



Association of Directors of Public Health

COMMISSIONING A PATIENT-LED NHS – IMPLICATIONS FOR DIRECTORS OF PUBLIC HEALTH

In 2001 there were 100 Directors of Public Health in English Health Authorities. Almost overnight Alan Milburn launched “Shifting the Balance of Power” on the unsuspecting NHS, with the creation of more than 300 PCTs, which soon became mini Health Authorities. This rapid and unplanned development stretched public health capacity, and many PCTs remained without a Director of Public Health in place. Here we are in August 2005 and “Commissioning a Patient-Led NHS” is launched, and we are creating larger NHS organisations again, say 100 new PCTs (Commissioning Health Authorities?) I am sure many DsPH and managers in PCTs and SHAs will shrug their shoulders, accepting that we work in a political system and try to make the best of this latest tsunami on this part of the NHS structure. But what does this mean for public health directors?

Over the last couple of years there has been much positive progress, with a new Choosing Health Strategy, the development of PSA targets and Local Area Agreements to secure some of the most important public health objectives. Some of the big issues like tobacco control and the recognition of the obesity epidemic are moving forward and at least inequalities is being targeted and monitored. More involvement with GPs through the new GMS contract and local strategic partnerships are positive developments. The Wanless report achieved Treasury support for the fully engaged scenario and DsPH have played a crucial leadership role at regional, SHA and PCT levels.

The immediate difficulty will be how to maintain public health leadership in local strategic partnerships with “lower-tier” local authorities at district and borough levels. The emerging model for joined up NHS/LA public health has been developing most effectively between coterminous PCTs and unitary authorities. Work is in progress to look at the optimal arrangements for joint DPH appointments between the NHS and local government, with all the benefits for delivering local area agreements and building an effective public health delivery system. In rural areas new PCTs are likely to be at county level, which is good for strengthening coterminosity at this level, but makes these joint appointments in unitaries more problematic. We need to find a way to sustain joint NHS/Local Authority Directors posts at this unitary authority level.

The other big issue is how we ensure that in a time of potential fragmentation (and privatisation) of primary care providers with the emergence of practice-based commissioning (GP fund-holding) that the public health delivery system remains intact. One of the gains in PCTs was the engagement of primary care and GPs new public health priorities. The nGMS contract is a useful tool, strengthening public



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health in school settings and other children's services led by local authorities is another. The new PCT/Commissioning Health Authority DsPH will need to ensure that they have an effective delivery system to ensure important health priorities are delivered through promoting health, preventing disease and diagnosing and treating patients in this new complex world. We should guard against any reductions in public health capacity, as a public health service should not be considered part of management costs. It will be a more complex world in the future, and we need to make sure that during the time of change we do not lose the current historic opportunities for collaboration with primary care and local government..

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