Thank you for the opportunity to respond to this call for evidence. This evidence for the Health Select Committee has been submitted by Jonathan McShane, Chair of the Public Health System Group (PHSG), after discussion with the members of the PHSG.

The Public Health System Group

The PHSG provides a single forum for public health system leaders and partners in England to discuss priority strategic questions and issues in protecting and improving the public’s health. The objective of the group is to support the system to have greater impact on public health outcomes by improving cohesion and strategic working between system leaders.

While recognising that the organisations that Group members represent are developing individual responses to the Health Select Committee inquiry, the Group felt it was important for the Chair to submit an evidence package which set out the issues on which the system leaders represented on the Group (excluding those employed by statutory bodies who are required to remain impartial) have reached a consensus.

Chair’s summary

The move of public health from the NHS to local authorities was the right decision and the transition went well despite the concerns expressed in advance. The existence of the PHSG supported this by ensuring that all parts of the system engaged and tackled the key issues jointly.

Local authorities have enthusiastically embraced their new responsibilities to protect and promote the public’s health in their areas. Alongside the other new bodies in the system (including Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards), they are already making real progress in joining up public services with a view to delivering the maximum health gain for their local population. While some issues remain (including around data sharing and restrictions on the ability of the workforce to move around the system effectively), with the focus of prevention in the Five Year Forward View and Government commitment to a childhood obesity strategy, there is reason to be optimistic for the future so long as the Government creates a positive climate and supports the system to work more effectively.

We continue to believe that there is a very strong economic and health case for more investment in prevention. However, we also believe that there are a range of interventions that could support our shared ambitions for public health that require minimal financial investment. We need action to ensure that an appropriate legislative and regulatory framework is put in place to improve the health of the population by changing the behaviours of individuals (such as measures to reduce sugar and alcohol consumption), tackling broader determinants of health (such as interventions to reduce worklessness and improve poor housing conditions), and giving local authorities the powers they need to take action locally to promote health (such as wider planning and licensing powers). In addition, central government
needs to join up initiatives and avoid situations where there are multiple funding streams for local government to navigate (e.g. around a dozen in relation to physical inactivity), resulting in the duplication of effort and reducing the impact on outcomes.

Looking ahead, I believe that the System Group has much to offer both in its influence over emerging policy and its ability to address whole system issues.

**Opportunities of local authorities having a population health focus**

Moving public health into local authorities was the right move. The transition of public health to Local Authorities was motivated by the recognition that they have both a greater understanding of the needs and issues faced by their communities and stronger links with those communities than the NHS has been able to develop. This means local authorities are therefore better placed to plan and implement public health services and make a major contribution to improving the health of their local population.

Research suggests that the provision of healthcare represents only a very small percentage of what contributes to length of life and years of healthy life. There is evidence that public health investments which tackle both health and the wider determinants of health deliver improved health outcomes as well as having wider benefits including reducing crime, lowering sickness absence, and impacting on welfare demands.

Local authorities are ideally placed to respond creatively to their new duties as public health authorities alongside their wider responsibilities including those for economic development, transport, and social care. They can consider how to use the whole of their resources, not just the Public Health Grant, to improve the health of local people and communities.

The scale of the public health challenge means no one part of the system can make sustained progress on its own. Local authorities have significant experience of developing effective local partnerships and are now pulling together interests from across the public, private and third sector to focus on delivering real improvements in health. Health and Wellbeing Boards are becoming a key forum where local partners can agree how to harness the sum of local resources to address key health challenges.

For example, health checks commissioned by the local authority might result in individuals being offered advice and support from health trainers provided by the third sector or to medical intervention by primary care providers.

Community pharmacies can also link public health services to clinical services. For example an overweight patient undergoing a medicines use review (MUR) for hypertension can be referred to a weight management service. This referral is more effective if the community pharmacy provides an NHS weight management service commissioned by the local authority. Conversely a patient with hypertension attending a pharmacy based weight management service may mention that they don’t always take their medication. This patient could then have an MUR with the
pharmacist where the reasons for non compliance could be explored and solutions discussed, if necessary the patient could be referred back to the GP.

Health and Wellbeing Boards bringing together all the relevant interests and focusing on the needs of the local population can help to drive this process.

