Written evidence submitted by Dr Rachel Joyce MB, BCh, BSc(Hons), MSc, FFPH (PHP0006)

This is a personal submission and does not reflect the opinion of any organisation I work. The points are general points and do not reflect any specific local service.

I am a public health doctor who is also trained as a GP. I have been a Consultant in Public Health, a Director of Public Health, a Medical Director, and a Medical Adviser.

My main concerns are:

1. The support to NHS commissioning that is provided by public health specialists, in particular what is known as 'Health Care Public Health' mostly delivered through the 'Core Offer' is not delivering in some areas as well as it could;
2. The lack of a career structure for public health in the NHS which will have effects in the medium and longer term as public health trained doctors retire.
3. The future viability of Public Health medicine as a medical specialty;

Public Health (PH) is defined as “The science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society”. Work is divided into three domains:

- **Health protection** – The public will know this as managing outbreaks of disease and pandemics, immunisation programmes, and the management of incidents such as bio-terrorism and chemical incidents that may affect human health. Most of this work is undertaken now in Public Health England (PHE), although there are still functions in the NHS and local authorities. Environmental health also delivers key PH functions in district authorities but are not part of the specialist PH workforce.

- **Health improvement** – The public will know this as the promotion of health and wellbeing and the prevention of disease – particularly by focussing on investigating and reducing risk factors such as obesity and teenage pregnancy rates. Much of this work is now undertaken in top tier local authorities (where the Directors of Public Health sit), and is best delivered in partnership with and by commissioning health services, and also working closely with other local authorities (particularly in terms of housing and sport/leisure), and the third sector.

- **Health care public health** – The public will understand this as the optimisation of health service provision to ensure the best clinical outcomes possible within the resources allocated by government. This involves the assessment of health care needs and the clinical effectiveness of different interventions, the development of evidence-based “pathways of care”, prioritisation of resources to focus on the most effective and value for money (cost-effective) care and evaluation of health services and new health technologies. They use medical knowledge (most fully trained PH doctors), health economics and statistical analyses, evaluation skills and critical review of the medical literature (this requires five years of additional training on top of normal medical training). [Screening sits somewhere between the second and third domain, and the National Screening Committee and local implementation of screening programmes are PH led].

1. The support to NHS commissioning that is provided by public health specialists, and the 'Core Offer' (ie the Health Care Public Health - third domain)

Many health care PH consultants have historically been employed in the Department of Health (many of the Chief Medical Officers have been PH doctors), Cancer Registries, Clinical Networks, the National Screening Committee, NICE, Medical Schools and Research Departments, PCTs, NHS England, PHE - and now top tier authorities. Most of the workforce - in top tier authority PH staff were previously employed in PCTs (Primary Care Trusts). A small number are employed by NHS Trusts and CCGs, but there is no recognised career structure for these staff.

**CCG support:**

I believe that the move to top tier local authorities has led to a much better coordination and planning for health improvement/prevention (the second domain listed), and the staff involved and the engagement of councillors in this process should be commended. I also believe the Health and Wellbeing Boards have been key vehicles for delivering a joint understanding of strategic needs and agreeing joint priorities, engaging key stakeholders in health and wellbeing.

However, in terms of the Health Care PH domain, the Department of Health guidance document "Healthcare Public Health Advice Service to Clinical Commissioning Groups" https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216835/Healthcare-Public-Health-Advice-Service-Guidance-FINAL.pdf states * for planning purposes we would suggest that something in the region of 40% of the local PH specialist team might be engaged in this work, with a rough coverage of 1 wte [health care] specialist per 270,000 or so people.*
I do not believe there are many areas that meet that level of provision of PH support to Clinical Commissioning Groups. Staffing does not match the Faculty’s recommended levels [http://www.fph.org.uk/staffing_guidelines](http://www.fph.org.uk/staffing_guidelines) overall and in many cases a switch of employer may have led to a switch in emphasis (eg away from health care PH to health improvement).

