

Public health post-2013 - structures, organisation, funding and delivery inquiry

The Royal College of Physicians of Edinburgh ("the College") is pleased to respond to the House of Commons Health Committee's inquiry *Public health, post-2013 – structures, organisations, funding and delivery*; and to consider both whether the reforms introduced under the Health and Social Care Act have achieved their aims for the public health landscape and what further improvements may be necessary.

Local Authority Public health

Changes to public health delivery and new structural arrangements post Health and Social Care Act came at a time when Local Authority budgets were already under pressure. The national spend for local authority public health budgets was initially ring-fenced; but as time has gone by resources coming to local authorities to deliver public health services have been substantially reduced. Some services were mandated for local authorities to provide under the new arrangements, although there were concerns that the listed mandated and non-mandated services were not based on assessment of need, mortality, morbidity or the social structure of local populations in terms of its age, social class or ethnic diversity. Councils have to prioritise from among the services it is mandated to provide, those where they judge acute social need to be greatest, those where risks are greatest to the reputation of the council (such as child protection), and those which will prevent disease and improve health in the long run. Inevitably there is severe pressure on the general preventive services which protect the whole community and are the basis of a population based strategy. De facto health improvement and prevention are therefore deprioritised.

The burden will be borne by the poorest and most disadvantaged and the consequences are likely to be an increase in the health inequalities gradient. Along with the UK Faculty of Public Health, the Academy of Medical Royal Colleges and others, the College opposes the Department of Health's recent decision to reduce the ring-fenced public health grant to local authorities. While Government announcements on increased spending for the NHS and a commitment to prevention are welcome, we are concerned that spending is still being cut on local authority provided health services. Separating spending in this way is a false economy and the cuts to local authority preventative services (eg mental health services, drug and alcohol services, sexual health services) will generate additional future costs to both the NHS and local authorities.

The shift to local authorities has also brought with it other problems, which were flagged in advance of the reforms, but for which no provision was made in the new system. Directors of Public Health (DsPH) as either senior consultant level physicians or equivalently trained non-clinical specialists had

clearly defined senior roles in NHS organisations. No provision for the retention of that seniority was made. Instead DsPH have in many cases experienced loss of seniority, loss of consultant status and had their professional autonomy and experience devalued with the consequent loss of morale and exit from the profession. In some areas resource pressures have also led to a gradual reduction in the specialist workforce that is dedicated to working on Health Care Public Health (HCPH) with CCG NHS commissioners. The UK Faculty of Public Health has a number of examples where private consultancy has been used by CCGs or DsPH because of a lack of those necessary skills or limited capacity within their existing teams working on mainstream health services commissioning, suggesting unmet need is developing.

Another issue is that local authorities are intrinsically political organisations. The new public health teams in local authorities have had to find a role within this democratic accountability process. Some have made the transition seamlessly, for others it has been a difficult process. This is exemplified by the role of the use of guidelines. Up to 2013 NICE had produced 48 guidelines on optimal and cost effective disease prevention, health improvement and some health protection interventions. These guidelines provided evidence based solutions to many of the imperatives within the Public Health Outcomes Framework against which local authorities were to be held accountable for their public health delivery. A way of ensuring that this knowledge base transferred to local authorities would have been to mandate the use of NICE Public Health Guidelines in local authorities. This opportunity was missed and matters made more complicated by giving the newly created body, Public Health England (PHE), some apparently overlapping functions with respect to evidence development. The result is that NICE guidelines, along with information from Public Health England have to compete with a range of other possible sources of information available to local authorities with the final arbitration as to what should hold sway being made on grounds which do not automatically or routinely relate to the scientific evidence.

Public Health England

Public Health England (PHE) was created from a number of organisations providing various public health functions, the largest of which was the Health Protection Agency. PHE's functions are consequently wide ranging and very diverse. Inside PHE the health protection function remains intact and the surveillance functions and the collection of routine data are strong.

However, there are a number of aspects of the structure and activities of the other parts of PHE which could be explored by the select committee.

As a national body PHE needs to focus on the population as a whole and one of its principal audiences is national government. But it also has a role in supporting local authorities. One thing that PHE could have done is support the implementation of NICE public health guidelines at local level. There is little evidence that this has been the case in any systematic way, indeed the production of additional evidence from PHE has sometimes served to cloud the issue.

Second, PHE has not had a clear and consistent standard for the evidence it either promoted or uses. Sometimes the evidence which has been used e.g. on electronic cigarettes has been less than optimal. The organisation needs to have a standard - and there is now very extensive methodological work in public health science to support the setting and maintenance of such a standard. Establishing rigorous standards for evidence-based products would benefit the population and reassure professionals. Cherry picking evidence to fit in with current controversies devalues the currency of evidence and brings no credit to PHE. Its standards should be at least equivalent to that of NICE's public health guidelines.

Third, PHE has struggled to give the impression that it is independent of government and that it speaks with a clear and independent voice on matters relating to the health of the public. Therefore the relationship between PHE and Government may need to be reconsidered for PHE to establish a reputation for independent, evidence-based and above all trusted expertise.

In their response to this inquiry the UK Faculty of Public Health has noted concerns about unclear role responsibilities and boundaries in the event of a public health emergency. These concerns and potential gaps should be investigated to ensure trust from staff and the general public. They also conclude by stating that the future of the profession may be uncertain due to cost reductions and a more fragmented workforce. We would encourage the Committee to take these concerns into consideration.