggles individuals face to overcome unhealthy habits. There needs to be a culture shift and GPs will increasingly need to look at patients from a preventative perspective in order to combat this.

19. More emphasis needs to be put on GPs' day to day role in public health. Public Health England would be well advised to develop coherent and persuasive evidence for the efficacy and level of specific interventions, to ensure 'buy-in' from clinicians and the effective use of their time and skills.

20. The proposal to hold GP practices to account for public health outcomes, including 15% of the QOF allocation, is welcomed but will place an additional training and education burden on GPs. Adequate training provision will have to be in place to ensure that GPs fully understand Joint Strategic Needs Assessments and the roles of other public health professionals. The case for enhanced training of GPs, which the College and others have been pressing for some time, is also now stronger than ever.

21. Ultimately, GPs and public health professionals need to understand each other's roles. To facilitate this, opportunities for GP training placements in public health should be increased as they are currently limited.

The future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Wellbeing Boards, Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies)

22. It is crucial that consortia are closely engaged with the Health and Wellbeing Boards to encourage alignment between healthcare and public health commissioning.

23. Much will depend on the willingness and ability of the members of local Health and Wellbeing Boards to cooperate and coordinate activities—costs of backfill and appropriate contracts are always necessary for full engagement by health professionals.

24. A further financial challenge is the fact that each consortium may need to work with the Health and Wellbeing Boards, Directors of Public Health and HealthWatch organisations of more than one local authority, and vice versa. It is essential that these interactions are supported by adequate funding to allow them to flourish. They also need to be constructed in a way which is not overly bureaucratic as a failure to do so will work against the fundamental aims of “Liberating the NHS”.

25. Given the shared responsibility of all healthcare professionals for public health issues, it is desirable to have as close co-operation as possible on workforce planning. It is therefore entirely sensible for Public Health England to have a role within Health Education England, and similarly for local authorities, presumably through local Directors of Public Health, to have a role in local provider skills networks.

*The creation of Public Health England within the Department of Health:
How the Government is responding to the Marmot Review on health inequalities*

26. We endorse the suggestion from the Faculty of Public Health that Public Health England should have a degree of independence either as a special health authority or as an executive agency.

27. The report of the Marmot review identified a variety of social and economic causes for health inequalities that do not appear to be properly acknowledged in the Government’s proposals for public health.

The future of the Public Health Observatories

28. As has been stated earlier, GPs already use information about care services to support and advise their patients; and this is a vital part of primary care which can be enhanced by more accurate data and by information technology solutions. It is anticipated that a far greater volume and quality of information from all health and social care sources will be a vital tool to aid GP commissioners. This must also include access to public health information, as currently produced by Primary Care Trusts and the regional public health observatories: these datasets need to be retained if the public health function moves into local authorities.

The structure and purpose of the Public Health Outcomes Framework

29. It is of utmost importance that public health responsibilities do not become divorced from healthcare, since the primary care team has so many opportunities to influence public health. The purpose of the outcomes framework must be to prevent this separation. Equally important, the framework should be structured so that its objectives are effective and measurable.

30. To realise this dual challenge, outcomes should apply equally to the partners involved and also have enough evidence base behind them to ensure that appropriate interventions can be designed and monitored.

31. This is important because it is essential, especially given the current restricted financial situation, that those public health initiatives that can be shown to be most effective are resourced and that perverse incentives and outcomes are avoided.

Arrangements for funding public health services (including the Health Premium)

32. It is important that any outcomes incentivised through the Health Premium must be clearly measurable and genuinely responsive to specified public health activities. They must also aim at maximal health gain in those areas where the greatest improvement is needed and must not be designed to disempower challenged communities if it is solely outcomes based.

33. It will therefore be important to target incentivised outcomes at those groups which are particularly disadvantaged. There is great value in the use of regular health checks for people with learning disabilities. Incentives like this can have an immediately positive effect on inequalities.

The future of the public health workforce (including the regulation of public health professionals);

34. Success of the proposed reforms will be dependent on the engagement and hard work of public health professionals, and care should be taken that their status and working conditions are not unduly impacted in moving them into local authorities.

35. The future of the professionals is perceived as highly uncertain and some loss of high quality medics is already occurring. The lack of clarity about future employment routes for senior medics in the public health profession is causing great concern.

36. It will be of the utmost importance that the functions of the Health Protection Agency (HPA) and the National Treatment Agency for Substance Misuse, when transferred to the Department of Health, retain their independence. If an outbreak of flu or measles happens quickly, it is currently unclear as to who, under the proposed reforms, would be responsible for the management of the situation.

37. The funding of the RCGP Research and Surveillance Centre (RSC) must continue to be provided through the Department of Health (following the abolition of its current funder, the HPA) if major virus outbreaks are to be monitored effectively. In the flu outbreaks of recent years, the centre's twice weekly reporting and surveillance of influenza-like illness and other respiratory diseases has become increasingly important.

The abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse

The public health role of the Secretary of State

38. The proposed new powers for the Secretary of State to protect the population's health are welcomed but must clarify the degree of intended involvement in both strategic and operational Public Health functions.

June 2011

Written evidence from John Kapp (PH 185)

SUMMARY

The cause of health inequalities is that the rich can afford to, and do access complementary therapy, and the poor cannot afford it, so suffer untreated and uninformed. The way to eliminate health inequalities is therefore to mass-provide NICE-recommended complementary therapies free at the point of use, on GP prescription. The main treatments which are clinically appropriate for most patients, are the Mindfulness Based Cognitive Therapy (MBCT) eight week course for depression under CG23, and CG123, spinal manipulation and acupuncture for low back pain, under CG88.

ADMINISTRATION

I have created the Social Enterprise Complementary Therapy Company to contract with public health commissioners to administer this, and to provide patients with their statutory right to NICE-recommended treatments if their doctor says it is clinically appropriate. For details, see our website www.sectco.org. which contains many papers about this subject.

June 2011

Written evidence from Unilever UK and Ireland (PH 186)

EXECUTIVE SUMMARY

- The Government and public health bodies have developed a number of strategic responses to tackle the health challenges facing the UK. These include building physical activity into everyday life, promoting healthier food choices, and reviewing how food is promoted. In the UK, the diet and health debate is increasingly focused on out-of-home consumption and the role of employers in improving the nation's health.
- Unilever UK & Ireland (Unilever) welcomes the opportunity to make a submission to the Health Select Committee inquiry into Public Health. The paper outlines Unilever's belief that only a partnership approach will successfully address the public health challenges that we are presented with today; businesses role within this partnership; our involvement in the Public Health Commission and as one of the signatories to the Government's Responsibility Deal on Public Health.
- In 2008, Dave Lewis, then Chair of Unilever UK & Ireland, was invited to Chair the voluntary and independent Public Health Commission which comprised representatives from the food industry and public health sector. The Commission set out to explore all aspects of the Responsibility Deal proposal identified by the Conservative Party in an open and transparent manner, and in the spirit of seeking to make a positive contribution to the challenges of public health. The Commission made a series of recommendations for improving and aligning the contributions of businesses, charities and public sector organisations in tackling public health issues around diet, alcohol consumption and physical activity. The report was considered by the Conservative Party as it developed its Responsibility Deal.

- In March 2011, under the Government’s Responsibility Deal for Public Health, Unilever signed up to ten pledges including labelling, reduction of salt and removal of trans fats, promotion of physical activity and employee health and wellbeing. Unilever has and will continue to make advances with product reformulation and innovation where we can enhance the nutritional value of our products and provide helpful information to consumers about nutrition content. In addition, Unilever made an individual pledge to work in partnership with SMEs in the Leatherhead area, where our headquarters in the UK is located, to promote health and wellbeing to their employees
- There is considerable debate regarding the appropriate role of business in tackling public health challenges which is often difficult and emotive. However, these challenges are great with cardiovascular disease causing 50,000 premature deaths a year, over a quarter of adults overweight or obese, and 2.8 million people with mostly Type 2 diabetes rising to an estimated 4 million by 2025 in the UK. Unilever believes that there is a legitimate role in public health for business as a commercial organisation, an employer, part of the local community and with the people who buy our products. Indeed, the wider public policy trend in relation to addressing a host of issues within the broad context of sustainability supports a multi-agency approach to achieve long term change.

1.0 Introduction

1.1 The paper outlines Unilever’s belief that only a partnership approach will successfully address the public health challenges that we are presented with today; businesses role within this partnership; our involvement in the Public Health Commission and as one of the signatories to the Government’s Responsibility Deal on Public Health.

2.0 About Unilever

2.1 Unilever employs almost 7,000 people across 20 sites encompassing manufacturing, distribution centres and R&D in the UK & Ireland. Unilever is one of the largest consumer goods companies globally. The portfolio ranges across food, home and personal care products including tea, spreads, ice cream, detergents, washing powder and shampoo. Unilever products can be found in nine out of ten UK homes, this brings a unique understanding of how consumers live and work which can drive positive behaviour change.

