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Executive Summary

1. This submission has been written by a group of Public Health Specialty Registrars, has 100 signatories and covers four main themes:
   a. The Future Health of the Nation
   b. The Illusion of the Ringfence,
   c. Presenting Advice without Fear or Favour and
   d. The Loss of the Evidence Base

2. We have included several recommendations within these themes to address the issues highlighted, which include:
   a. Public Health is included within the NHS ring-fence.
   b. Public Health England is given powers to hold local authorities to account for the delivery of public health activity.
   c. Public Health voices need to advocate without fear or favour.
   d. All local and national Public Health policy decisions should be supported by a robust assessment of the available evidence.

Introduction

3. We are a group of Specialty Registrars who are in training to be Public Health Consultants and therefore represent the future Directors of Public Health (DsPH) and Public Health England (PHE) workforce. We are employed by NHS Trusts during our training and work in many different organisations. We come from very diverse backgrounds, some of us are doctors, others have expertise in various areas of public sector work, such as local government, or have previously worked in the third sector or healthcare. We are uniquely positioned to comment on this inquiry, having gained an overview of the challenges and issues facing public health through our training placement rotations in local authorities, CCGs, NHSE and PHE. This submission represents the views of the individuals undersigned.

4. Public health is pivotal to the future sustainability of the NHS and is vital in protecting and improving the health and wellbeing of the population. Good health and wellbeing are the bedrock upon which the economic viability and prosperity of a country is built. Consideration of them must underpin all Governmental policy. We welcome this opportunity to make a submission and commend the Health Select Committee in this choice of inquiry. We hope that the findings will be used to shape the future direction of Government policy for public health.

5. Prior to the Health & Social Care Act (HSCA) 2012, public health professionals were involved in planning and commissioning healthcare services based on population need and, whilst they worked in partnership with Local Authorities, they remained autonomous and were free to openly challenge policy where it ran counter to population health.
6. Re-organisation introduced by the HSCA has fragmented the public health system and distanced it from the NHS at a time when a public health approach, guided by need and grounded in evidence, should be at the forefront of ensuring a cost effective, economically viable approach to the future of healthcare in its widest sense.

7. These are our personal views based on our experiences.

The Future Health of the Nation is in Crisis

8. As the World Health Organisation (WHO) affirms, health is not merely the absence of disease or infirmity but encompasses physical, mental and social wellbeing. Health therefore comprises not only the NHS providing healthcare downstream, but a public health system, which works upstream to promote and protect health for all, intertwining with the NHS to deliver high quality services as well as influencing the wider determinants of peoples’ lives to reduce health inequalities and improve overall wellbeing.

9. The NHS is under pressure as never before through a combination of increasing demand, chronic underfunding and workforce crises of retention, recruitment and morale. One sign of this pressure is that a number of Trusts, which were previous beacons of clinical excellence have been placed into special measures. The need for a robust public health system to minimise the load on healthcare services is critical.

10. And yet, deeply worryingly, public health is also under stress. The public health system is fragmented and as organisational memory is lost through staff turnover, gaps in the system seem to be widening posing risks to continuity of the service, particularly in areas such as health protection and healthcare public health. Communication between national and local initiatives is often poor and the drivers for priority-setting and decision-making appear less transparent, less systematic and no longer based primarily on need.

11. The impact of the current climate on the public health workforce is significant. Deep cuts to local authority budgets resulting in the inevitable staffing losses, changes to terms and conditions and, in some places, a devaluing of the role of public health professionals, risks a further exodus of skilled, experienced staff from our discipline. Where public health should be leading the commissioning of healthcare, failure to recognise these in-house skills is leading to outsourcing of this work to private organisations, placing further costs on the public purse. As the public health consultants of the future, we represent a public resource and investment whose breadth of skill development is hindered by the fragmentation of the public health system and whose prospects of delivering on that investment in sustainable public health leadership posts looks uncertain at best.

12. The Five Year Forward View enshrined the need for a ‘radical upgrade in prevention and public health’ and stated that the ‘future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain’ all now depend on this. However there appears to be a paradox between rhetoric and reality. Despite a commitment to embed prevention from the Department of Health, the reality is public health budgets have already been and continue to be substantially cut. (£200m in-year cuts in 2015-16 and 3.9% cuts
annually thereafter). This is ultimately a cut to the NHS in all but name and threatens its very survival.

