UK Public Health Network consultation response

Transforming the public health system: reforming the public health system for the challenges of our times

https://www.gov.uk/government/publications/transforming-the-public-health-system/transforming-the-public-health-system-reforming-the-public-health-system-for-the-challenges-of-our-times

This submission does not necessarily reflect the position of all member and observer organisations of the UK Public Health Network as its membership includes statutory agencies. This submission is supported by members who are third sector public health organisations.

The design and culture of the UKHSA

1. What do local public health partners most need from the UKHSA?

Within the reformed system, local public health partners and authorities must have codesign of national policies and there should be effective flow down from national to local. This will help to ensure connectedness between UKHSA and its regional and local partners.

The 2012 arrangements laid down the assurance role of DsPH and their public health teams in health protection and screening and immunisation. We are concerned that there is no clear agreement on where health protection assurance will lie in the reformed system. We ask that local authorities and the NHS have joint commissioning of Section 7a through ICSs, and that real oversight (including data access) of screening and immunisation lie with DsPH.

Local public health teams and DsPH will inevitably continue to deal with health protection matters in their areas, which must be accounted for within the Government's plans. PHE worked on important health protection areas on a UK-wide basis, and this should not be lost. We therefore request a memorandum of understanding between UKHSA and the devolved nations as well as DsPH in England.

Resources should be devolved from UKHSA to local government for the health protection response work they undertake in tandem with national and regional agencies. The current capacity of local government will continue to be important beyond the current pandemic response. We therefore ask for guaranteed resources from UKHSA to support the action that local public health partners will take on the ground.

Sufficient health protection professionals are vital to ensure expertise in every local authority as well as regionally and nationally. UKHSA should place high priority on increasing the numbers of public health specialists and analysts in training.

2. How can the UKHSA support its partners to take the most effective action?

It is going to be of critical importance that UKHSA engages effectively with its partners in the devolved nations: Public Health Scotland, Public Health Wales and the Public Health Agency in Northern Ireland, with acknowledgement of the now different public health landscapes across the UK nations.

UKHSA must also factor in the land border between Northern Ireland and the Republic of Ireland (and its membership in the EU), and the considerable practical challenges this can pose from a local public health perspective. An all-Ireland public health agency exists, and it is crucial that UKHSA works alongside them. Cooperation between agencies will be vital to tackle the spread of infectious diseases as well as other health determinants across borders. This is a crucial aim which needs to reach up into the political strata to be effective.

According to the DHSC policy paper, “reducing bureaucracy and promoting integration” is the rationale behind these reforms. UKHSA must consider how it can meet these stated aims while oversight of the other public health domains will sit with OHP and NHSE/I. Its partners' actions will be limited in reach if system-wide integration is not achieved. Ensuring that an advisory system group (similar to PHSG) as well as an advisory workforce group (a standing group, for example) are prioritised within UKHSA’s governance will help to ensure effective partnership working.

The new agency will be supporting local public health partners, who deliver health protection and health improvement functions, yet UKHSA will only have oversight of one of these. It is our belief that UKHSA's success in supporting its partners to effectively deliver both functions will depend on how much it listens to the local perspective.

3. **How do you think the health protection capabilities we need in the future should differ from the ones we have had to date?**

We see a particular strength of the new system as being its data analytical capabilities and welcome this as part of the improved health protection functions of UKHSA. We would like to see greater transparency of the intent of increased data analysis capacity, however, as well as links between NHS, UKHSA, OHP, local authority and other data at all levels. Ensuring that data analytical structures are coherent and shared with partners would be a promising way to take forward the Government's stated aims to support the integration of the public health system.

We have concerns with regards to UKHSA's data, knowledge and intelligence capabilities – we understand that not all data is expected to sit with the agency, such as cancer registries. We also understand that – currently – data, knowledge and intelligence is supplied to the devolved nations. With data being held by different parts of the system, a 'data passport' should be considered by the UK Government. This would combat the obstacles local teams and the devolved nations encounter when trying to acquire data held in another part of the system – for instance, local partners having to pay large sums for data relevant to their local health protection capabilities.