3.0 Policy context to business and public health

3.1 The Government and public health bodies have developed a number of strategic responses to tackle the health challenges facing the UK. These include building physical activity into everyday life, promoting healthier food choices, and reviewing how food is promoted. In the UK, the diet and health debate is increasingly focused on out-of-home consumption and the role of employers in improving the nation’s health. The Government’s response to, “*Working for a Healthier Tomorrow*”⁴⁹³ called on employers to invest in workplace health and wellbeing. The Marmot Review⁴⁹⁴ sets out the most effective evidence based strategies for reducing health inequalities in England with business as employers in the community tackling the social determinants of health inequalities.

3.2 In 2008, Andrew Lansley, then Shadow Health Secretary established the Public Health Commission to look at a proposed “responsibility deal” by the Conservative Party between government and business. Dave Lewis then Chairman of Unilever UK & Ireland accepted the invitation to Chair the Commission on the basis that, firstly, it was politically impartial and independent, with its findings shared with all parties at the same time; and, secondly, that the panel should be balanced and comprise of all sides of the debate, therefore, the Commission representatives were drawn from the food and drink industry and public health sector based on their expertise. All Commission members participated in a voluntary capacity. Whilst participants were cautious about taking part, everyone wanted to make a positive contribution to public health.

3.3 Up until the Commission was established a lot of energy had gone into the areas where parties disagreed. However, it was clear if we could identify those issues we could agree upon, and there were many, real progress would be made.

3.4 The Commission members agreed from the outset that they would like to work differently from other Government committees they had served on. The Commission explored all the aspects of the Responsibility Deal in an open and transparent manner will all papers made available on the Public Health Commission website which is still operational and contains all the details of the meetings and the final report: <http://www.publichealthcommission.co.uk/>.

3.5 The Commission published its final report, “*We’re all in this together, Improving the Long-Term Health of the Nation*”⁴⁹⁵ in 2009. The report set out recommendations for improving and aligning the contributions of businesses, charities and public sector organisations in tackling public health issues around diet, alcohol consumption and physical activity.

⁴⁹³ Dame Carol Black’s Review of the health of Britain’s working age populations (2008) *Working for a Healthier Tomorrow*.

⁴⁹⁴ Micheal Marmot’s Review of Health Inequalities in England post-2010, (2011) Fair Society, Healthier Lives.

⁴⁹⁵ The Public Health Commission, (2009) *We’re all in this together: Improving the Long-Term Health of the Nation*.

3.6 The Conservative Party considered the report as it developed its proposal. The *Responsibility Deal on Public Health* was launched in March 2011 with the food and drink industry pledging to meet a series of targets on physical activity, health at work, food and alcohol, as well as individual pledges. Unilever has signed up to ten pledges covering food, physical activity, health at work and an additional individual pledge:

3.6.1 Food

- Reduce salt levels to meet targets by the end of 2012.
- Provide calorie information in out-of-home settings from September 2011 in accordance with the principles for calorie labelling agreed by the Responsibility Deal.
- Remove artificial trans fats from products by end of 2011.

3.6.2 Physical Activity

- Contribute to the communication and promotion of the Chief Medical Officers' revised physical activity guidelines.
- Increase physical activity in the workplace.
- Tackle the barriers to participation in physical activity faced by some of the most inactive groups in the society (within our employee base).

3.6.3 Health at Work

- Embed the principles of the chronic conditions guides within HR procedures to ensure that those with chronic conditions at work are managed in the best way possible with reasonable flexibilities and workplace.
- Use only occupational health services which meet the new occupational health standards and which aim to be accredited by 2012–13.
- Include a section on the health and well-being of employees within annual reports and or websites including staff sickness absence rate.
- Implement some basic measures for encouraging healthier staff restaurants and vending outlets including: the provision of healthier foods; responsible portion sizes; provide fruit and vegetables; and calories or GDAs on menus per portion as a minimum.

3.6.4 Individual Pledge

- To work in partnership with SME organisations to help them to promote health and wellbeing amongst their staff in the Leatherhead area only for the pilot.

4.0 Unilever's approach

4.1 There is considerable debate about business becoming involved in public health which should be acknowledged. Concerns have been expressed about whether activity in this area is more public relations than substance, a way of avoiding regulation or in conflict with duties to shareholders. The following sets out how we are seeking to address public health issues and seeking to meet the pledges signed up to as part of the Responsibility Deal.

4.2 Unilever is committed to growing our business but not at the expense of the environment and social well-being. The *Unilever Sustainable Living Plan*⁴⁹⁶ commits the company to doubling the size of our business and at the same time halving our environmental impact and increasing our social impact. In the UK this means we are working with Government and other stakeholders to help meet public health targets. We have been addressing health and nutrition issues directly with employees through occupational health and consumers through our products for many years.

4.3 Nutrition

4.3.1 As a food manufacturer, through product reformulation and innovation we can enhance the nutritional value of our products and provide helpful information to consumers about nutrition content. Through the Food and Drink Federation (FDF), Unilever was instrumental in leading Project Neptune, a salt reduction activity. This succeeded in achieving a 30% reduction in salt levels in soups and sauces over three years (10% reduction year on year 2003–06). In 2003, Unilever introduced its Nutrition Enhancement Programme (NEP) based on international and a range of national dietary guidelines to assess and improve the nutritional quality of our food and beverage portfolio. By the end of 2008, we had eliminated 30,370 tons of trans-fats, 18,000 tons of saturated fats, 3,640 tons of sodium and 37,000 tons of sugars globally. This is an ongoing process in order to help us improve the nutritional content of our products.

4.3.2 Through our involvement in the Commission and the insight gained from the medical community we recognised that there was concern about trans fat intake out-of-home. Unilever, therefore, signed up to removing partially hydrogenated fats from the portfolio and across the business. Unilever has removed the partially

⁴⁹⁶ The Sustainable Living Plan commits to helping more than a billion people take action to improve their health and well-being; halve the environmental footprint of the making and use of our products; and enhance the livelihoods of hundreds of thousands of people in our supply chain (2010) <http://www.sustainable-living.unilever.com/>.

hydrogenated vegetable oil (p-HVO) from Elmlea, which in turn has removed the artificial transfat from the product. This was technically very challenging and consequently we have made a substantial investment to overcome this challenge. The reformulation process began in 2009 and the product was re-launched in mid 2010.

4.4 *Consumer awareness and behaviour change*

4.4.1 Unilever believes that positive guidance drives positive consumer behaviour by using GDAs as opposed to colour-coding. Unilever uses per portion GDA information on all its food brands to help consumers make informed choices. We oppose the use of colour-coding of GDAs as this may lead to inaccurate conclusions on the nutritional composition of similar foods. As a result, the system can create significant anomalies whereby healthier and less healthy food products are both labelled red for key nutrients. Such a simple labelling system often removes the incentive for food manufacturers to reduce salt, saturated fat and sugar content of their products as any improvements will not be rewarded by a change in label colour. For instance, Unilever has provided the people who buy our products with healthier options. Our spreads range offers a *light* option containing almost half the fat of our *original* version and now outsells it. Under a colour coded system both options would be labelled red.

4.4.2 The Commission highlighted the untapped opportunity to give consumers nutrition information when they eat out-of-home. The out-of-home sector accounts for over eight billion meals ever year. Until recently that was eight billion meals without any nutrition information. Over half of the meals eaten out-of-home are in schools, hospitals and workplace restaurants. These are often provided by contract caterers with highly managed menus and should be considered prime candidates for introducing nutrition information quickly and effectively.

4.4.3 The Responsibility Deal has now called for nutrition labelling to be displayed in a consistent manner to that used on foods sold in supermarkets, as this will help build nutrition literacy and give consumers a more informed overview of their whole diet. As a result, Unilever has driven consistency in nutrition information across our business. We use the same GDA information on our retail brands, our restaurant menus and in both our out of home product packs and communications. Unilever's Food Solutions business which sells products and services out-of-home is making good progress in working with our customers to put GDAs on menus. Now over 100 NHS restaurants have and GDAs.

4.5 *Occupational Health*

4.5.1 *Fit Business* is a workplace health intervention programme based on the provision of information to employees that allows them to make healthy choices, and support their lifestyle behaviour changes. The programme aims to reduce levels of obesity, Type 2 diabetes and cardiovascular disease.

4.5.2 In 2009, *Fit Business* began with a year-long workplace health pilot with 2,000 employees and has now been rolled out to all 7,000 employees in the UK and Ireland. The programme includes: health checks to help employees understand health measures like blood pressure, cholesterol, Body Mass Index (BMI), and to provide tailored advice enabling them take control of their own health; nutritional information in employee restaurants showing calorie, fat, sugar and salt content and GDAs to allow employees to make informed and balanced choices; guidance on being more active in the workplace which can help employees reach the daily recommended exercise levels in line with Change4 Life guidance; extra support for high risk people, based on the health profile or their role; and alignment of mental health and personal resilience activities.