The transition from the NHS to local authorities

The transition saw the transfer of some 4,000 members of staff from the NHS to local authorities and the establishment of Public Health England from tens of predecessor bodies. Despite initial concerns, this was handled well and was completed without major disruption to the delivery of services.

In research undertaken with public health teams by RSPH in 2015\(^1\), around 40% of respondents said the move from the NHS to local government had helped to reduce inequalities and improve the public’s health. 43% were unsure about whether the move had had a positive impact on the public’s health, although very few disagreed with the premise that health outcomes were being improved for the public (17%). The results show an improvement on the previous year’s research when more than half (52%) of respondents were unconvinced that the move would help reduce inequalities and improve the public’s health in the future, and only 15% believed that the transition was improving health outcomes. The results of this snapshot survey would suggest that internally public health teams have an increased confidence that the transition to local government has had a beneficial impact on improving public health outcomes.

Public health teams already have a well-established relationship with the relevant CCG(s) and have therefore had little difficulty in reaching agreement on how public health support would be given to the NHS.

Consistent with the Department-Director of Public Health’s role as principal adviser on health matters, public health teams are sometimes seen as having a key role brokering discussions between councils and the local NHS. The ‘core offer’ to the NHS was seen as providing an opportunity to influence Clinical Commissioning Groups’ (CCGs’) commissioning towards greater prevention and addressing health inequalities.

The relationships between CCGs and councils is critical to ensuring an integrated approach to population health care and prevention. Councils recognise that they need to build on the significant progress which has been made in building these relationships through Health and Wellbeing boards in order to further develop place based approaches to prevention.

However, some issues remain and need to be addressed:

- Access to data – the move to local authorities left many staff who had previously had access to key NHS data, unable to access this. This needs to

---
\(^1\) In Good Health, RSPH (Feb 2015)
be addressed urgently to ensure that decisions are taken on the best available evidence.

- Workforce mobility across organisations - regulatory barriers that make it difficult for people to contemplate moving from one sector to another need to be removed. The main barrier concerns continuity of service which at the moment cannot be offered for all aspects of employment when people move between the NHS and local government; this must be addressed so that employers know that they are choosing between the best candidates and individuals do not feel constrained in their job choices.

- Fragmentation of the immunisation and vaccinations and screening services – Directors of Public Health are often not able to access the data that they need to have an overview of the position locally despite this being part of their population role.

- In areas where commissioning sits with a number of bodies, local areas need support and advice to ensure services deliver the best outcomes. The *Making it Work* guidance for sexual health, reproductive health and HIV is an excellent example of effective support.

These are some of the issues that the PHSG will be looking to work together on over the coming months.

**Delivering a whole systems approach**

The focus on prevention in the NHS *Five Year Forward View* is welcome but real improvements in health outcomes will also demand a sustained focus on the sort of upstream interventions that public health in local authorities is best placed to deliver. Local authority public health teams therefore have a critical role both in leading and supporting work on the wider determinants of health and in advising and influencing work on population health and services (mostly undertaken by NHS and primary care).

Integration between health and social care and, in time, with wider economic and social initiatives is a welcome goal. Local Authorities are responsible for social care and with an increased focus on integrated health and social care, public health can therefore provide an important bridge between NHS and social care. Public health also bridges the wider socio-economic factors that influence public health. It can therefore be an important link to ensure that all parts of the system focus on the health of the population. Community pharmacy provides both health and social care, for example, supporting a patient recently discharged from hospital by providing the necessary support to enable them to take their medicines as intended in addition to supplying the medicines.

Local authorities have responded to their new public health duties with a great deal of creativity and a whole system approach in mind. There are examples of a wide range of innovative approaches to improve the health of their local communities including investing in economic development, job creation, environmental health, emergency planning, healthy schools, active travel, safer communities and enabling older people to stay independent for longer.
The emerging work in Greater Manchester is an excellent example of trying to ensure a whole system view of health underpins a whole range of local strategies.

