Written evidence submitted by UK Faculty of Public Health (PHP0066)

Headline recommendations

I. Public health funding: The 20% cut to public health funding¹,² must be reversed;

II. Ring-fenced grant: The ring-fence must be maintained beyond 2017/18;

III. Public health leadership: Directors of Public Health (DsPH) must be appropriately positioned at board level in the local authority, in accordance with primary and secondary legislation, in order to discharge their responsibilities effectively;

IV. Independent voice: Public health specialists in PHE and local authorities must be assured an independent voice to advocate evidence based interventions;

V. PH Workforce: Parity of esteem between all members of the specialist public health workforce will be crucial;

VI. Statutory regulation: Statutory regulation of public health specialists from backgrounds other than medicine and dentistry merits urgent implementation;

VII. NHS commissioning: Public health expertise must be embedded by legislation within CCGs and NHS England, including at Board level;

VIII. Healthcare public health: The specialist workforce dedicated to working with CCGs and the wider NHS on health care public health must be strengthened;

IX. Competition: Regulation to safeguard patient care and population health;

X. Access to data & intelligence: Data access for public health analysts within councils and researchers must be strengthened;

XI. Health protection & emergency preparedness: The system for emergency preparedness must properly delineate responsibilities, and funding must be assured;

XII. Upstream interventions: Rapid action on the 12 priorities of FPH’s manifesto. ³

About the UK Faculty of Public Health

The UK Faculty of Public Health (FPH) is committed to improving and protecting people’s mental and physical health and wellbeing. FPH is a joint faculty of the three Royal Colleges of Public Health Physicians of the United Kingdom (London, Edinburgh and Glasgow). Our vision is for better health for all, where people are able to achieve their fullest potential for a healthy, fulfilling life through a fair and equitable society. We work to promote understanding and to drive improvements in public health policy and practice.

As the leading professional body for public health specialists in the UK, our members are trained to the highest possible standards of public health competence and practice – as set by FPH. With 3,300 members based in the UK and internationally, we work to develop knowledge and understanding, and to promote excellence in the field of public health. For more than 40 years we have been at the forefront of developing and expanding the public health workforce and profession.

The importance of realising a “radical upgrade in prevention and public health”

Public health is the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals. It is well established that the determinants of health – and ill health – cannot be influenced by health policy on its own, and are determined largely outside of the NHS.

People with a higher socioeconomic position in society have greater life chances and opportunities to lead a flourishing life. The more opportunities and access to opportunities people have, socially and economically, the better their health. This link between social conditions and health must not be a “footnote to the ‘real’ concerns with health” – but the main focus.

Prevention of long-term conditions is far more cost effective than treating illness as it occurs. Focusing on prevention can reduce high long-term treatment costs and improve health outcomes – avoiding premature deaths and ensuring a more sustainable NHS. In 2010, 70% of the NHS budget was spent on long-term conditions – yet only 4% cent of the health budget spent on prevention. This is rapidly decreasing as public health funding is being decimated.

Truly achieving a “radical upgrade in prevention and public health” requires more than reversal of cuts to public health funding alone. It requires a healthcare system grounded in public health principles and a public health framework with strong primary and community care relationships.

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It requires equitable, upstream social and economic policy at national and international level\(^8\) to address the unequal distribution of power, income, goods, and services – and consequent unfairness in the immediate circumstances of peoples' lives – access to healthcare, education, work and leisure; homes, communities – and chances of leading a healthy life.

FPH’s manifesto\(^9\) outlines 12 evidence based practical actions that will contribute to securing the NHS’s long-term sustainability, through commitment to preventative action – strongly aligned with the FYFV. FPH further supports:

- A tobacco levy – a cost-effective way to guarantee resources regardless of public finances.\(^\text{10}\)
- Giving Hospital Trusts a £200million target to reduce avoidable procurement and agency staff commissioning costs.\(^\text{11}\)
- Giving NHS Trusts a £200million target to reduce ‘interventions of limited clinical value’.\(^\text{12}\)
- Addressing unacceptable country-wide variation in quality of care.\(^\text{13}\)

The current context: major cuts to public health funding

FPH submits this evidence in the shadow of recent confirmation that the ring-fenced public health grant will be cut by around 20% by 2020 – compounded by comparable cuts in local and national Public Health England manpower. In addition to the confirmed £200million cut to the ring-fenced public health grant; the Comprehensive Spending Review 2015 (CSR) unveiled further real terms cuts by 3.9% each year to 2020/21 (a cash reduction of almost 10%).