4.5.3 The pilot had a measurable impact on employees: 62% reported an increase in energy; 46% made changes to their diet; 35% decrease of overweight, obese or very obese respondents based on BMI; and, 25% increase of above average or athletic fitness heart rate. The pilot was independently evaluated by the Institute of Public Policy Research (IPPR). Their report noted a number of public policy implications⁴⁹⁷ for Government to encourage employers to take a more leading role in promoting in-workplace health and well-being by sharing best practice and providing support to SMEs; consistent communications for behaviour change; and partnership working for national health outcomes.

4.5.4 Unilever has made an individual pledge as part of the Responsibility Deal to work in partnership with local SMEs in the Leatherhead area to help them promote health and well-being amongst their staff. This means that we will extend our 2011 *Fit Business* programme to a selection of small local businesses and we will work with local partners, such as the Leatherhead Chamber of Commerce, local PCT and the District Council to find ways of engaging with employees in these businesses and establishing how workplace health schemes can be extended into the community. The pilot was launched in February 2011 and will cover healthy cooking; physical activity; mental wellbeing; and drug, alcohol and smoking.

5.0 *Conclusion*

5.1 There is considerable debate regarding the appropriate role of business in tackling public health challenges which is often difficult and emotive. However, these challenges are great with cardiovascular disease

⁴⁹⁷ Myriam Cherti and Reg Platt on behalf of the IPPR (2010) *Fit Business* Evaluation.

causing 50,000 premature deaths a year⁴⁹⁸, over a quarter of adults overweight or obese⁴⁹⁹ and, 2.8 million people with mostly Type 2 diabetes rising to an estimated four million by 2025 due to ageing but also the rapidly rising number of overweight and obese people⁵⁰⁰ in the UK.

5.2 Unilever believes that there is a legitimate role in public health for business as a commercial organisation, an employer, part of the local community and with the people who buy our products. Indeed, the wider public policy trend in relation to addressing a host of challenging issues within the broad context of sustainability supports a multi-agency approach to achieve long term change.

June 2011

Written evidence from the Institute of Public Health (PH 187)

By Professor Carol Brayne and the Public Health Theme (CLAHRC Cambridgeshire and Peterborough), in consultation with colleagues at the Institute of Public Health, University of Cambridge and the wider service public health community.

- There should be a single National Public Health Service for England as a special health authority within the NHS, encompassing all 3 domains of public health, or as an executive agency of the department of health.
- Public health is at risk of becoming fragmented by reforms with damaging consequences for commissioning of quality services.
- Health and Social Care Bill should be amended so that the Secretary of State remains accountable for the commissioning and delivery of a comprehensive health service free at the point of need, for the whole population.
- DPHs must be a statutory member of the Health and Wellbeing Board and directly accountable to the local authority CEO.
- GP consortia must cooperate with the DPH, so public health expertise into planning, commissioning and delivery of health services can be maintained.
- Fragmentation of commissioning responsibilities, and eradication of GP practice boundaries increases the likelihood of people falling through the net.
- The budget for public health should be ring-fenced and not subject to other pressures such as those of reduced local authority budgets
- Healthcare (health services) Public Health has been overlooked in these reforms. Public health specialists in this area provide expertise to commission clinical and cost effective services for the local population based on need. Public Health professionals *must* be put at the heart of commissioning.
- New arrangements should *strengthen* working relationships between academic public health and service public health, enabling public health research and practice communities to engage more effectively with each other.
- The recruitment and training of public health professionals is in danger of being severely damaged as a consequence of the Health Bill. The profession must continue to recruit high calibre candidates.

1. THE CREATION OF PUBLIC HEALTH ENGLAND WITHIN THE DEPARTMENT OF HEALTH

1.1 We believe that there should be a single National Public Health Service for England set up as special health authority within the NHS encompassing all three domains of public health. Alternatively, it can be set up as an executive agency of the department of health. The specialist public health workforce currently employed in PCTs and SHAs should be employed on NHS terms and conditions by the National Public Health Service and seconded as required to sub-national and local teams, including commissioning consortia or any organisation requiring public health input. This would allow the Directors of Public Health, jointly appointed with the local authority, to be supported by the public health specialists. Support would be available nationally and locally, by all 3 domains of public health—health protection, health improvement and healthcare public health.

1.2 PHE should not come under the DH, as the public health workforce would lose the independence to challenge powerful interests whose actions risk the health of the population, and could no longer be a powerful advocate for the health of the public. This model would also allow for quality training programme for the future public health workforce, and robust mechanisms for maintaining professional competence would be easier to administer if the public health workforce were integrated.

⁴⁹⁸ British Heart Foundation (2009) Coronary Heart Disease Statistics.

⁴⁹⁹ Cross-Government Obesity Unit (2008), Healthy Weight, Healthy Lives: A Cross-Government Strategy for England, Department of Health.

⁵⁰⁰ Diabetes UK (2010) Diabetes in the UK.

2. THE ABOLITION OF THE HEALTH PROTECTION AGENCY AND THE NATIONAL TREATMENT AGENCY FOR SUBSTANCE MISUSE

2.1 Health protection incidents are always complex, and often require expert input at national, regional and local levels, involving multi professional collaboration. The current proposals lack clear lines of accountability and communication for protecting the health of local population. Local authorities have been given duties around protecting the health of the population, but if PHE (health protection) also has responsibility, there is a risk of duplication and confusion. This is of vital importance at all times, but particularly at times of emergency eg the flu pandemic, when there is no time to debate accountability.

2.2 With the duty of the protection of the health of the public moving to local authorities, it is not clear how the after hours health protection function will be delivered when PCTs are abolished. Public health consultants currently at the PCT, supported by Public Health Registrars in training, perform many health protection roles providing expert knowledge on infectious diseases eg infection control, sexual health (HIV and AIDS), TB contact tracing, as well as emergency planning. It is not clear where this function will be held in future, or how the accountability will work when there is a serious outbreak of disease such as E coli, flu pandemic or a meningitis outbreak.

2.3 If PHE were to be set up as a special health authority, this would also allow the HPA to continue research activities which are under threat if it becomes part of the DH as proposed in the Health Bill.

3. THE PUBLIC HEALTH ROLE OF THE SECRETARY OF STATE

3.1 Splitting the role of the Secretary of State into two, (1. a duty to secure provision of public health services; 2. to act with a “view to” securing the provision of health services for the purpose of the NHS), relieves the SoS of his accountability for a comprehensive health service. This has directly resulted in the fragmentation of public health with little regard for the consequences on commissioning of quality services for populations.

3.2 In the past, costs and provision were balanced at population level by public health as honest brokers without specialism. There is no gain for patients in changing the current accountability of the secretary of state. We believe that the Bill should be amended to make it clear that the Secretary of State remains accountable for the commissioning and delivery of a comprehensive health service free at the point of need, for the whole population through a statutory “duty” to do so.

4. THE FUTURE ROLE OF LOCAL GOVERNMENT IN PUBLIC HEALTH

4.1 The Bill must require that the DPH be a health professional, the local representative of PHE, an independent advocate for health, who reports to the Chief Executive of the Local Authority so that the importance of the role is clear and reinforced. The DPH provides expert strategic leadership in public health, and so must be in the position where they can exert a major influence on decisions made by the local authority, yet still maintain independence to provide advice and speak publicly. The DPH also needs to be able to influence commissioning decisions, so there must be a duty for consortia to cooperate with the DPH. In this way, public health expertise into planning, commissioning and delivery of health services can be maintained.

4.2 If the DPH is jointly appointed by PHE and the LA, then the DPH will be accountable to the secretary of state for health, the CMO, the LA, and possibly the NHS commissioning board. This could lead to confusion.

4.3 The DPH will need a wide range of expert support from public health specialists and practitioners with skills and expertise in a wide range of areas including public health. DPHs need to be properly professionally qualified and so there needs to be statutory provision on appointment processes, and qualifications, as well as statutory registration for non-medical public health specialists.

4.4 The DPH must be a statutory member of the Health and Wellbeing Board and directly accountable to the local authority CEO, be responsible for managing the ring-fenced public health budget and public health staff, have direct access to the local authority’s cabinet and councillors, and not be removed from his/her position without the approval of both the local authority and the Secretary of State.

4.5 Local authorities should be accountable for protecting and improving the health of their populations at all times, including outbreak and emergency situations

5. ARRANGEMENTS FOR PUBLIC HEALTH INVOLVEMENT IN THE COMMISSIONING OF NHS SERVICES

5.1 There have been no arrangements laid out for public health involvement in the commissioning of NHS services. Public Health professionals *must* be put at the heart of commissioning, which is where the profession has been for over 30 years, providing the expertise for which its workforce are trained. The public health workforce is already disappearing and their skills will be more expensive to purchase from the private sector under a fragmented market. If this skill disappears altogether, the health care system will be distorted by expensive demand and the need for rationing, and poorly informed from a population and contextual angle. Commissioning decisions must be grounded in quality information systems, needs assessment, service model development, standards and specifications, and design which ensures a balance between cost effectiveness, quality improvement, impact on education and training, and the long term sustainability of the local health

economy. This is the core business of public health as it has been practised in the UK, and will continue to be practised in Wales and Scotland.