The guidance also describes recommendations for specialist health care PH expertise input into CCGs which I have reconstructed in the table here, with the last column describing in my view the effects of the move of PH out of most NHS commissioning organisations.

<table>
<thead>
<tr>
<th>Stages in the Commissioning Cycle</th>
<th>Specialist Healthcare PH</th>
<th>Examples of Outputs</th>
<th>Implementation</th>
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| **Strategic planning - Assessing Needs** | - Using and interpreting data to assess the population’s health, this may include – Supporting CCGs to make inputs to the Joint Strategic Needs Assessment and to use it in their commissioning plans.  
- Development and interpretation of neighbourhood/locality/practice health profiles, in collaboration with CCGs and local authorities  
- Providing specialist PH input to the development, analysis and interpretation of health related data sets including the determinants of health, monitoring of patterns of disease and mortality  
- Health needs assessments (HNA) for particular conditions/disease groups – including use of epidemiological skills to assess the range of interventions from primary/secondary prevention through to specialised clinical procedures. | JSNA and joint health and wellbeing strategy with clear links to CCG commissioning plans  
Neighbourhood/locality/practice health profiles, with commissioning recommendations  
Clinical commissioners supported to use health related datasets to inform commissioning  
HNA for condition/disease group with intervention /commissioning recommendations | JSNA and Health and wellbeing planning going well across most areas of the country.  
Mostly working well.  
This seems to have become more remote from the NHS and probably suffers from PH intelligence skills not being embedded in NHS organisations.  
There appears to have been a reduction in the use of detailed condition/disease/client group health needs assessments in NHS commissioning, probably as a result of PH skills not being embedded in CCGs. |
| **Reviewing Service Provision** | - Identifying vulnerable populations, marginalised groups and local health inequalities and advising on commissioning to meet their health needs. Geo-demographic profiling to identify association between need and utilisation and outcomes for defined target population groups, including the protected population characteristics covered by the Equality Duty | Vulnerable and target populations clearly identified; PH recommendations on commissioning to meet health needs and address inequalities. | - JSNAs work well to identify inequalities and at risk groups. Detailed further analysis particularly if commissioning is solely for NHS purposes is probably less available due to PH skills not being embedded in CCGs. |
| | -- Support to CCGs on interpreting and understanding data on clinical variation in both primary and secondary | | - Most needs assessments and PH intelligence analysis is only strategic nowadays with less resource available |
| Care | Includes PH support to discussions with primary and secondary care clinicians if requested  
|      | - PH support and advice to CCGs on appropriate service review methodology | to CCGs for detailed work. |
| Deciding Priorities | Applying health economics and a population perspective, including programme budgeting, to provide a legitimate context and technical evidence-base for the setting of priorities - Advising CCGs on prioritisation processes - governance and best practice. | Review of programme budget data Review of local spend / outcome profile Agreed CCG prioritisation process |
|      | As this was a key request in terms of support in most core offers, this work persists but anecdotally has less resource attached to it and new trainees in PH are less exposed to NHS systems and priorities meaning the skill set may become scarce. | As this was a key request in terms of support in most core offers, this work persists but anecdotally has less resource attached to it and new trainees in PH are less exposed to NHS systems and priorities meaning the skill set may become scarce. |
|      | - Work with CCGs to identify areas for disinvestment and enable the relative value of competing demands to be assessed  
|      | - Critically appraising the evidence to support development of clinical prioritisation policies for both populations and individuals  
|      | Horizon scanning: identifying likely impact of new NICE guidance, new drugs/technologies in development and other innovations within the local health economy and assist with prioritisation | Clear outputs from CCG prioritisation  
|      | Clinical prioritisation policies based on appraised evidence for both populations and individuals.  