This follows the 12% already cut from the national social care budget since 2011;\(^\text{14}\) and estimated real-term reductions in local government funding and income of 37% and 25%, 2010-15. 32% is also to be cut from Department of Communities and Local Government funding by during this CSR.

Statutory public health functions may also change post-2017, with serious implications for critical health and public health services provided by local authorities, eg already fragmented sexual health services, health visitor services and fulfilment of new local responsibility for children 0-5 years. All of these non-mandated services are already at most serious risk.

\(^7\) FPH draws attention to efforts in Scandinavia to embed public health as a foundation block of the health care system

\(^8\) FPH notes the ground-breaking Welsh Government, Well-being of Future Generations (Wales) Act 2015, http://bit.ly/1QZzMTf and also draws attention to the


\(^12\) FPH draws attention to the Academy of Royal Colleges report, Protecting resources, Promoting value: A doctors guide to cutting waste in clinical care, November 2014, http://bit.ly/1kQO96D


We cautioned in 2012 of the risks to adult and child safeguarding posed by the Act.\textsuperscript{15} Yet, as a consequence of the Act, today, in 2015 a key component of the very services designed to ensure safeguarding of vulnerable children from serious risk – is now itself not safeguarded. With 0-5 services now not mandated, FPH reminds the Health Committee of the 2011 Munro Review of Child Protection\textsuperscript{16} which outlined a child centred system cross-party 1001 Critical Days manifesto.\textsuperscript{17}

FPH further underscores that safeguarding does not end at 5 years. Local authorities have responsibility for children 0-19 and adults – responsibility across the life-course. This is about a coordinated, system wide approach, linked with social care and all of the other elements of the system. FPH urges Government to ensure that these important services are fully funded and protected.

FPH is also concerned that the CSR signals the grant’s replacement with a retained business rate model. Eventual redistribution may particularly hurt deprived local authorities striving to address greater health needs and wider health inequalities. Should the ring-fence be removed, the NAO warns PHE’s ability to influence and support public health outcomes will be tested.\textsuperscript{18} \textbf{We strongly advocate long-term maintenance of the ring-fenced public health grant beyond 2018.}

\textbf{Commitments by the Prime Minister and NHS England}

FPH welcomed the Prime Minister’s commitment to increase NHS spending in real terms every year in this Parliament, rising to at least an extra £8billion a year by 2020. We further welcomed his recognition that the costs of obesity, smoking, alcohol and diabetes necessitate: “a completely new approach to public health and preventable diseases – prevention, not just treatment. Tackling causes, not just symptoms.”\textsuperscript{19}

The Secretary of State for Health affirmed that assurance. Alongside welcoming NHS England’s Five Year Forward View’s (FYFV) call for a “radical upgrade in prevention and public health”,\textsuperscript{20} a “vision” is needed, he announced, “encompassing the move to prevention, not cure, with much bigger focus on public health.”\textsuperscript{21} That vision is critical to the NHS’s sustainability.

\textbf{It is a false distinction and false economy to consider NHS and public health funding as separate.} FPH is surprised and gravely concerned that the Government, while pledging “to support financially [the FYFV],”\textsuperscript{22} has limited that commitment to NHS spending. This contradicts not only the

\begin{itemize}
\item \textsuperscript{15}UK Faculty of Public Health, Health and Social Care Bill – Risk Assessment Summary, 2012, \url{http://bit.ly/14BaH2u}
\item \textsuperscript{16} The Munro Review of Child Protection: Final Report A child-centred system, 2011, \url{http://bit.ly/TmJRdAL}
\item \textsuperscript{17} The 1001 Critical Days Manifesto, 2013, \url{http://www.1001criticaldays.co.uk/the_manifesto.php}
\item \textsuperscript{18} National Audit Office, Public Health England’s grant to local authorities, December 2014, \url{http://bit.ly/1NQZiLj}
\item \textsuperscript{19} The Prime Minister’s Office, PM on plans for a seven-day NHS, May 2015, \url{http://bit.ly/11Lwvk3}
\item \textsuperscript{20} NHS England, Five Year Forward View, October 2014, \url{http://bit.ly/1fivuwY5}
\item \textsuperscript{21} The Rt. Hon. Jeremy Hunt MP, Making healthcare more human-centred and not system-centred, July 2015, \url{http://bit.ly/1HzUmrx}
\item \textsuperscript{22} The Rt. Hon. Jeremy Hunt MP, Making healthcare more human-centred and not system-centred, July 2015, \url{http://bit.ly/1HzUmrx}
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Prime Minister and Secretary of State’s commitment and vision; but conclusion of the FYFV itself – that public health investment needs “explicit support from the next government.”