There are huge opportunities for delivering improvements in the health of local populations by encouraging and supporting the contribution that can be made by both health staff and the wider workforce. RSPH and the Centre for Workforce Intelligence mapped the “wider public health workforce” in 2015\(^2\). The wider public health workforce was defined as:

> “any individual who is not a specialist or practitioner in public health, but has the opportunity or ability to positively impact health and wellbeing through their paid or unpaid work.”

This estimated that there are approximately 15 million people in paid employment that have the ability to impact on health and wellbeing through their work. These people span 57 occupational groups and within these groups there are 185 working occupations.

For example, the Healthy Living Pharmacy framework supports the whole pharmacy team to be more involved in the prevention of ill-health of their customers. The framework also provides the pharmacy teams with an additional accredited qualification in promoting healthy living. Across England, the fire service’s work with vulnerable groups has demonstrated the potential of the wider, non-health focused, workforce to make a real difference. Research\(^3\) suggests that 84% of residents in social housing would confidently speak to their housing officer about their own health and wellbeing.

A really effective whole system approach needs to make much more effective use of the wider workforce.

**Looking ahead**

This inquiry comes just over two years since transition and it is therefore too early to arrive at firm conclusions about what is working, what is not and why. However, a number of councils have found that some improvements have already been achieved, and that these were accelerating in some important areas such as smoking prevalence, obesity and alcohol harm reduction.

Investing in prevention is an economic imperative as it is cost-effective and will reduce short and long-term demands on health and social care services and increase economic productivity.\(^4\) We should be reducing demand for health and care services through prevention which is a much better investment in the future especially given the forecasts which show the potentially catastrophic consequences and unsustainability of continuing poor diets, physical inactivity, smoking and harmful drinking.

---

\(^2\) Understanding the wider public health workforce, CFWI/RSPH (July 2015)

\(^3\) SITRA/PHE (2014)

Increased investment in primary prevention will support a healthier, more productive workforce across the country. Doing so will move the UK to a productive, higher wage, lower welfare, lower tax economy. With prevention there are consequent savings to the Government in terms of reduced disability benefits for the older workforce, better returns on training and investment for business by maintaining the experience of the older workforce. As our population ages, a healthy later middle age is important for productivity, and reducing the social security budget.

Revenue raising proposals would include a package of measures which could raise revenue of upwards of £2bn annually and provide additional funds for prevention. These would include:

- Implementing the proposed levy on tobacco manufacturers **estimated to raise an additional £500M.** Raising additional funds that could support interventions such as services to help people stop smoking.
- Re-instating the duty escalator for alcohol, **estimated to raise £1.2bn over four years.** As the OECD reported, harmful alcohol consumption places significant costs on society. Alcohol taxation in the UK is relatively high compared to other countries but the costs to society far outstrip the revenues raised. Reininstating the duty escalator would not only recoup an estimated £1.2 billion over the next four years, it would help to counter the health risks generated by low alcohol prices.
- Introduction of taxes on sugar-sweetened soft drinks, confectionary and snacks **estimated to raise an additional £1bn.** The evidence linking sugary food and drink with overweight and obesity as well as dental decay is accumulating and examples of governments introducing taxes on sugar-sweetened soft drinks, confectionary and snacks are growing in number and providing useful indications of the effect of such taxes. The Government should consider these types of policies for both reducing the consumption of sugar across the population and raising needed revenue to support prevention and care services.

We firmly believe that there is a very strong case for more investment in prevention, not less. There are also a range of national and local interventions that could support our shared ambitions for public health. We need action to ensure that an appropriate legislative and regulatory framework is put in place to improve the health of the population by changing the behaviours of individuals (such as measures to reduce sugar, processed foods and alcohol consumption) and tackling broader determinants of health (such as interventions to reduce worklessness and improve poor housing conditions).

---

5 Action on Smoking and Health/Landman Economics, February 2015
8 The Alcohol Health Alliance reports that costs to society from alcohol harm exceed £21 billion, which is more than double the tax receipts from alcohol duties (£10 billion).
Local communities could benefit from greater local powers in terms of planning and licensing in order to prevent the proliferation and clustering of businesses which may have a negative impact on the public's health.

Finally, increased information and evidence is key for all areas. There is no comprehensive surveillance system for non-communicable diseases in England but without information we will not be able to tackle prevention and promote wellbeing effectively.

14 December 2015