|      | PH advice to clinical commissioners on likely impacts of new technologies and innovations | |
|      | As this was a key request in terms of support in most core offers, this work persists but anecdotally has less resource attached to it and new trainees in PH are less exposed to NHS systems and priorities meaning the skill set may become scarce. | |
| Procuring Services | Taking into account the particular characteristics of a specified population:  
|      | Providing PH specialist advice on the effectiveness of interventions, including clinical and cost-effectiveness (for both commissioning and decommissioning)  
|      | Providing PH specialist advice on appropriate service review methodology - Providing PH specialist advice on medicines management  
|      | Providing specialist input to the development of evidence based care pathways, service specifications and quality indicators to improve patient | PH Advice on focussing commissioning on effective/cost effective services  
|      | PH advice to medicines management eg ensuring appropriate prescribing policies  
|      | PH advice on development of care pathways/ specifications/ quality | Again these areas were identified as high need in most core offers, and so the work has persisted. However, the capacity to provide this specialist expertise has reduced and has become more remote. The skill set is set to become scarce as trainees are less exposed to clinical effectiveness and evidence based medicine within NHS systems.  
<p>|      | Much of this work has ceased, losing a key skill set from the NHS. This is because a PH skill set is not | |</p>
<table>
<thead>
<tr>
<th><strong>Outcomes</strong></th>
<th><strong>Indicators</strong></th>
<th><strong>Embedded in CCGs</strong></th>
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<tr>
<td>PH advice on modeling of the contribution that interventions make to defined outcomes for locally designed and populated care pathways and current and future health needs</td>
<td>PH advice on relevant aspects of modeling/capacity planning.</td>
<td>Much of this work has ceased, losing a key skill set from the NHS. This is because a PH skill set is not embedded in CCGs.</td>
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<td><strong>Monitoring and Evaluation - Supporting patient choice - Managing performance - Seeking public and patient views</strong></td>
<td><strong>Clear monitoring and evaluation framework for new intervention/service PH recommendations to improve quality, outcomes and best use of resources</strong></td>
<td>This persists in areas of joint work but is increasingly less evident in NHS only commissioning.</td>
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<td>PH advice on the design of monitoring and evaluation frameworks, and establishing and evaluating indicators and benchmarks to map service performance</td>
<td><strong>Working with clinicians and drawing on comparative clinical information to understand the relationship between patient needs, clinical performance and wider quality and financial outcomes</strong></td>
<td>Much of this work has ceased, losing a key skill set from the NHS. This is because a PH skill set (including a PH medicine skill set) is not embedded in CCGs.</td>
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<td><strong>Providing the necessary skills and knowledge, and population relevant health service intelligence to carry out Health Equity Audits and to advise on Health Impact Assessment and meeting the public sector equality duty</strong></td>
<td><strong>Health equity audits. PH advice on Health Impact Assessments and meeting the public sector equality duty.</strong></td>
<td>I believe this is mostly not now provided by PH staff, partly because PH is not embedded in most NHS organisations.</td>
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<tr>
<td>Interpreting service data outputs, including clinical outputs</td>
<td><strong>PH advice on use of service data outputs.</strong></td>
<td>This persists in areas of joint work but is increasingly less evident in NHS only commissioning.</td>
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It should be noted that the "Core offer" of PH support to NHS CCGs is agreed with local Memoranda of Understanding. The CCGs have no budget, and no SLAs. The advised 40% of consultant time, ie one consultant per 270,000 population to support the core offer functions is probably not being delivered in most settings due to resource constraints and different priorities of their new employers. The best way for CCGs to have more control over the core offer would be for them to hold the budget for this part of the PH function.

