Executive summary

1. Improvements to public health are complex and need good inter-disciplinary and cross-organisational working, which can be facilitated by trained public health specialists.
2. This in turn needs to be supported by the right structures and agreements so that skilled public health expertise is not marginalised either by a poor understanding of the role or by financial constraints leading to a lack of long term investment in organised public health.
3. Examples of issues relating to the role of public health in NHS specialised commissioning and links with the wider system are considered.

Background

4. These are my views, which relate to public health in England after the 2013 reforms. I have worked in public health (PH) for 24 years having previously been a GP. I currently work as a public health consultant in the NHS England Specialised Commissioning Team (West Midlands), an embedded role with my contract held by Public Health England. I have worked in NHS specialised commissioning for 11 years. The NHS reorganisation has improved some aspects of public health whilst others have become more problematic so this provides an opportunity to comment on some of these problems.

PH working in NHS England specialised commissioning

5. After the 2013 changes my contract was transferred to PHE whilst I effectively continued to do the same NHS role albeit with more complex accountabilities, effectively to two organisations. As always with reorganisation there were opportunities to work with a wider group of PH colleagues although the potential for this has not been realised to the degree that I would have hoped. I can link well with colleagues in my local PHE centre but linking with local authority (LA) colleagues attached to or supporting CCGs has been very limited.
6. Linking with PH colleagues is important because specialised services are technical and expensive but the patients will always be part of a care pathway that usually has its origins in CCG commissioned services or even relate to LA services, such as advice on weight management for patients potentially need
obesity surgery. The opportunity here is to not just to ensure better services for
patients but to facilitate improvements in care in the “upstream” elements so as to
try and prevent patients needing more complex (and expensive) interventions. As
an example renal failure needing dialysis can often be delayed if some of the risk
factors are well managed in general practice.

Public health, health services and disease prevention

7. The need to improve upstream care seems to have been well recognised in the
Five Year Forward View from NHS England. It also seems to be increasingly
recognised that health services can only survive financially, with the constant
pressure on the NHS to expand and improve care, if population health improves,
potentially a win-win situation. To cut public health funding that has been top-
sliced from the NHS, either to fund PH in PHE or in LAs, is an indirect cut of
historical NHS funds and will only exacerbate the long term pressures in the NHS.
When investing public funds there needs to be a reasonable balance between
improving health and disease prevention, and funding the direct care aspects of
the NHS. This balance appears to be worsening at the moment with the cuts to
public health funding.

8. One of the needs for effective public health is for trained practitioners to work
across different organisations, such as LAs, CCGs, NHS England, or provider
trusts, so as to try and bridge the gaps that appear and often to work with like-
minded colleagues be they designated PH practitioners or people with a strategic
view of health. This raises the problem of where PH specialists should be situated
in terms of a suitable employing base. Whilst PHE provides a body of like-minded
people and a critical mass to try and shape national policy it needs to work hard to
ensure that public health can bridge the many organisations involved in delivering
health. This is not to say that PHE is not delivering but cutting funding will not
help PHE maintain its reach or its remit.

Establishing public health specialists with the new NHS

9. When the 2013 reorganisation separated many PH colleagues I worked hard to
make sure that the role of a PH specialist in the NHS’ specialised commissioning
services was both understood and maintained. Many people are unsure of how
this particular role works whilst they can more easily understand the work of PH
specialists in health improvement and health protection. Along with the Faculty of
Public Health, we have termed this part of the discipline Healthcare Public Health
(HCPH), possibly a slightly unwieldy term.

10. In particular I continued a public health network for the small number (about 20 in
total) of PH specialists across England in a similar position to myself. This
helped to facilitate the induction of new appointments to these isolated and
technical posts that were spread across 10 teams but also helped to make the
case for our role with senior NHS England managers and senior PHE managers.
11. Despite the contracts being held by PHE, initially there was not a wide understanding of HCPH and we made the argument that even specialised healthcare is part of the wider health pathway and in one sense the opposite end to health improvement. In many cases you cannot prevent diseases until you have recognised the problem occurring at the NHS end. A simplistic example would be that we did not recognise the need to decrease smoking until the problem of the increase in lung cancer in the NHS had been researched and the causative factors established.

12. The end result of the first phase of this work in advocating the role of HCPH is that we now have an agreement, which took two years to arrive at, between PHE and NHS England about what both organisations can expect to be delivered through role such as ours in specialised commissioning.

Public health and collaborative commissioning

13. Simon Stevens has highlighted the need for collaborative commissioning between NHS England specialised services and CCG commissioned services. In some ways this has the potential to reinvent some of the more successful aspects of the previous system with specialised Commissioning Groups accountable to local PCTs. Public health specialists can play a key role in facilitating service change and improvements in care by looking at the care pathway. However, those of us on the NHS side will need to work with PH colleagues in the CCGs and anecdotally it appears that PH support to CCGs is highly variable and often limited. This needs reviewing as the NHS changes will be limited if the optimum support, such as well-defined PH support, to the various teams is not in place.

Recommendation

14. The wide role and long term nature of delivering public health through skilled expertise needs to be maintained and recognised. As the outcomes of public health work are often not immediately apparent it is easy to undermine the public health role by a lack of investment. Organisational issues in supporting public health also need to be addressed possibly by mandating a high level role for public health, such as was needed prior to 2013 by creating Directors of Public Health as executive directors in PCTs.

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