5.2 GPs are not trained in *population* health, GPs are trained in *individual* health. The local population includes not only those on the GP practice register, but also those not on *any* register such as the vulnerable populations who are likely to be underrepresented. Consortia cannot selectively commission services, rather they must commission for the population based on a needs assessment carried out by population health experts. GPs must have a duty to collaborate with public health specialists at all stages of commissioning, including needs assessment. Commissioners must retain a responsibility for the provision of a comprehensive health care service to protect and promote the health of the population for which they are responsible.

5.3 Most pathways of care will span a range of interventions from prevention to rehabilitation, and include both generalist and more specialist areas. Collaboration with specialists outside the NHS is important for almost all these stages, and requires public health specialist advice. Across the whole range of health services, this task is immense and becomes highly specialised, requiring a general understanding of the particular health and service area (cardiovascular, maternal and child health etc.) as well as general skills, in order to commission in an integrated way.

5.4 One of the most contentious areas of commissioning is exceptional funding decision making. Public health specialists currently take the lead in decisions around funding treatments which are not within NHS guidelines. This role requires a population perspective on budgets and evaluating evidence, which will be competences of crucial importance for GP consortia. Whatever the arrangement for the future, decisions must be informed by public health expert opinion.

5.5 Related to this, we are concerned that the White Paper and related Bill, in its current state, makes no provision for a strong means of generating the evidence to underpin the advice (public health research). We believe that the commissioning process should mandate commissioners to:

- regularly draw on research evidence to inform commissioning and to ensure that commissioning organisations have access to high quality, local, research partners (including Universities) which will inform the local and national commissioning process;
- oblige providers to undertake and support high quality research; and
- include a suite of appropriate research metrics (some of which may be used as proxy measures for clinical quality) to ensure that the obligations of providers to support research are being met.

6. ARRANGEMENTS FOR COMMISSIONING PUBLIC HEALTH SERVICES

6.1 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 proposal, services in these areas will be commissioned by multiple bodies. This is a waste of money and expertise. This fragmentation, together with the proposed eradication of GP practice boundaries increases the likelihood of individuals, even whole areas, falling through the gaps, and particularly leaves vulnerable children and adults at risk.

6.2 Provision for joint commissioning must be strengthened, and cost shunting between health, public health and social care avoided. Clarity is required to establish how each part of the system will work together to ensure effective and coordinated commissioning.

7. THE FUTURE OF THE PUBLIC HEALTH OBSERVATORIES

7.1 The public health system must have access to up-to-date, comprehensive public health intelligence on which to base decisions. Robust and accessible public health intelligence underpins all service commissioning, outcomes assessment, planning and redesign of services, and surveillance of infectious disease in the community. It is about collecting data, analysing and interpreting it. Only with this information can health needs be established, the modelling of future scenarios of future needs, and the assessment of the impact and effectiveness of interventions.

7.2 The cut in 30% of funding for PHOs is already resulting in the departure of skilled staff. Once these skills are lost they cannot be recovered, as future analysts will find another profession. There is a serious risk to provision of information if the future funding of public health observatories is not guaranteed. The Government is not acting to preserve the skills in the Public Health Observatories, whose existence is being prolonged only by a short term extension, with no clear strategy for the longer term. The public health observatory role should be protected, and clarification is required on how this, and access to health service data at population level, will be ensured. More generally, national and local public health intelligence efforts need to be joined up. If funding to the regional PHOs is not guaranteed, this will lead to gaps in surveillance and monitoring, in turn affecting ability to produce trend data in population health and health inequalities.

7.3 There also has to be an appreciation of the role of public health research at the core of the improvement of the health of the nation, and the role of healthcare observatories in analysing public health datasets to provide reports on the health of the nation. The removal of PCTs will also remove any guarantee that research

plays a role in the provision of safe, and effective services, since Local Authorities and commissioning consortia are unlikely to commission research to the same, or any, extent, and equally may not welcome hosting research. The gap that this leaves will put the UK backwards in its international standing of its medical academic institutions, and affect the health and wellbeing of the population. It seems to us that the UK has fast changed from being one of the best places in the world to do true population based epidemiological research to near the worst.

7.4 We must also remind ourselves that public health intelligence functions include not only public health observatories, but also cancer registries and regional epidemiology units. The scarce local public health intelligence skills that currently lie within PCTs need to be protected.

8. THE STRUCTURE AND PURPOSE OF THE PUBLIC HEALTH OUTCOMES FRAMEWORK

8.1 Our stated position in respect to the Public health outcomes framework was submitted in response to the consultation document Transparency in Outcomes—Proposals for a public health outcomes framework. Briefly, we highlighted:

- a need for clarity on the actual measures and methods to be used, as well as the purpose of measuring them;
- Questionable measurability of several indicators;
- data collection for poorly defined items; and
- risks in reproducing another “target culture”, with arguably less of the benefits.

8.2 We suggested improvements could be made if indicators are: strengthened to guarantee measurability and validity; if indicators described as outcomes actually are outcomes; transparent and care is taken not to merge definitions that do not mean the same thing (eg wider determinants of health and wider determinants of health inequalities).

9. ARRANGEMENTS FOR FUNDING PUBLIC HEALTH SERVICES (INCLUDING THE HEALTH PREMIUM)

9.1 We suggest looking at Australia’s example, where a proportion of the taxation income from alcohol and tobacco goes to fund national public health measures aimed at supporting changes to the environment which make healthy life easier. We could extend that here to other health damaging products, such as confectionary and sugary drinks. The funding of health protection and health service public health should be raised nationally, not locally if we want these services.

9.2 The budget for public health should be ring-fenced and not subject to other pressures such as those of reduced local authority budgets. The uses must be clearly defined, and the amount calculated from a realistic baseline. There is a 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 health inequalities.

9.3 There is a risk of unfair allocation of the health premium. Specifically, there is no guarantee that deprived areas will receive more funding as they did in the past, or that vulnerable groups will have access to services, because it will be more complex to evidence improvement in health status. There will be a need to review and evaluate any mechanism for allocating the health premium, to ensure a level playing field. The health premium could be incentivised, however, to ensure that it leads to reductions in health inequalities if there is corresponding support for data collection on reliable metrics to evidence:

- a reduction in inequalities where activity is specifically targeted to do so;
- milestones and progress towards improved health in the community as a whole; and
- the geographical distribution of resources and relative performance in relation to changes in health status. (To monitor the balance between rewarding relatively “richer” areas, who might achieve clinical targets more easily, at the expense of those experiencing far greater socio-economic (and health) disadvantage).

10. THE FUTURE OF THE PUBLIC HEALTH WORKFORCE

10.1 The term “public health” in the White Paper and the Health bill is both confusing and used to denote a number of interconnected services relating to the health of the population and some of the public health professionals who are involved in these services. However, its use in this generic way does not do justice to the many different components of public health, nor to the highly skilled health professionals within these components. As a result, we believe that one very important domain of public health, has been overlooked: Healthcare Public Health.

10.2 There are three domains of public health: health improvement, health protection and health services or healthcare public health—which must all be covered by the public health system if the health of the public is to be fully protected and improved. This forgotten element relates to the planning, audit and evaluation of health services. Public health specialists in this area provide expertise to commission clinical and cost effective services for the local population based on need. There are about 200 public health experts practising this

subspecialty, with the training to analyse extensive amounts of information and data, and to interpret the findings in order to meet population health needs. They work with colleagues in public health observatories, academic public health and health economics, and are also trained in management and leadership so that they can deliver service change, including decommissioning, where needed.

10.3 Commissioning has been handed to GPs who have no specialist training in health services planning nor the expert population or epidemiological skills required. The speciality of public health medicine emerged from the recognition of a need for systematic training. Until relatively recently, this was through recruitment of experienced medically qualified professionals (of any speciality) to the public health training programme. At this time of the NHS, public health physicians provided the honest broker population role. The future scenario as it stands is extremely worrying, as without expert input into the commissioning of health services, we run the risk of commissioning services that are not cost effective, not clinically effective and not integrated into patient care pathways.

10.4 Another area of public health with minimal mention in the White Paper is high quality public health teaching and research, which are nevertheless crucial. Links between service and academic staff have often been weak in the past. Local authorities do not generally have a strong research tradition. The new arrangements should be *strengthening* working relationships, enabling public health research and practice communities to engage more effectively with each other (such as in the CLAHRCs). Academic public health consultants currently have honorary contracts with the PCT, and have input into public health matters at local and regional level. So in the new structure, it is unclear where academic public health will link. As well as playing a key role with the three strands of public health, academic public health is of course integral to the education and training of public health undergraduates, postgraduates and the specialist training of public health doctors and trainees.

10.5 Consultants in Public Health are very concerned that, with one strand of public health moving to local authorities, and uncertainty surrounding healthcare public health, and around the future of the public health observatories, the public health workforce is becoming fragmented and it will be increasingly difficult to collaborate and share skills. It is increasingly likely that skilled staff will no longer see a future career in public health.