13. Recommendations:

- Public Health organisations must address all major domains of public health, including healthcare public health, when setting priorities and these should directly address the most pressing, well-recognised concerns for the health of the public
- Public Health training should remain in the NHS but with the public health system realigned to the NHS to prevent the loss of key skills and reduce fragmentation
- Public Health voices need to advocate loudly, independently, without fear or favour and hold Government to account on their commitment to health

The Illusion of the Ringfence

14. When Health Secretary Andrew Lansley originally set out his rationale for transferring public health functions to local government, one of his key reasons was to ‘prevent the public health budget from being continually raided for clinical purposes’. Since 2012, public health has seen more significant ‘raids’ on its budgets than ever happened in the NHS.

15. Since the 2012 HSCA, Local Authority public health budgets have, in theory, been 'ring-fenced'. The term 'ring-fence' creates an illusion of a dedicated budget within local government that can only be used for activities to directly improve the health and wellbeing of the population and to reduce health inequalities.

16. The reality is very different. A key issue with the ring-fence is the lack of a clear definition of 'public health activity'. Aside from 5 mandated activities, it is up to local authorities how they spend their public health budgets. Some councils have sought to prioritise existing work areas above new public health responsibilities. Some public health teams have been told to identify internal savings to be moved from public health budgets to prop up pre-existing council services, often at the expense of clinical services such as sexual health. This process has seen the funds dedicated to public health activity reduce year on year in many councils, despite the ring-fence. The lack of a definition for public health activity has enabled councils to badge pre-existing activity as public health. Examples include libraries, leisure centres, fixing pot holes, parks maintenance etc.

17. Although the public health grant paid to local government has stayed the same since 2012 (with the notable exception of the £200m in-year cut in 2015), public health will continue to see its budgets squeezed, both by direct cuts to the local government grant (public health is no longer part of the NHS, and not protected by the NHS ring-fence) and by internal pressures on council budgets which require DsPH to 'give up' public health grant internally to support wider council services, some of which could be legitimate, much of which is not. Public health services are at the epicentre of this perfect storm of financial pressure and are likely to pay a heavy cost. Although DsPH, in theory, can refuse to sign off a budget that is not appropriate, in reality this is highly unlikely when their job is dependent on signing it.
18. Influencing wider spend is an argument for removing the ring-fence. There is a wide spectrum of local authorities out there, and whilst some may embrace the opportunities to use public health skills to achieve best value across a range of services, in many cases public health is likely to shrink and risks becoming something that is delivered in name only. Given the long term nature of many of the Public Health Outcomes Framework (PHOF) outcomes and the lack of ‘teeth’ within PHE to hold local authorities to account, by the time the consequences of this action appear in the outcomes it will be too late. The public are likely to pay the price of both poorer health outcomes and the rising costs of downstream healthcare.

19. The recent reference to public health in the Spending Review, 2015 fails to appreciate the broad, cross cutting nature and value of public health:

‘This Spending Review finishes the job of reforming the public health system, delivering average annual real-terms savings of 3.9% over the next 5 years. Across the country, councils have already begun to develop new ways to deliver public health, showing that it is possible to deliver better health for local people and also better value for the taxpayer, but there is more to be done. Councils can seek to deliver efficiencies in this area’

20. Public health is not simply a set of services which ‘deliver public health’ and can therefore be done ‘more efficiently’. Public health encompasses expertise and skills in epidemiology, health economics, social return on investment and much more. Local Authority public health should be enabled to deliver increased efficiencies across the whole of Local Authority organisations as well as the NHS rather than being seen as a limited set of activities which can be delivered more cheaply. It would be helpful to view public health advice as akin to legal advice, a set of professional skills which can be utilised widely and expertly as a resource across public services.

21. Recommendations:

- **Public Health is included within the NHS ring-fence to prevent further reductions in an already limited budget**
- **The Public Health mandate is strengthened and a clearer, unambiguous definition of ‘public health activity’ is agreed**
- **Public Health England is given powers to hold local authorities to account for the delivery of public health activity**

Presenting Advice without Fear or Favour

22. The majority of public health professionals are now employed by organisations with a political agenda. This risks political control of professional opinion, not the influence of political opinion by professional expertise.