We also ask for DsPH to have direct access to all data (including PID) by right, for LKITS to continue supporting local authorities and for DsPH to have sufficient resources to employ public health analysts locally.

DsPH will always become involved in health protection crises within their local areas. It is therefore crucial that UKHSA acknowledges their expertise and value by providing an emergency response fund and easily accessible surge capacity, set aside for local use.

4. **How can the UKHSA excel at listening to, understanding and influencing citizens?**

Some of the language chosen for these reforms, particularly around 'health security', could have damaging consequences for the public’s trust in the new agency. It is vital that the

public trust in PHE is translated to the new agency, particularly as UKHSA will be engaging with vulnerable groups and will hold sensitive data on citizens, but it is unclear how this will be managed with this change in terminology and image. Good communication about UKHSA's function and powers will be vital to ensure meaningful and transparent engagement with citizens. This can only be achieved through robust governance, listening to local public health partners on the ground.

It is currently unclear what the coming together of certain functions of PHE with JBCI and NHS Test and Trace to make up UKHSA will look like and what its bandwidth of authority will be. This will be even less clear to citizens outside of the public health profession.

We understand that there will be an influx of NHS Test and Trace staff to UKHSA. How the new agency navigates this new dynamic will be crucial. Dominance of NHS Test and Trace staff within UKHSA will internally alter the identity of national public health. The external image it cultivates will have to be carefully managed to maintain public credibility and ensure consistency in the public health workforce.

Health improvement

1. **Within the structure outlined, how can the independence of scientific advice to Government be best safeguarded?**

We are pleased that the role of the CMO will be "strengthened" and they will have direct oversight. However, the governance should ensure that the independence of the teams working in the Office for Health Promotion is also safeguarded. Partnership with civil society and the voluntary sector needs to be embedded in the system as it has a key role to play in ensuring the independence of scientific advice.

The CMO may come under political pressure at times. The CMO must be able to operate independently of political pressure as much as possible.

Independence should be safeguarded as the Office for Health Promotion grows. This requires the right structures to be put in place, including checks and balances, open and transparent governance and having the relevant firewalls in place.

PHE carried out successful national level reviews of public health harms and cost-effective interventions at national level. We would like to see the mechanisms for independent public health reviews kept in place. The role of Government in addressing the "power imbalance" with some industries requires a clear framework for protecting health policy from commercial interests. This should be based on existing PHE guidance: https://www.gov.uk/government/publications/principles-for-engaging-with-industry-stakeholders/principles-for-engaging-with-industry-stakeholders

There is an opportunity for new expert independent advisory committees in areas which have not had these before, including health inequalities and non-communicable diseases. There is also an opportunity to set up a new scientific advisory group, as well as allowing current independent groups to continue and expand.

2. **Where and how can system-wide workforce development be best delivered?**

The UK Public Health Network welcomes the opportunity for the new system to deliver strategic workforce functions and ensure there is more support for the proper development of the public health profession. This includes increasing the number of public health

specialists in training and public health analysts. There should be sufficient health protection professionals to ensure expertise in every local authority, as well as regionally and nationally.

Workforce development should be kept as integral as possible and needs professional leadership. We recommend collaborative workforce planning with key public health organisations – the Association of Directors of Public Health, Faculty of Public Health, Royal Society for Public Health, the UK Public Health Register, and others – to take this forward.

System-wide workforce development must support "action across government on prevention and the wider determinants of health" if the new public health system is to deliver. It should include a broader vision of the public health workforce not limited to traditional public health roles with public health in their name but include all roles across government and the NHS that have the potential to improve the public's health.

Future leaders, those in public health training and those who aspire to have careers in public health, should be able to navigate the system and should not be adversely affected. The three domains of public health – health improvement, health protection and health care public health – must be unified.