10.6 The training of public health professionals is in danger of being severely damaged as a consequence of the Health Bill and the consultation paper "Developing the Healthcare Workforce." In order for public health training to maintain its high standards, it must continue to recruit high calibre candidates. If there is any doubt as to the quality of training or the career path, then the best candidates will choose another speciality. In order to keep the specialty attractive to doctors, the training must keep its place alongside other specialties, with similar routes of access, standard setting and quality assurance, and with registration with the GMC after completion of training. If it is to remain an attractive career option then it must have equity of pay with comparable careers.

10.7 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 their employers. This is not currently required for those from backgrounds other than medicine. It is therefore necessary for specialists in Public Health to have some registration eg with the Health Professions Council.

11. HOW THE GOVERNMENT IS RESPONDING TO THE MARMOT REVIEW ON HEALTH INEQUALITIES

11.1 Unfortunately, it looks as though the bigger picture changes are of an increasingly fragmented society, which with low employment and youth disengagement, is likely to lead to greater inequalities. The "Big Society" exists already in many more affluent areas, but is much rarer in disadvantaged communities alienated from mainstream society.

11.2 The Government clearly has a preference for voluntary approaches and responsibility deals over regulation in relation to health improvement and protection, and responsibility seems to rest largely with individuals to look after their own health and wellbeing. Legislation has a complementary role to play, and should be used where appropriate.

11.3 The role of social marketing has been increasingly adopted in the NHS as a mechanism to motivate consumers to choose "healthier" options, yet social marketing conducted in commercial style may lead to loss of trust between community and public health. Nevertheless, national-level campaigns can become launching pads for locally designed and administered public health interventions, creating context-specific local-level campaigns.

11.4 However, information-giving is generally a weak way of changing behaviour particularly if used in isolation. Most people value their health but engage in behaviours that are damaging even though they are aware of the damage they might do. "Nudging" can be used to improve our health, and is the dominant approach today, however, Marteau et al. note that few nudging interventions have been evaluated for their effectiveness, so evidence that nudging alone can improve population health is weak. It is critical that such health messages are grounded in solid evidence from appropriate research generated on relevant populations.

Policy making must take into account the full range of interventions for which there is evidence of effectiveness, and ensure that monitoring and evaluation of initiatives takes place.

11.5 Evidence also shows that behaviour change campaigns only modestly increase knowledge and modify attitudes, with minimal effects on long term behaviour. Individual behaviour cannot happen in isolation of socio-environmental factors, and the most socially advantaged have more resources to adopt health promoting activities. The government needs to address barriers such as poor housing and unemployment that prevent people from making healthier choices. Poverty is the key risk factor for poor health, so structural economic policies are arguably more influential in this area of public health.

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June 2011

Written evidence from Stephen Peckham (PH 188)

PROPOSALS FOR THE FLUORIDATION OF WATER SUPPLIES

INTRODUCTION

1. This submission is focused on an aspect of public health policy that is of particular current relevance but which also is explicitly referred to in consultation documents on the White Paper and has wider implications in England. Water fluoridation has been a controversial policy for many years and despite the commissioning of a systematic review in 1999 the topic remains controversial in terms whether there is sufficient evidence to support policy maker claims of effectiveness and safety, the legislative framework for the introduction of fluoridation schemes and whether fluoridation is ethical given its status as an intervention that is meant to prevent dental decay.

2. The government proposes shifting responsibility for public health from the NHS to local authorities. With respect to water fluoridation this involves changing the responsible authority from the SHA to a unitary or higher tier local authority. This change raises questions about current proposals for the implementation of water fluoridation schemes (in Hampshire and elsewhere) but does little to address problems of water fluoridation policy more generally or the conduct of consultations for water fluoridation proposals highlighted by the recent experience in southern Hampshire.

3. While from an organisational perspective there are many important areas of the current proposals for changes in public health responsibilities, Committee members are requested to give this issue special attention given the numbers of people affected by fluoridation proposals and the specific circumstances of plans to implement fluoridation in the Southampton area.

In considering proposals for public health the Committee is requested to:

- (a) Examine the regulations for guiding consultations on the implementation of water fluoridation schemes (2005) and consider repealing sections of the Water Act 2003 and the relevant Statutory Instruments that provide powers for fluoridation.
- (b) Call for a halt of current proposals for fluoridation schemes introducing 1ppm (as per current government policy) until a full review of recent evidence has been completed including an assessment of why levels have or are being reduced in other countries such as Ireland, Canada and possibly the USA as a result of health concerns.
- (c) Recommend that no new schemes are implemented until new arrangements being proposed for public health responsibilities are in place.

THE LEGISLATION AND REGULATIONS

4. The current legislative framework is embodied in the 2003 Water Act and regulations passed in 2005 relating to the indemnity of Water Companies and public consultation arrangements. The indemnity arrangements were agreed with water Companies who were concerned about potential legal action by their customers over the negative effects of water fluoridation. Public consultation arrangements were agreed following two years of Parliamentary debate and water fluoridation remains unique in health care provision and public health as the only area where specific consultation guidelines have been set by Parliament.

5. The 2003 Water Act makes provision for a specific process to be followed prior to the implementation of water fluoridation. Responsibility for undertaking the feasibility studies and consultation is currently with Strategic Health Authorities. However, public consultation is only undertaken after the SHA has been convinced that water fluoridation is both technically feasible and cost effective. Furthermore the 2005 regulations state that the SHA only has to take account of the results of a consultation but that the final decision is theirs alone.

In fact, as currently drafted, the regulations allow for an SHA to decide on a course of action even if all responses to the consultation have not been in favour of the SHA's decision. As the judge in the recent judicial review on the Southampton case noted—public opinion (including the views of local councils and MPs) is not a relevant consideration for any course of action decided by the SHA—they only have to show that they took such opinion into consideration. Even if 99% of the public responding to a consultation object the SHA can still go ahead. This has important implications for the conduct of public consultations.

6. In parliamentary debates prior to the making of the 2005 regulations Government Ministers consistently stated that no fluoridation schemes would go ahead without local public consent. Clearly this is not the case.

EVIDENCE ON EFFECTIVENESS AND SAFETY

Three issues are important here:

- (a) The evidence on efficacy.
- (b) The relevant dose—currently 1ppm in the UK.
- (c) Evidence of safety.

7. There have been two major systematic reviews of water fluoridation. The most important of these is the York Review commissioned by the UK government in 1999 to provide a comprehensive review of the evidence on water fluoridation but which only served to create further controversy (McDonagh et al 2000, Cheng et al 2007). The review authors concluded that in fact the studies examined did not give clear evidence of caries reduction and that *“The research evidence is of insufficient quality to allow confident statements about other potential harms or whether there is an impact on social inequalities.”* (page xiv). The review found that the research evidence on the affect of water fluoridation on dental caries was rather mixed with many studies being old (undertaken when dental decay rates were substantially higher), observational or insufficiently controlling for confounding factors (such as the use of fluoridated toothpaste) and concluded that there was a need for good quality studies to assess the effect of and safety of fluoridation.

8. More recently a review by the US National Research Council provides a thorough analysis of the impact of fluorides in water (including animal and human studies and toxicological research) highlighting many problem areas. It draws similar conclusions to the York Review—that there are probable detrimental health impacts from fluorides and that not enough is yet known about the wider health impacts of fluoridation and further research is needed (NRC 2006).

9. There is no requirement to ingest fluoride as fluoride contributes to, but is not necessary for, the remineralisation process in the enamel of the tooth surface and high levels of fluoride kill the bacteria that create the acids that damage the tooth enamel. Recent studies have demonstrated that there is little or no difference in rates of dental caries between children consuming fluoridated and un-fluoridated water and that in fluoridated areas. (Warren *et al* 2006)

10. In the UK the Government and advocates of water fluoridation continue to promote 1ppm as the “optimum level” of fluoride despite the fact that the “optimum level” in Canada is 0.7ppm, in Eire it is 0.8ppm and in Hong Kong it is 0.5ppm and most recently, the USA has proposed lowering the maximum allowed level of fluoride to 0.7ppm.

11. The “optimum dose” of fluoride is only relevant in discussions about prevention of dental caries as there is no physiological requirement for fluoride in the human body. It is argued that water fluoridation does not lead to levels in excess of these limits based on reference dose (achieved by using average weight for an adult or child), but as water fluoridation delivers fluoride by level of concentration in water the individual dose of fluoride received by the individual is not controlled and depends on how much water you use for bathing, drinking, cooking etc and also on your weight. Also, water is not the only source of fluoride as we now use fluoridated toothpaste and other dental products, fluoride is also found in tea, processed food (from fluoridated countries), pesticides (residues of which remain on food) etc (SCHER 2010). A recent analysis of fluoride exposure in the UK National Diet and Nutrition Survey suggests that we should be concerned about increasing fluoride levels with over 15% of people consuming more than 5mg of fluoride a day (the figure that World Health Organisation (WHO) considers adverse health effects can occur in adults). For children the situation is more worrying. In the USA a study in Iowa found that 90% of three-month-olds consumed over their recommended upper limits Some babies ingest over six mg fluoride daily, above what the Environmental Protection Agency and the WHO say is safe to avoid crippling skeletal fluorosis (Levy et al 2001). Since the 1980's numerous studies have highlighted over consumption of fluoride and recommend using fluoride free water for reconstituting infant formula (Clarkson 2000, Bazalef et al 2001, Siew et al 2009)—advice also given by the American Pediatric Society and the American Dental Association.