**Support to NHSE and CCGs from PHE**

I believe that the screening and immunisation and dental PH functions provided by PHE into NHS England are working well. This is because the teams were embedded from the beginning into the NHS England structures. The Health Protection Function provided by PHE is essentially a continuation of the Health Protection Agency and so is little changed in terms of substance. The central PHE team have also produced some very useful information analyses that are key documents to underpin robust commissioning plans.

I do however believe that the health care function within PHE is ill-defined and somewhat remote from the NHS. This function was not embedded into the NHSE structures in the way that the screening and immunisation and dental PH specialist staff were, and I believe this should be rectified.
Summary of point:

Due to the fact that PH is no longer embedded in the day to day operations of NHS commissioning, I believe that PH expertise, in particular health care PH, has become more remote and mostly strategic. The day to day operational use of PH skills within the NHS commissioning cycle have in my opinion suffered as a result. The flip side of this is the fact that health improvement functions have probably improved overall. However, the loss of some of the value for money, evaluative and evidence-based skills that the health care PH doctors and specialists have will be a loss in terms of high quality commissioning for a population.

2. The lack of a career structure for public health in the NHS which will have effects in the medium and longer term as public health trained doctors retire

There is no career structure now in the NHS for PH doctors and specialists. There are however many PH doctors working in leadership positions in the NHS and in private sector organisations. Some of these are key NHS leaders at a high level in the NHS and in organisations like NICE. Those that are doubly trained in both medicine and PH have a unique skill set that is particularly useful in NHS leadership and planning.

As the training and career progression that previously produced this doubly trained set of clinical and medical leaders has largely disappeared, there is a significant risk that when this cohort of individuals leave or retire, it will leave a significant gap that will not be easily filled. I would urge the DOH to recognise this risk and to address this by facilitating the development of PH career pathways within the NHS. This would also help to address the issue raised in point 1. about a shortage of PH skills embedded in the operational, day to day running of NHS commissioning.

3. The future of Public Health Medicine as a medical specialty

As highlighted above, those who are doubly trained in medicine and PH have a unique skill set that is particularly useful in the planning and commissioning of NHS services (health care PH). Without a continued recruitment of doctors into PH training posts and training and work within NHS settings this will become a scarce resource. The proportion of public health trainees who are doctors is at an all time low.

The change of employer for PCT PH doctors from the NHS to local authorities has meant a change in the focus of much of their work. A larger focus on health improvement and less on health care PH as a consequence of a new employer may mean that there is less need in local authorities for medically trained PH specialists. Job satisfaction has also reduced. A recent survey http://bma.org.uk/news-views-analysis/news/2014/march/disheartened-public-health-doctors-tempted-to-leave showed that over 63% of medical PH staff have strongly considered leaving the profession - a much higher figure than non-medical staff. Moreover, those working for local authorities were much more dissatisfied than those working for the NHS http://careers.bmj.com/careers/advice/Half_of_public_health_consultants_in_local_authorities_want_to_leave_their_jobs,_survey_finds, with bureaucracy and the overall direction of their organisation being key issues highlighted.

Summary of points 2 and 3

Unless there are urgent steps to ensure that there are sufficient medically trained PH staff with training and work opportunities in NHS settings, embedded in the day to day operational delivery of NHS commissioning, planning and services, this unique and powerful skill set will disappear, as will many of the NHS leaders of the future. Structural change in terms of both training and job opportunities are needed.

In summary, there have been some positive changes in the move of PH staff to local authorities. However, there has been a significant negative impact in my opinion on the function of health care PH, particularly in the operational parts of clinical commissioning. The lack of a career structure for PH within the NHS means that both health care PH and the specialty of PH medicine (ie duelled trained in medicine and PH) may disappear. This would be harmful to robust health service planning and the development of the medical leaders of the future.

I would suggest the following as constructive ways forward:

- PH training should include placements in NHS commissioning and provider organisations;
- Efforts need to be continued to encourage doctors into PH and to retain their skills, particularly in NHS settings;
- There needs to be a post qualification (ie consultant and above) career structure in the NHS developed;
- The 'Core offer' budget should be identified and given to CCGs. This would allow CCGs to have a greater say on how PH supports its commissioning function, and where local arrangements cannot be made to work, would allow the CCG to procure this support from elsewhere, or embed it directly in its own workforce.

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