A whole systems approach to workforce development should be co-ordinated nationally with regional structures of the Office of Health Promotion led by the Regional DsPH tasked with translating this regionally and ensuring implementation. Local authorities already have expertise in this area, which has been strengthened because of the pandemic, and their involvement and input is crucial.

The separation of health protection from the other functions of public health is a major concern and allowing public health experts to lead the system will ensure there is an integrated public health response. Creating a joined-up system is crucial to success.

3. **How can joined-up working across government on the wider determinants of health be best strengthened?**

The UK Public Health Network strongly welcomes the commitment to joined up working across government in the policy paper, and the acknowledgement that health is driven by wider determinants, which is within the remit of other departments.

An Office of Budget Responsibility for Population Health can strengthen joined-up working across Government on the wider determinants of health, as recommended by the UK Public Health Network: https://ukpublichealthnetwork.org.uk/resources/return-to-investment-can-an-office-for-budget-responsibility-improve-fiscal-and-economic-planning-to-improve-the-publics-health-and-wellbeing-discussion-paper/

Health Impact Assessments (HIAs) across Government should be encouraged. The Department of Health and Social Care has outlined simple tools for recording the results of a HIA and how to carry out good quality HIAs: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216008/dh_120106.pdf

Processes need to be put in place to ensure that the new ministerial board on prevention is able "to drive and co-ordinate cross-government action on prevention and improve accountability on the wider determinants of health." The lessons of the past are that

deliverables based on outcomes are essential to drive true accountability. We recommend this board champions the use of HIAs and is chaired by the Prime Minister to ensure representation from across Government.

Public health expertise should be given flexibility and mobility across Government, for example through secondments, fellowship schemes and common career pathways and training programmes across organisational boundaries and between national/regional/local levels.

A Public Health and Wellbeing Act for England, centred on the requirement to address health inequalities and health improvement across all public bodies, at all levels, should be considered. Admired models include the Welsh Future Generations Act: https://gov.wales/well-being-future-generations-act-essentials-html#section-60674

Lessons can also be learned internationally. New Zealand's Better Public Services reform agenda and New Zealand's wellbeing model should be looked at when considering how to strengthen cross-Government working.

4. **How can these reforms be designed and implemented in a way that best ensures prevention continues to be prioritised over time?**

Insufficient public health funding remains a key challenge. The Singapore Health Promotion Board has been cited by Government as an example of success for the OHP to model itself on, but the per head investment is more than double that in England.

There is mounting evidence that preventative investments are cost-effective, generating a better outcome than the next best use of resource. A study published by the BMJ shows that a median return on investment of public health interventions is 14:1. Cuts to public health services are short sighted and represent a false economy: https://jech.bmj.com/content/71/8/827

CIPFA and PHE proposed a common, transparent approach to evaluate the costs and benefits of preventative investments in public health, to change the way prevention is considered – as a true investment – yielding benefits across place and time – rather than merely to generate savings: https://www.cipfa.org/evaluatingpreventativeinvestments

Spend per capita at local level is a quarter per capita lower than it was at its high point in 2015/16. If there is no new money, then better alignment of the existing money in the system is essential. A second, less preferable, option of ensuring prevention continues to be prioritised over time is dedicating a percentage of NHS spending to investment in local public health. This aligns with the commitments set out in the NHS Long Term Plan to improve prevention. The NHS should also define what their spend is on public health and inequalities and commit to increasing this over time.

A new Prevention Strategy alongside reforms, building on the 2019 Green Paper, will help to ensure that the new system coheres around a shared purpose and action is focused on increasing healthy life expectancy while reducing health inequalities.

Reforming the regional tier

1. **How can the local authority and Director of Public Health role be strengthened in addressing the full range of issues that affect the health of local populations?**

There needs to be a greater emphasis on system leadership as part of the local Director of Public Health role, and their responsibilities as system leaders should be clarified. This is crucial in a fragmented system. We would be pleased to see new guidance issued on the increased importance of the DPH role in the system.