12. Warren et al (2009) have highlighted the complexity of quantifying fluoride intake in areas where there is widespread water fluoridation and increased availability of fluoride containing products. They argue that “... it is doubtful that parents or clinicians could adequately track children's fluoride intake and compare it with the recommended level, rendering the concept of an “optimal” or target intake relatively moot.” (p114). Their conclusion supports Burk and Eklund's (2005) view that the term optimal fluoride intake be dropped from common usage and Ismail and Hasson (2008) also argue that “We believe that dentists should dismiss the misconception that there is a balance between dental caries and fluorosis, because patients can accrue the

benefits of topical fluorides without developing fluorosis and without systemic intake.” (1465). The inability to control individual dose renders the notion of an “optimum dose” obsolete.

13. In fluoridated areas over a third of children have dental fluorosis, with studies in Newcastle UK and Hong Kong identifying levels of 54%, and studies have shown that between 2 and 7% of children have mild to severe brown staining (Irish Forum on Fluoridation 2002, Levy et al 2006, Lo and Wong 2006, Tabari et al 2000). Most recently the US Department of Health and Human Services has proposed substantially reducing the maximum permissible level of fluoride from 1.2ppm to 0.7ppm as a direct response to research showing that 41% of 12–15 year-olds experience dental fluorosis (Associated Press 2011).

14. In their recent review of water fluoridation the EU Scientific Committee on Health and Environmental Risks highlight that young children are likely to exceed the upper tolerable limits for fluoride consumption in areas with water fluoridation greater than 0.8ppm and using fluoride toothpaste although the estimates of ingestion are probably underestimated as they are based on ingestion from food and beverages in non fluoridated areas (SCHER 2010).

15. It is suggested that long term ingestion of fluoride can lead to other more long term health problems but here the evidence is also unclear (McDonagh et al 2000, NRC 2006). The National Research Council (NRC) review was a wide ranging examination of over 1000 studies on the effects of fluoride in water. While the focus of the review was to examine the effects of water fluoridation at between 2 and 4ppm, it identified a number of studies demonstrating health effects at levels lower than 2ppm including effects to the central nervous system and brain at 1.8ppm, brittle bones at <1.2ppm, osteosarcoma in young boys at 1ppm, thyroid gland at 1ppm and hypersensitivity reactions of 1% at 0.25ppm (NRC 2006). The NRC review authors were particularly concerned about thyroid effects and there are strong clinical grounds that support this view. Osteosarcoma has also been highlighted by SCHER (2010) as an area where there is evidence of problems requiring further research.

SUMMARY

16. The evidence on the effectiveness and safety of water fluoridation is generally of poor quality and current monitoring (in the UK and other countries) has not been developed to adequately assess any health impacts. Most studies demonstrating effectiveness are methodologically flawed. Those that control most for confounding factors show little or no benefit. Water fluoridation has led to very high levels of dental fluorosis with potentially 3–7% of children suffering moderate to severe fluorosis than can lead to tooth damage. Dental fluorosis is not simply an aesthetic problem. Evidence on over ingestion in young children and babies is very strong and is giving increasing cause for concern in other countries where water is fluoridated.

PROPOSALS IN THE WHITE PAPER

17. The consultation document on commissioning for public health issued by the Department of Health in conjunction with the White Paper makes provision for local authorities to take responsibility for decisions about water fluoridation after HSAs are abolished. Such an approach with regard to water fluoridation is supported by the findings of the Nuffield Council (2007) report on public health ethics. In fact government ministers have consistently argued that it is important that an issue such as water fluoridation should be decided locally and that proper account needs to be taken of local people’s views—reflecting ministerial statements in the House between 2003 and 2005.

18. Giving responsibility to local authorities provides a more locally accountable solution than at present. However, if councils operate within the current regulations (as approved in 2005 and CDOs letter of 2008) they do not have to heed the outcome of any local consultation. There is also a question about what majority is required where more than one council is involved in a proposal. For example in the Southampton case there are 4 district councils, one county, one unitary and a town council involved—in this case all opposed to current proposals for implementation but with one calling for a referendum.

IMPLICATIONS FOR CURRENT DEVELOPMENTS

19. Currently the South Central Strategic Health Authority is pressing forward with plans to fluoridate in the face of widespread local public opposition and opposition from local councils and MPs. This stance is being supported by the Department of Health despite the fact that they have highlighted the crucial importance of local authorities and local people being able to take decisions about water fluoridation.

20. Implementation is being based on arguments and analyses made in 2008. This ignores changing proposals re public health, improved dental health figures in the city, recent concerns about appropriate and safe levels of fluoride and the objections of local people and councils. If the decision was made under the proposals for public health currently being suggested then no fluoridation would take place.

21. In Southampton this means that it will be the only scheme that has been imposed by a non-elected body without local support or consent. Given the paucity of good quality evidence on effectiveness and safety this is, as defined by the Nuffield Council report, as unethical. Indeed given that fluoride is added to prevent a disease (dental decay) the dosing of water without consent is unethical anyway.

BROADER IMPLICATIONS

22. Issues about consultation and decision making are crucial in relation to public health decision making. Currently while public health involves important decisions about individual lifestyles, legislation on water fluoridation gives the final say to unelected bodies and public health professionals. Such bodies and professionals have been happy to ignore relevant evidence in order to maintain their own policy position in the face of growing evidence and local political decisions. This places untenable and unaccountable power in the hands of professionals.

23. The addition of fluoride is done for prevention of disease and there are very clear and important issues of consent here. Fluorides in water are unregulated despite claims that they have a medicinal effect (ie prevention of dental caries). Current processes for implementation have no mechanisms for proving public or individual consent.

SUMMARY AND CONCLUSION

24. While the evidence of effectiveness and safety of water fluoridation is highly contestable the proposal to shift responsibility to local authorities is welcomed. Ideally the provisions in the 2003 Water Act and the 2005 regulations should be repealed and the Government's commitment to expand water fluoridation dropped on the basis that this is a policy that is not supported by good evidence and is likely to cause harm.

25. Recommendations to be considered by the committee:

- (a) Advise the government to halt all proposals for water implementation schemes currently under discussion until new arrangements are put in place for decision-making about such schemes.
- (b) Review the current legislative framework for consultation on schemes to ensure that consultations have real meaning. This involves repealing relevant sections of the 2003 Water Act and the ensuing 2005 regulations.
- (c) Review advice on consumption of water fluoridation to young children and babies to ensure that excess fluoride ingestion levels are not exceeded.
- (d) Review current policy that states that 1ppm is the optimum level of fluoride in water in the light of evidence on excess ingestion.
- (e) Consideration should be given to assessing the addition of fluoride to water as being done for medicinal purposes and the MHRA should be asked to assess and regulate fluoride additives to water in the same way that other preventive medicines are assessed.

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June 2011

Written evidence from Spearheads (PH 189)

A. AUTHOR

Submitted by Dr Ruth Wallis on behalf of the London NHS (former) Spearheads Health Inequalities Network (Network Chair).

The London Health Inequalities Group draws together Directors of public health and health inequalities leads from the 11 most deprived areas in London (Barking & Dagenham, City & Hackney, Greenwich, Hammersmith & Fulham, Haringey, Islington, Lambeth, Lewisham, Newham, Southwark and Tower Hamlet); formerly known as ‘Spearhead areas’ and aims to reduce health inequalities in London through effective public health practice.

B. WRITTEN EVIDENCE

1. *Creation of Public Health England within the Department of Health*
2. *Abolition of the Health Protection Agency and the National Treatment Agency for Substance Misuse*
3. *Public health role of the Secretary of State*

3.1 Need for sustained leadership to address inequalities in health and maintain investment in health improvement.

3.2 Need for oversight of impact of changes in financial climate and policy change on health.

3.3 Association of Public Health Observatories (APHO) key to developing a national picture, informed by local work.

4. *Future role of local government in public health (including arrangements for the appointment of Directors of Public Health; and the role of Health and Well-being Boards, Joint Strategic Needs Assessments and Joint Health and Well-being Strategies)*

4.1 Local Authorities have a major historical role in Public Health, most powerful when they enforced Public Health legislation and had resources to invest in housing and environmental improvement, and provided health and core services to those in need, in the absence of a universal service (pre NHS Care) They remain an important influence on the health of their residents, through advocacy, prioritisation (investment, service allocation), effective partnership, and service commissioning. The DPH within a local authority needs to have the highest possible influence across council directorates to influence health determinants (strategic development, safety, planning, public realm, housing, as well as children’s service and adult services). This means that the DPH needs to be a council director, accountable to the Chief Executive, or jointly across the local NHS Commissioning Board and the Council, to maintain influence.