It contradicts PHE’s evidence-based advice to Government that “it will be neither effective nor feasible to attempt to solve an epidemic of largely preventable long-term diseases, through risks eg. obesity, poor diet, physical inactivity, smoking and excessive alcohol consumption, by ramping up spending on hospitals, clinicians and services.”

These cuts will rapidly generate substantial additional burdens on the NHS. The value for money, cost-effectiveness of public health, and case for increased public health investment, is well established. Severe cuts, and the ring-fence’s removal, will:

1. Worsen significantly health and wellbeing of local populations;
2. Increase inequalities across the life course, including within hard to reach groups;
3. Compromise delegated health protection and health improvement functions;
4. Make harder provision of population healthcare advice, and will hence;
5. Increase the burden of preventable non-communicable disease, putting further pressure on the NHS (already spending 70% of its budget managing long-term conditions)
6. Contradict deficit reduction – it will increase the deficit. Every £1billion “saved” will generate at least £5billion additional NHS, social care and wider economic costs.

The public health and medical profession were united in opposition to the £200million cut to the ring-fenced grant. The Academy of Medical Royal Colleges, representing 22 Colleges and Faculties and 200,000 members – and a broad cross section of professional bodies, including the Local Government Association and Society of Local Authority Chief Executives, called for the £200million cut to be reversed and no further cuts to be made. FPH’s membership are again united in

References:

24 PHE, From Evidence into Action: Opportunities to protect and improve the nation’s health, October 2014, http://bit.ly/ZT2i3h
27 DH consultation on proposed target allocation formula 2016/17 http://bit.ly/1NRfTm
38 Professor Simon Capewell, University of Liverpool, 2015
40 Signatories to the AoMRC letter included: The UK Faculty of Public Health, The Association of Directors of Public Health, British Dental Association, NHS Confederation, Chartered Institute of Environmental Health, Local Government Association, London Councils, Royal College of Nursing, Society of Local Authority Chief Executives, UK Health Forum
opposition to the CSR’s decimation of public health funding – and anticipate again a united opposition.

**FPH’s position on the Health and Social Care Act 2012 (the Act)**

In March 2012, FPH called for withdrawal of the Act and urged the Government to adopt an NHS stabilisation plan.\(^{41}\) FPH’s professional, evidence based analysis made clear that the Act would harm patients, undermine the public’s health, lead to service fragmentation, worsen health inequalities and prevent effective health and social care integration.\(^{42, 43, 44, 45, 46, 47, 48}\)

Regrettably, the risks to population health identified are now being realised. Detailed Evidence demonstrating realisation of these risks is found within FPH’s report on the Act’s impact.\(^{49}\)

**Prioritising concerns about the Act**

The Act’s scope and measures prompted concern from many professional bodies. FPH produced a risk assessment\(^ {50}\) outlining six key concerns:

1. Loss of a comprehensive NHS and withdrawal of NHS services;
2. Increased competition and costs;
3. Reduced quality of care;
4. Widening health inequalities;
5. Risk to effective discharge of public health responsibilities;
6. Risk to the public health workforce.

In 2014, we conducted a membership survey to determine whether the concerns identified were warranted, and, if so, to grade and prioritise them. The 200 members responding reflected the demographic and work characteristics of FPH’s membership. Respondents reported substantial ongoing concerns about the Act’s scope and implementation. Most consistently rated the risks identified as still ‘high’ or ‘extreme’. The following key threats emerged:\(^ {51}\)

I. **Infrastructure for public health:**
   a. Short-term nature of ‘ring-fence’ for local public health budgets;
   b. Lack of access to information about the use of health services.

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\(^{41}\) UK Faculty of Public Health, Action update, March 2012, [http://www.fph.org.uk/action_update](http://www.fph.org.uk/action_update)


II. NHS Planning and delivery:
   a. Loss of insight on addressing population need, effectiveness and efficiency for NHS commissioners;
   b. Fragmentation of services and poor coordination of care.

III. Public health workforce:
   a. Concern about workforce fragmentation and the impact on patient and public safety because of changes resulting from Act.

Major ongoing concerns

I. PH Funding – as detailed above
II. Loss of the ring – fenced grant, as detailed above
III. Public Health Leadership – Directors of Public Health (DsPH) roles and accountability

FPH welcomed the Act’s affirmation that DsPH are local authority Chief Officers\(^{52}\) in line with the position of the Directors of Children’s Services and Adult Social Services. Accordingly, DsPH are responsible for exercising the local authority’s new public health functions. We also welcomed secondary guidance affirming appointments would be consistent with FPH standards. This ensures DsPH in local government have the necessary technical, professional and strategic leadership skills to promote, improve and protect health and provide high-level, credible, peer-to-peer advice to the NHS about public health in relation to health services.