Local DsPH need a meaningful place in both ICS and Health and Care Partnerships to play their essential prevention role across the system. Their role should not be side-lined to one workstream but, rather, allowed to influence across the whole agenda.

We ask the Government to clarify where DPH advice to the NHS will sit given that CCGs are likely to be subsumed by ICSs.

The Health and Social Care White Paper aims to strengthen local public health systems. Strengthening the DPH role is an opportunity to do this. The FPH and ADPH lobbied to ensure the sovereignty of local leaders was acknowledged; as well as their importance in terms of the emerging ICSs and their need to be on both the Executive Board and the wider boards. Additionally, we ask that local authorities and their representative organisations (LGA, ADPH, SOLACE) are represented on the boards of both UKHSA and OHP.

Resources for DsPH have diminished over time and need to be replenished for them to be able to leverage change across systems and undertake the long-term planning and investment needed to secure improvements in public health.

Government should consult on what additional powers and responsibilities could accelerate local public health action on the wider determinants of health. Planning, transport, licensing and other areas offer potential. The consultation should consider the inclusion of public health as a licensing objective for local authorities.

2. **How do we ensure that future arrangements encourage effective collaboration between national, regional and local actors across the system?**

A strong set of national objectives and supportive metrics which provide the accountability framework for the whole system is essential. However, local and regional flexibility is also needed to ensure approaches are responsive to the needs of local communities. We need clarity of responsibilities, and clear lines of accountability and communication between bodies and agencies, including ICSs.

Prevention Plans at ICS level should provide a framework for marrying national objectives with local circumstances, developed in partnership with local authorities. Such plans should be mandated with clear criteria for how local stakeholders will be included in their development. The DPH role should be influential across the whole ICS agenda, and ICS should be actively engaged in Health and Wellbeing Boards.

Regional DsPH have been told that they will ‘assure’ the health protection system, but more transparency is needed on how they will enact their role. Regional DsPH have an important convenor role and they must be allowed to lead across public health aspects.

Regional teams need to be adequately staffed to be able to effectively support RDsPH in their convenor role. They need to be able to work across UKHSA, NHS and local government across the region to provide the glue that links the system together. The NHS public health workforce should also have hard-wired links with local and regional DsPH and local public health teams.

Greater clarity about what we understand by regions is also needed, as regions operate differently at the local level. Co-terminosity is crucial to ensure that the local, regional and national levels operate under a shared understanding.

Regional arrangements should be co-designed with local partners and building flexibility into the system will allow for differences across the regions and ensure cohesion with local systems. A one size fits all approach to regional working must be avoided.

3. **What additional arrangements might be needed to ensure that regionally focussed public health teams best meet the needs of local government and local NHS partners?**

The system should be built around the local DPH. There should be subsidiarity between the regional tier; the regional system should serve the needs of the local level by mandating the needs of the local system and the work that needs to be put in place at regional level to enhance the local roles.

Activity at the national and regional level should respect the sovereignty of the local system and should involve those at the local level at the formative stage, in terms of development and implementation.

A supportive framework will facilitate and strengthen partnership working at the regional and local level. While fostering and maintaining individual relationships is important, they cannot be relied upon as the sole driver for collaboration.

Local and regional sector-led improvement (SLI) programmes must be sufficiently resourced and funded. A strengthened and transparent SLI process would not only provide assurance but also continue to drive innovation by both challenging and supporting local and regional teams. We believe the ADPH SLI Programme Board is best equipped to lead this and the ADPH Networks should be supported and funded to undertake SLI work at regional and sub-regional levels.

Regions need to have the scope and independence to develop approaches built on local insights while also being accountable to the national vision. A clear role needs to be articulated for the RDsPH so they can deliver a locally responsive but nationally accountable strategy for the region.

There is a high degree of interconnectedness across the system: local - regional – national; organisations – sectors – professions. It is vital that the notion of a public health system working as a whole is not lost as the structural changes are actioned. This includes ensuring collaboration and cooperation across all four nations of the UK.