4.1 Public health must become a core activity for the local authority rather than seen as a specialist “add-on”. For this to happen, local authorities need to influence NHS commissioning. This could be by giving the local DPH with local elected members the power to sign off or reject GP commissioners’ plans if they are not directed at improving health and well-being of the population (eg put financial balance as a higher priority to improving health outcomes rather than equal priority. It could be by establishing common goals and collaboration supported by Public Health across organisations.) Local authorities will need training and development to take on this role and a system of “delegation” needs to be agreed to ensure that Local authorities are supported to deliver on a full range of their responsibilities.

4.2 Public Health influence x NHS.

4.2 Much discussion of the DPH is written as if he/she works alone. No DPH will have much impact without a highly trained, well-functioning team working with them. Advocacy can be powerful but is unlikely to be influential in a challenging financial environment. Any moves to centralise PH resources into PH England need to ensure continuity of local knowledge and relationships.

4.3 Public Health will be a major new responsibility for the local authority, partly relative to the reduction in local authorities other responsibilities eg education, and also because of the substantial income likely to be attached to the broad definition of public health. Both the services commissioned and the mechanisms of commissioning differ between councils and the NHS, and there is a need to ensure that commissioning across NHS and local authority is coherent, although the mechanisms for doing this are unclear (partnership, holding to account etc).

The financial environment is likely to make protecting investment in health improvement challenging (not ring fenced). Much of the financial benefit from investment in health improvement will be in the NHS, and arrangements need to ensure that investment can continue even when benefits are achieved in other organisations.

4.4 An effective specialist public health function requires a critical mass, as with most clinical specialities. This means that individuals should not work in isolation, and that elements of public health practice should be part of a coherent function. In general, specialist services are less effective in generalist environments, and may move towards less expert tasks. The Acheson Report, Public health in England clearly set out the risks of a divided public function, and this still applies.

Information and understanding of local populations health needs is fundamental to public health; and is supported by clear definitions of boundaries, preferably consistent with local authorities. The inclusion of unregistered populations within local populations is welcomed.

The health and well-being board as currently constituted muddles two roles: i) a strategic role coordinating local efforts to improve health and well-being; and ii) maintaining financial balance with an operational coordination role which involves joint commissioning. The relationship with Clinical Commissioning needs to be clarified, and the accountability of the local authority for decisions.

4.5 Local health strategy should be informed by JSNA, which is dependant on both local information which can be shared (same boundaries/geographical definition), and public health intelligence. This will be critical in the development of JSNA, and enabling commissioners to address local issues, including inequalities.

5. *Arrangements for public health involvement in the commissioning of NHS services*

5.1 Approximately, 50% of reductions in mortality will arise from health service intervention and 50% from primary prevention and work on determinants of health. It is essential that Public Health continues to work with NHS commissioners to commission evidence based services and inform prioritisation. Public Health influence is critical to this.

5.2 At a local level, best use needs to be made of public health expertise to improve health and reduce health inequalities. This would encourage a collaborative approach across agencies, informed by local need (JSNA), to agree common priorities. Public health would provide consistent advice to organisations, based on population priorities.

6. *Arrangements for commissioning public health services*

6.1 There is a real danger that there will be multiple providers doing a bit of health promotion to various parts of people, eg one provider for smoking, another for physical activity, another for diet, etc. There need to be safe guards to ensure that public health services are coordinated locally and that commissioning is aimed at reducing and that health inequalities, as well as improving health.

Potentially the new arrangements will be more complex, and yet services provided will need to be simple to use, to join up and to be used by those whose needs aren't met by mainstream provision. The potential for local innovation involving communities (eg estate based) would need resourcing initially

6.2 Epidemiology is a core skill of public health and part of the core team. Expert additional work can be commissioned but local intelligence is essential to local priority setting, local surveillance and change management.

7. *Future of the Public Health Observatories*

7.1 The current system of leads for each PHO with local work supporting local Public Health departments works well and future arrangements need to support this model informed by local needs.

8. *Structure and purpose of the Public Health Outcomes Framework*

8.1 The NHS needs to retain responsibility for meeting Public Health outcomes—improving public health is central to its business. Public Health outcomes should matrix with NHS and social care outcomes.

8.2 Some process measures are required for PH actions that take 5–10 years to show financial dividends as well as health outcomes, eg stop smoking quit numbers.

9. *Arrangements for funding public health services (including the Health Premium)*

9.1 The Health Premium needs to be used to pump prime Total Place pilots that promote joint working to improve health outcomes and reduce health inequalities, including schemes that will take more than one year to deliver.

9.2 Funding of public health services needs to stay with the main NHS commissioning budget.

9.3 The recent exercises to identify the Public Health budget need to be repeated within the local authority to establish a baseline and prevent cost shifting if current local authority expenditure is transferred on to the Public Health budget.

9.4 Areas such as East London have historically had their population undercounted (ie the census), so impacts of changes in resource allocation formula need to bear this in mind.

There have already been reductions to the budgets available for public health, via transfer of resources to providers (health promotion), loss of health improvement staff (eg immunisation co-ordinators), management cost savings and taking on responsibility for other NHS functions within existing public health resources.

10. *Future of the public health workforce (including the regulation of public health professionals) Public Health is a specialist Profession with expert skills and knowledge.*

10.1 Maintaining an integrated training programme across the three domains of public health (i.e. health improvement, health protection and health services) is essential. The inclusion of one workforce which provides expertise to improving health needs to be more widely extended to make health improvement part of all Clinical practice, and in those providing services.

10.2 We need to retain a route for senior people to come into public health from different routes, whilst encouraging younger people to enter via the training schemes as the depth of knowledge and skills brought by people with different backgrounds strengthens public health.

12. *How the Government is responding to the Marmot Review on health inequalities*

The Marmot review sets out specific evidence based recommendations to reduce health inequalities. These focus on action at national level, across the range of local authority commissioned services, including schools and employment, the NHS and voluntary sector. The emphasise investment in prevention, making sure services reach those in need and the importance of coherent service provision.

It is fundamental to their effective implementation that the DPH has influence across local authorities business, and can enable services to provide a coherent care pathway across the NHS and local authority. Joint appointments would support this.

June 2011

Written evidence from Shamsher Diu (PH 190)

I am writing you as I am extremely concerned about the Government's proposals for public health. I feel that the Government has sidelined public health. This is demonstrated by the fact that none of the NHS Futures Forum workstreams included any reference to public health (there was only one representative from the entire profession). I believe that this was a serious omission.

PUBLIC HEALTH ENGLAND

I support the creation of Public Health England (PHE) if:

1. PHE is independent from the Department of Health. Having PHE in the DH is not liberating NHS from political control and it is unlikely to have the public's trust as it will be viewed as an arm of the Government. PHE needs to be out of day to day control of politicians.

2. PHE encompasses all the domains of public health:

- Health protection and resilience (infectious diseases, environmental hazards and emergency planning);
- Health improvement (lifestyles, inequalities and the wider social, economic and environmental influences on health); and
- Health services (service planning, developing clinical care pathways, commissioning, audit, investigating Serious Incidents, efficiency and evaluation).
- Public Health Intelligence (information and analysis)

This will prevent the fragmentation of PH functions and produce efficiencies through synergy.

3. PHE acts as the employing body for all public health specialists. This will ensure that a critical mass is achieved by pooling resources. The staff can then be seconded to other organisations e.g. Local Authorities, GP Consortia, Acute Trusts, Mental Health Trusts or Community Providers. This will prevent the fragmentation of the workforce and assist in the training of new PH specialists.

DIRECTOR OF PUBLIC HEALTH (DPH)

The role of the DPH is fundamental to the success of the implementation of PH locally. This individual needs to be qualified in PH and to be a registered specialist in PH. The DPH must be able to give independent professional advice across all three domains of public health and supported by a comprehensive public health team that needs to include health analysts. The DPH must be accountable directly to the Chief Executive of a Local Authority and be jointly appointed by Public Health England.

PUBLIC HEALTH (PH) STAFF

PH staff need to report to the Director of Public Health. However, the staff need to work closely with all the stakeholders. There should be a duty of cooperation placed upon all stakeholders, as the success of PH depends on joined up working.

TRAINING OF PUBLIC HEALTH SPECIALISTS

Training of new PH staff into a new public health system needs to be attractive to recruits and retain high quality staff. Medically qualified individuals are likely to be deterred from entering the profession if there is not a clear training pathway which has equivalency with the rest of the medical profession. Organising training is a complex task that will be complicated by the fragmentation of the profession.

STATUTORY REGULATION

This is the best mechanism for providing effective protection of the public. All specialist public health staff must be appropriately qualified and should be appointed through a statutory Advisory Appointments Committee.

ACCOUNTABILITY

The accountability for the functions and delivery of PH need to be more clearly defined. At the end of the day who is going to be held accountable?

In summary, I feel that the Government's proposals are an unnecessary disruption, with no clear advantages being outlined—but with plenty of disadvantages.

Unless the Government modifies its current proposals for PH, as indicated above, there will be a fragmentation of public health which will lead to an ineffective and inefficient PH service which in time will impact on the public's health. A co-ordinated, flexible public health service within the NHS e.g. special health authority will bring advantages of outlined above and indeed reduce costs too by reducing duplication and fragmentation.