The guidance made clear that these legal responsibilities should translate into there being direct accountability between the DPH and local authority CEO for exercise of the local authority’s public health responsibilities; and that DsPH would have direct access to elected members. However, there is much local variation in practice. It is important that DsPH have ready access to the CEO and elected members.

IV. Independent voice

PHE provides national leadership on public health issues and a critical role advocating on behalf the people of England on the basis of unbiased, expert assessment of health needs, and what can and should be done to meet these needs. It must provide independent, transparent and evidence-based information on population health and well-being, trusted by the public, professionals and government.

FPH suggests now (as in 2011) that PHE’s ‘operational independence’ would be better assured as a Special Health Authority. PHE employees are governed by the Civil Service Management Code, including rules and restrictions on what may be said in public about policy and professional issues (eg. before Select Committees). FPH remains concerned that this compromises PHE employees’ ability to speak independently, its organisational independence – and public perceptions.

FPH has similar concerns about the politically restricted nature of local authority DPH and public health posts. Many members have reported, in confidence, incidents of gagging, loss of independence, pressures placed on the development and messaging of the statutory, independent DPH Annual Report, and public advice on infectious disease. FPH reminds the Committee of its previous evidence to the Committee’s inquiry into PHE.53

V. Public Health Workforce

Since the Act, different employers have been trying to coordinate terms and conditions to cover seniority, pension arrangements, leave entitlement as well as salaries and incremental scales. It is important public health leaders have experience of working across local government, the NHS and PHE. We need a single public health system with easy movement between employers.

The biggest risk faced is not being able to attract medically qualified specialists to work in local authorities. Public health support to the NHS is provided by local authorities and doctors are needed in multidisciplinary teams to support acute service re-configuration, development of integrated primary care, and health and social care coordination. FPH is deeply concerned by general reductions in public health consultant posts within some local authorities, movement of medically qualified consultants to PHE, and restructuring of smaller teams. Budget cuts place teams at greater risk.54

FPH is concerned by the contraction of local and national PHE services generally, and, in particular, frontline health protection services. The Acheson report was clear on the need to ensure presence of one Consultant in Communicable Disease Control per 400,000 of the population. Yet, by 2012 this dropped to one in 500,000 and, unless arrested, could drop to 1 in 700,000. The capacity and capability to deliver, with depleted and disconnected public health workforce, for example, a level of response to pandemic influenza, as was the case in 2009, is now at serious risk.55

VI. Statutory Regulation

54 FPH is feeding into the long term review of the workforce commissioned by the DH, PHE and Health Education England, http://bit.ly/1IeyAie
55 UK Faculty of Public Health, Staffing guidelines: Standards for Effective Public Health Teams, http://www.fph.org.uk/staffing_guidelines. FPH is happy to provide further evidence to substantiate on this point
It is vital for protection of the public that all public health specialists are covered by statutory regulation (SR). Despite Government commitment in 2012 that SR would be implemented for public health specialists from backgrounds other than medicine and dentistry it will now, indefinitely, not proceed. SR had been a key aspect of the Government’s 2012 public health workforce strategy.

The commitment was to address the anomaly by which medically qualified public health consultants are regulated by statute, but consultants from backgrounds other than medicine and dentistry are not. Failure to regulate over a third of the specialist public health workforce could lead to serious risks to the public’s health and well-being and erosion of public confidence. It undermines equivalence within the multidisciplinary profession, whereby a large number of public health professionals who qualified through identical training routes are not regulated by comparable statutory mechanisms. 56, 57, 58

VII. NHS Commissioning & VIII. Healthcare Public Health (HCPH)

Effective health services cannot be effectively commissioned without public health expertise. Effective healthcare commissioning and meeting the FYFV’s challenges require CCGs to deliver highly competent local commissioning of effective and efficient healthcare services based on need.

The value public health specialists traditionally brought to that CCG role was recognised in the Act which made this service to CCGs a statutory part of the public health role of local authorities in England. This HCPH function is one of the three core domains of specialist public health practice in the UK, (along with Health Protection and Health Improvement).

Since the Act, there has been pressure on transferred public health functions. One consequence in many places has been reduction or elimination of the specialist workforce dedicated to working on HCPH with CCG NHS commissioners. FPH is aware of many examples where that function is substantially limited or absent.

