Written evidence submitted by Phil Ayres (PHP0117)

Please can I be clear that the views I express here are my own, and not that of my employer or any professional body.

Questions

- What are the legislative barriers to successful collaboration and effective action from hospitals to improve population health?
- What legislative action is needed to mandate hospital participation in health promotion for individuals and populations?
- What regulatory and financial incentives can be introduced to support hospitals in promoting health?
- How does the current public health workforce enable health promotion, health protection and better value health care in hospitals?
- How can the wider workforce in hospitals work towards the same goals?
- How can hospital Boards be supported or changed so they can most easily pay attention to the opportunities for collaboration to achieve population or public health goals?
- What are the best ways for hospital and local authority leadership teams to work together to achieve positive change in this area?
- How can we replicate collaboration between the leadership teams in health and social care right through the organisations they lead?
- When all this is working well, what does a compelling picture of success look like?

Background and rationale

I have been a consultant in public health in an acute Trust for 20 years. Originally appointed by Liam Donaldson in 1996, I was one of a small number of consultants whose role was to bring public health skills to our trusts.

The work focussed initially on clinical governance, but with the publication of *Choosing Health* and *Implementing Choosing Health* in the mid-2000s, there was a greater focus on collaboration with local public health initiatives and the delivery of public health programmes directly by acute trusts. This was in part regulated by the framework known as *Standards for Better Health* as used by the then Health Care Commission (now CQC). Through that framework, the Commission mandated that acute Trusts collaborate with local efforts, had plans ready in the event of major incidents or threats, and paid attention to the local Director of Public Health in considering any actions to promote and improve health. Taken together, these requirements were a Good Thing and I was personally held to account by the Board for their delivery.

Sadly, the demise of the HCC also led to the removal of those requirements and formal accountability for hospitals becoming more health promoting also faded with that. I do not know whether the concomitant reduction in interest and activity relating to membership of the WHO Health Promoting Hospitals Network on the part of English hospitals was a direct result of the same, but I suspect so. We also started to pay less attention to and time on the
DH’s own Sustainable Development Unit, which ran the excellent self-assessment of good corporate citizenship.

We currently have in place a set of legislative, organisational and cultural norms that mitigate against collaboration for better population health and keep the eyes of health providers fixed firmly on the prizes of good financial husbandry, meeting delivery targets, ‘passing’ external reviews, competing with similar organisations and ensuring that the detail of commissioning plans is consistent with clinical viability. None of those activities are ‘bad’ (except perhaps the requirement to compete); some will support the development of cross-organisational ways of improving the Public’s health. Sadly none of the activities of themselves or taken together directly seek to achieve that goal. Perhaps they produce better population health through hospitals’ actions, but it is not very deliberate; possibly not even on the map.

Luckily I work in an organisation where the Board of Directors recognises and welcomes the potential of a hospital being more public health orientated. I am encouraged to report to the Board regularly on the steps we are taking in that regard and I have been invited to a workshop with the Board on that very subject. But that is completely dependent on their good sense. There are no formal incentives or requirements designed to reward a forward thinking Board (like that of Leeds Teaching Hospitals) that naturally seeks to collaborate. Instead there is a row of disincentives that actually predisposes to the opposite. Set against the vision of the Five Year Forward View, I am left confused by that.

Hospitals remain a huge spender of NHS resources and without them squarely at the table of public health improvement, they will continue to be seen as somehow excluded and somehow a drain. Neither of those positions is acceptable. What we need is an approach which mandates partnership working to improve population outcomes.

**Conclusions**

There are some things that could really help promote public health action in hospitals with legitimacy and authority:

**National**

- Legislative or regulatory action to mandate hospital responsibilities to public health
- A clear framework of goals and results that hospitals are held to account against
- A strong theme of work in England that promotes the work and skills of public health in service providers, including health promotion, health protection and healthcare public health
- National support for health promoting hospital networks
- A clear structural change in national public health bodies to reflect the need for better hospital public health practices
- A requirement for hospitals, primary and community care providers and commissioners to work together and generate specific plans to improve population health
- A template for success against which performance can be judged
• Undergraduate education for clinicians that makes value in health care an accessible and priority topic

Regional

• Well-led regional networks and structures to promote hospital effectiveness in this field and on the basis of national changes
• Regional funds to promote and support good practice and innovation in this field

Local

• (In the absence of ‘horizontally merged’ health and social care organisations) A reciprocal statutory role for the local DPH on the hospital board and a clinical executive director in the local authority
• A requirement for dedicated public health skills or posts to be deployed in hospitals
• Local leadership group for action on population health which includes hospital executives
• A requirement for joint vision and plans to deliver improved population health that includes hospitals
• Education for practising clinicians that makes value in health care an accessible and priority topic
• Commissioners prioritising the delivery of population health outcomes in their plans
• Greater public accountability for action by hospitals on improving population health
• Primary care and hospital clinician accountability for population health as well as for the outcomes in patients they see
• Local funds to promote and support good practice and innovation in this field

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