I would be grateful if you took these comments into consideration in your deliberations on Public Health.

June 2011

Written evidence from the Training Programme Directors of the Faculty of Public Health (PH 191)

IMPLICATIONS OF THE CHANGES ON MEDICAL RECRUITMENT TO PH

INTRODUCTION

Public Health has always been the prerogative of many different professionals, and the Faculty of Public Health (FPH) formally recognised this and opened its doors to non-medical colleagues to be able to attain full membership through the training programme and examination route. Training in PH is multi-disciplinary, with people entering the programme from a variety of clinical and non-clinical backgrounds over the last ten years. Between 2003 and 2008, approximately 25–30% of the intake was from candidates with backgrounds other than medicine.

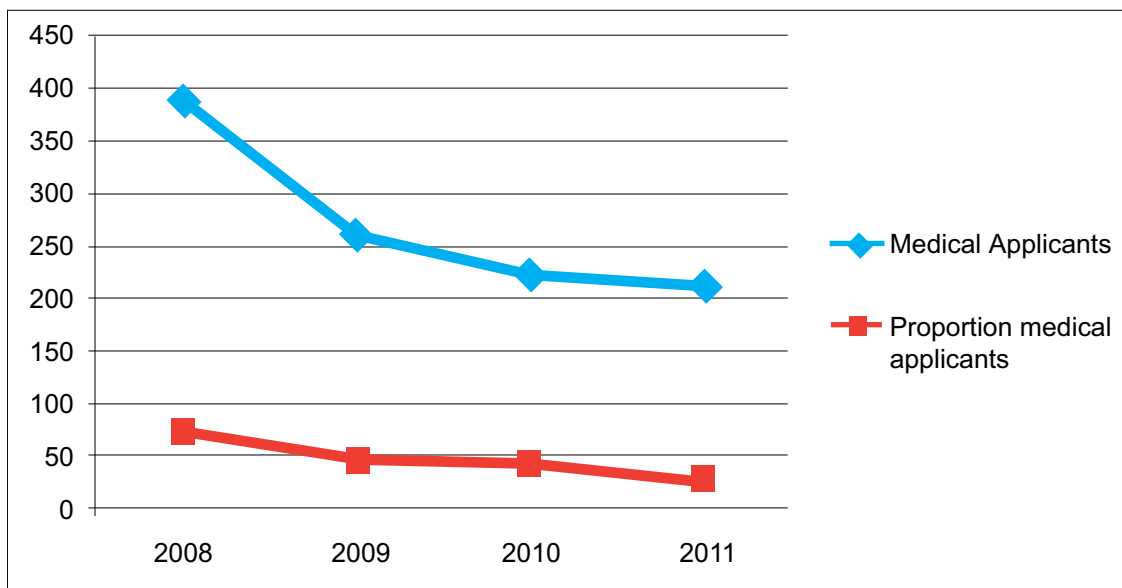
CURRENT SITUATION

Over the last five years, PH has moved towards a system of national recruitment. There is now a single recruitment process which covers England and Wales (and is likely to include Scotland and Northern Ireland soon) and which ranks candidates through a complex and well-validated process and then makes offers in that ranking order. As a result, we are appointing the best candidates to the speciality, regardless of background or geographical location.

This integrated process facilitates monitoring the data for applications and appointments. Figure 1 shows the number and proportion of applications to PH entering through the medical route. This has dropped from 67% to 29% over four years.

Figure 1

NUMBERS AND PROPORTIONS OF MEDICAL ENTRANTS TO PH



There has been a decline in the numbers of applicants to PH over the last four years, and the proportion of medical to non-medical applicants dropped again last year. For the first time, three Deaneries recruited only non-medical trainees in the cohort to start training in August 2011. What is clear is that, if this trend continues, there will be virtually no medical recruitment to PH within five years.

THE ISSUES

Recruitment into PH Medicine can occur at any stage, but Modernising Medical Careers put pressure on young doctors to choose their career path at the end of the second year of Foundation Training. This is much earlier than was the case in previous generations, when many doctors came to PH after time spent in another speciality, when they realised that they could achieve more at a population level than at an individual one.

Why might PH appear to be an unattractive career choice? There are long-standing issues around the profile of PH within the medical curriculum and in the Foundation Programme that are being addressed, but the present changes are also likely to have an impact. The possible reasons for this are:

1. Uncertainty

- (a) It is very unclear at present what the PH structures will be in the future. More damaging, it is very uncertain where they will be placed. The spectre of fragmentation remains, and young doctors may be unwilling to take the risk of there being no medical PH in the future.

- (b) There is a perception that Health Services PH is undervalued and unwanted. Despite some acknowledgment recently of the existence of health services PH, it is still not well understood at the centre and this is reflected in the constant use of the word 'advice' in relation to commissioning, rather than the integration of PH into the commissioning function. This branch of PH has always been medically dominated, and is often more attractive to medical graduates than the health improvement role.

2. *The NHS*

- (a) Trite as it may sound, most young doctors want their careers to be in the NHS. Contrary to the impression received by the Future's Forum, the concept of moving to the LA does not find favour with the majority of PH personnel.
- (b) Still less do they wish to leave the NHS before their training is complete, thus closing down many options. We have, so far, been unable to secure assurances that PH training will remain part of postgraduate medical education, and there is nothing about LAs in the workforce paper.
- (c) The perception that there might be a much-increased role for private medicine militates against PH.

3. *Loss of senior PH staff*

- (a) We are seeing increasing numbers of medical PH Consultants retraining in clinical medicine or leaving medicine altogether.
- (b) We are also seeing our most senior PH Medical consultants taking Voluntary Redundancy or early retirement. Most senior staff are medical, since non-medical colleagues are still climbing the ladder, so this is having a disproportionate effect on the relative numbers of medical and non-medical PH personnel.
- (c) This will also have an effect on our ability to train the next generation of PH professionals, and to provide population medicine training to other medical specialities.

4. *Terms and Conditions*

- (a) It would be naive to assume that Terms and Conditions do not play a part, although it is probably a small part of the decision-making process for young doctors.

IN CONCLUSION

Medical recruitment to PH has declined. The concern is that this trend is accelerating. If the current trend continues, and if nothing is done to encourage young doctors to believe that they have a future in the NHS in PH, we shall effectively eradicate medical recruitment over the next five years. It is also likely to discourage the best of our non-medical colleagues from entering PH, as they will no longer perceive it to be a genuine career path. This matters for a number of reasons:

- A clinical background, especially where an individual has completed some specialty training and practice, is one of a range of important backgrounds that add to a Public Health Specialists offer. Because doctors and other clinicians make such a powerful contribution to leadership and delivery of health care, it is essential to have a significant cohort of public health specialists who are from medical and other clinical backgrounds.
- The health protection function of PH requires doctors within its ranks; there are limited possibilities for non-medical PH personnel in health protection.
- The health services PH function, although not exclusively medical, benefits from having a considerable proportion of doctors. The understanding of the natural history of disease and the nature of clinical care will be needed by the Clinical Commissioning Groups.
- It will fundamentally change the relationship of PH to other Royal Colleges and specialities.
- The disproportionate number of doctors leaving the speciality, dictated by the age and seniority profile, means that the shift from a medical speciality to a non-medical one is happening extremely fast. Action to correct this needs to be taken as a matter of urgency.

Supplementary written evidence from UK Public Health Register (PH 87A)

I recently attended and was a speaker at a King's Fund conference on Public Health, at which Stephen Dorrell was present as a speaker/session chair. He shared with the audience some anecdotes about recent evidence received by the Committee in its Public Health Inquiry, in relation to the balance of medical and non-medical recruitment to training in the specialty of public health. He then invited those present to send further submissions to the Committee on this topic should we wish to do so.

I am writing in response to that invitation, as honorary registrar of the UK Public Health Register, to acknowledge that the evolving change in the balance between medical and non-medical public health specialists has been recognised by UKPHR, which, as the regulator for non-medically qualified specialists, is fully prepared for the increase in numbers requiring entry to its register.

There may have been some misinformation about the status of voluntary regulators and I would wish to confirm that UKPHR is a fully functional regulator, charging an annual registration fee of £250 to every specialist registrant, maintaining an up to date online register that may be interrogated by individuals and employers, and with a pool of independent, trained Fitness to Practise panellists to be called upon in the event of any question over a registrant's fitness to practise that might result in conditions on their registration, suspension or erasure from the register.

I do not propose to speculate in this letter on the reasons for the shift towards non-medically qualified public health specialists, although the NHS reforms and massive changes planned for the public health delivery system to take it outside the NHS may well be an important factor that particularly influences career choices among recently qualified doctors, the vast majority of whom are employed in the NHS. What this letter is intended to demonstrate is the existence of a robust, functioning regulatory body, UKPHR, which provides assurance for the public of the safety of the growing non-medically qualified public health specialist workforce.

Finally, I am enclosing UKPHR's most recent Report for the information of the Committee.⁵⁰¹

Dr Fiona Sim

July 2011

⁵⁰¹ UKPHR Report 2008–2010 (not printed here)