Public health expertise saves lives and maximises efficient use of scarce NHS resources. For these reasons, FPH continues to advocate for public health expertise to be embedded within NHS England at Board level and across all layers of the NHS.

FPH attaches a case study and recent definition of HCPH.59

IX. Competition

In 2013, FPH cautioned that unregulated competition could compromise quality of care and worsen health in the local statutory, private and independent provision of social care, and opposed the uncoupling of the commissioning support function from the NHS. FPH called for rejection of unfettered market competition for healthcare, protection of national sovereignty over health service policy and protection from EU competition law.

We again now highlight risk that CCGs, forced to open services to competition, would create unnecessary bureaucratic and financial burdens. Enforced tendering of one service could damage another interdependent service, leading to disruption of complex care pathways vital to high quality healthcare. Distorted CCG clinical priorities, fragmented services, damaged social care and public health integration, and inhibited innovation, risk disruption of population based health programmes.60,61

Regrettably, since 2013, there has been a loss of insights by NHS commissioners on addressing population need. Effective and efficient commissioning delivery is more challenging, and some services have fragmented and coordination of care worsened, eg. sexual health.62

Furthermore, whilst within its remit, the Government has not called for NHS exclusion from the Transatlantic Trade and Investment Partnership (TTIP). Inclusion of the NHS is likely to worsen health systems, weaken co-ordinated working and make it harder to ensure public health considerations are addressed across the NHS.63

X. Access to data, and Public Health Intelligence

Prior to 2013, public health consultants and academic public health researchers had effective, efficient access to vital, real-time data required to inform public health decisions. FPH called for previous statutory support for provision of that data to transfer to all relevant parts of the system, for arrangements for maintaining systems of surveillance and monitoring to be secured, and real time data flows for detection of health protection threats and response to be safeguarded.

Since 2013, problems with sensitive data access have affected public health analysts transferred from the NHS to local authorities and researchers using data for funded projects (with contracts not being renewed or initiated). This impedes effective public health action eg. undertaking health equity audits and taking action to address inequalities. Barriers include disruptions in data flow between the NHS and local authorities, lack of access to patient-level information for those in local authorities and providers charging for access to data.

FPH also emphasises disappointment at cuts to statistical products necessary for public health specialists to effectively undertake their work.\textsuperscript{64}

**Public health intelligence**

Public health intelligence has always remained under the DPH control. The DPH and public health team rely on access to data and knowledge and evidence from their local Health Intelligence and Knowledge Management Team, often at short notice, to implement services and carry out effective interventions to protect and improve the public’s health. FPH is concerned that some councils are removing health intelligence from the DPH control and subsuming it, along with other departmental analytical functions, under overall control of other council directorates, under ‘Corporate Intelligence’.

DPH control is essential to guarantee quick access and maintain the quality, independence and integrity of information gathering, information transfer and information implementation within the council. Crucial public health evaluation work by knowledge management teams in public health could also be hampered by new council reporting arrangements for corporate intelligence.

**XI. Health protection, resilience and emergency preparedness**

Prior to 2013, good liaison, cooperation and coordination existed between different branches of the health protection service – and excellent links between local, sub-national and national levels. FPH argued for preservation and development of those relationships – through the transition to the new system and beyond.

FPH remains concerned that the current system for emergency preparedness does not properly delineate responsibility between local authorities, PHE’s local centres and national bodies. Statutory regulations give DsPH responsibility for provision of information and advice. However, DsPH have no direct role in emergency response to incidents and outbreaks. This is unsatisfactory, unsafe and will be exacerbated by PHE and council funding cuts.

**Conclusions - effectiveness in delivering envisaged improvements to public health**

The Government’s policy of ‘empowerment of local communities’ offered great potential for health improvement through embedding public health expertise in local authorities, opportunities to work across the full range of council and local authority issues and determinants of health eg. housing, education and planning, and increase the focus on population health.

\textsuperscript{64} FPH draws attention to its response to the ONS consultation on statistical products, Oct 2013, \url{http://bit.ly/1O8Qd54}
While all DsPH and their teams are committed to delivering best practice, effective collaborative relationships and innovative solutions, the impact of the Act and public health (and wider) funding cuts has made realisation of this increasingly challenging. Those examples that exist will become harder to maintain, while for the most deprived councils, achieving the FYFV’s ambitions will be harder still.

FPH’s member survey highlights widespread problems, as detailed above. Many amendments proposed to strengthen the Act were not enacted; and the decimation of the local authority public health ring-fenced grant (and future removal of the ringfence) put population health in England at serious risk. Many risks identified during the passage of the Act are now being realised. FPH reiterates the recommendations made above.

14 December 2015