23. Embedding the Director of Public Health and public health teams within Local Government presents a theoretical opportunity to place public health at the centre of all policies and influence the wider determinants of health government wide. However, translating this theory into reality is dependent on Local Government valuing public health expertise. This
does not appear to have happened universally, reflected in the often downgraded seniority and position of DsPH, Public Health Consultants and other public health professionals, whom have seen their expertise undermined and undervalued.

24. Where a DPH is not placed in a senior executive position, their ability to influence and deliver on their public health mandate is threatened. When public health is neither valued nor enabled to provide meaningful strong leadership, free of vested political interest, public health can be impotent.

25. Whilst there can be benefit in influencing from the inside this can be particularly difficult in politically sensitive situations. There is considerable risk that politically unpopular decisions, which are necessary to address high need and high inequality, for example migrant health services, are not made and left unchallenged. Moving public health professionals under Local Government control can actually reduce their advocacy power and brings their impartiality and ability to champion public health into question.

26. The placement of PHE as an executive agency of Government threatens the autonomy of its priorities, its rhetoric and its release of information. The initial focus on fracking, the championing of health checks and recent disinclination to publish evidence on sugar clearly show a discord between pressing public health issues and paramountcy of action. The supposition is that public health expertise and opinion is coloured by the political priorities of Government and utilised to further political agendas, not driven by public health need.

27. PHE as an executive governmental department, rather than as part of the NHS, carries significant risk to the credibility of PHE advice and constrains its ability to engage in public sphere advocacy or challenge to Government either within health or cross departmentally. We have heard little from PHE spokespeople in the media, the voice for the public’s health seems in effect silenced and advocacy becomes the preserve of celebrities. There is noticeable scepticism of the impartiality of PHE, which damages the public profile and professional reputation of public health.

28. Recommendations:
   - Reinstate the cross party Cabinet Subcommittee on Public Health.
   - The ‘general function of NHS England is to promote a comprehensive health service so as to improve the health outcomes for people in England’. PHE should become an NHS organisation to restore its political autonomy and credibility.
   - Local Public Health teams should be employed by the NHS where their expertise is needed but also seconded and embedded within local authorities.

The Loss of the Evidence Base

29. The backbone of the public health specialist workforce is the ability to assess evidence, provide appropriate recommendations based on that evidence, and evaluate the effectiveness of any implemented recommendations. Providing such a robust assessment and evaluation of the evidence helps to ensure that high quality, effective services which
offer the best value for money can be offered both locally and nationally. This rigorous way of working also ensures that public health services can be directed at those with the greatest need and with the greatest capacity to benefit and hence have maximal impact on public health – and a healthy population in turn impacts economic prosperity.

30. Despite the obvious and clear need for continuing with robust evidence reviews, since the changes brought about by the HSCA, there are many examples when the evidence has not been effectively used or reviewed, often due to political decision making. Local sexual health services are among some of the key public health services which are likely to be affected by the £200m public health cuts. In some cases, this has already resulted in closing of outreach services, which often serve the most deprived people in our communities – this will ultimately widen already existing health inequalities. Furthermore, this cut is on the background of a national increase in rates of sexually transmitted infections and local outbreaks and is likely to negate recent improvements in teenage pregnancy rates.

31. The evidence clearly states the importance of focusing our efforts on prevention, as laid out in the NHS Five Year Forward View; such cuts are discordant with this aim and instead has simply resulted in ‘firefighting’ at the acute end of the spectrum – an expensive and ineffective public health approach and one which makes little economic sense.

32. The skills of the specialist public health workforce are being devalued, risking the loss of the real strength of this specialty. In addition, emerging evidence not associated with government priorities often disappears, meaning the translation of knowledge into practice is being lost, a further risk for the future health of the public.

33. There is a real opportunity to be built upon now that public health has developed stronger links with local authorities since being embedded within them. Given the cuts to local authority budgets, the skills of the specialist public health workforce, particularly around utilising the evidence base, should be capitalised on in order to ensure that budgets are being used in the most cost-effective way. In addition, these highly transferable skills should be utilised within NHS commissioning functions by bringing the specialty public health workforce back into the NHS.

34. Recommendations:
   • All local and national Public Health policy decisions should be supported by a robust assessment of the available evidence, which should be published in a timely and transparent manner.
   • In order to prevent the skills of specialist Public Health workforce becoming devalued and subsequently disappearing entirely, there needs to be a greater emphasis on implementing evidence-based public health services/initiatives and incorporating a robust evaluation process, regardless of government agendas.

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