

The Association of Directors of Public Health Response to Commissioning a Patient Led NHS

Introduction

“Commissioning a Patient Led NHS” does not focus particularly on public health or the public health function but leaves the door open for debate about functionality and delivery. The public health community must capitalise (and be seen to capitalise) on this opportunity. In recognition of PCTs statutory responsibilities and those of associated local authorities the public health function should underpin and drive evidence based strategies that demonstrably improve the health of populations and reduce health inequalities. Broadly speaking this will be delivered through the three domains of public health namely:

- **Health improvement and reducing inequalities**
- **Health protection and prevention**
- **Health and social care quality**

Oversight of these three domains for a defined population is the role of a Director of Public Health for a statutory organisation. (Appendix I)

Given the pace of the change underway following Sir Nigel Crisp’s July letter to the NHS and in recognition that structural organisation of new PCTs, this paper provides a view from the Association of Directors of Public Health (ADPH) on maintaining and developing the public health function. It is based on recent telephone conferences of the ADsPH executive and subsequent email discussions. It represents the views of the “jobbing” Director of Public Health (DPH) in the front line of delivery of the public health agenda.

The context

Public health policies and interventions work! Over the Queen’s reign public health initiatives have delivered sustained improvements in the public health. For example life expectancy rose from 66.7 years (males) and 71.8 years (females) in 1952 to 75.1 years (males) and 80.0 years (females) in 2002. Similarly Infant Mortality Rates fell from 27.6/1000 in 1952 to 5.3/1,000 in 2002. These dramatic changes are the result of many public health strategies for example through the three “Ps”:

- **Prevention:** reducing the prevalence of smoking, improved and increasing equity in education attainment, increasing wealth, improved housing
- **Protection:** vaccination and immunisation, clean air, health and safety legislation
- **Provision:** evidenced based management of life threatening and long-term conditions.

Despite unprecedented investment in the NHS over the last three years, the reality is a widening of health inequalities, an NHS that did not balance its budget in 2004-2005, and the burgeoning costs of social care. This re-organisation we recognise is partly driven by the need to “save” £250M. The Wanless reports informed HM Treasury that health and social care funded by taxation would be unaffordable in 2020 unless we all became “fully engaged”.

The principle public health challenge facing the NHS and local authorities is the need to maintain quality, independent living in an ageing population. The duty of partnerships should address the social, economic, environmental and health/well being of their population. This means reducing the impact of disease processes on individual disability and handicap (during the final fifteen to twenty years of life) through prevention or delayed onset.

The challenges

Improved public health will need significant shifts in the lifestyle of individuals through:

- prevention strategies tailored to individuals living in supportive communities
- providing safe and appropriate health promoting environments in day-to-day activities at work, at home, and during leisure pursuits.

Some of this can be achieved through legislation and national health promotion campaigns. However existing PCT public health teams have shown that, like their forebears in local authority Medical Officer of Health teams, work with smaller populations and communities adds synergy to these campaigns. Likewise sustained, targeted community and neighbourhood approaches are essential in tackling local public health problems and health inequalities.

Secondly these changes will be delivered against a background of local authorities and the NHS facing significant financial problems over the next few years with the prospect of little significant above inflation investment.

Thirdly the reconfiguration will result in PCTs becoming “powerful” commissioning organisations that, together with local authorities, are charged with improving health and reducing inequalities. The majority of PCT commissioning will be discharged on the advice of Practice Based Commissioning (PBC) teams. In addition the current PCT provider functions will develop into separate organisations by 2008. Therefore public health specialist action needs to be set into the context of separated commissioning and provider roles.

The response

Outcomes: Success in implementing the Governments public health strategies means that the public health function must become locally focussed and outcome driven. A key benefit of the current PCT arrangements is a very local public health specialist presence in communities working through PCT front line staff and primary care as well as local authorities and voluntary organisations. These developments need to be built on.

Commissioning: The reconfiguration of PCTs means that the clear separation of commissioning from providing will need to be reflected in the public health function without losing the links.

The Association’s view is that in order to develop and sustain “powerful” commissioning, and deliver their statutory responsibilities, and demonstrably improving health PCTs and local authorities will require input from dedicated specialist public health teams. This will need to be at senior level with the continuance of the Director of Public Health (DPH) role. The DPH provides local leadership that, in partnership with others, ensures local population’s needs are assessed and addressed through public health programmes.

Experience in a number of PCT areas has shown the benefits of having DPH presence at senior corporate levels of local authorities. Ideally, but not essentially, these are joint appointments. Such arrangements have supported the development of health improvement strategies and the functioning of Local Strategic Partnerships. These successes and the advent of Local Area Agreements highlight the need to make these arrangements more widespread.

To fulfil their task the DPH will need to be supported by a team of accredited public health specialists to support commissioning and to demonstrate health improvement through performance management arrangements. However bearing in mind the challenge of “Choosing Health” particularly promoting health as a desirable commodity new skills such as marketing expertise may prove essential

Provision: Equally important is the need to provide appropriate public health interventions in the front line as this is where the three “Ps” of public health practice are delivered. Implementing “Choosing Health” demands realignment and boosting of current public health provision. For example services provided by health visitors or through the National Healthy Schools Programme. As with the provision of health services choice and provider plurality needs to be present in the provision of health improvement services. To some extent this already exists, for example smoking cessation support, exercise on prescription initiatives, and young adult services; these are provided by a range of organisations in the NHS, as well as the voluntary and private sectors. These should be built on. Increasingly such organisations are likely to require dedicated public health specialist support.

A tiered approach to public health functions

The introduction of Practice Based Commissioning (PBC) as part of the reconfiguration of PCTs should provide a real opportunity to secure locally sensitive health promoting services in health and social care. PBC will give the local focus to public health programmes and outcomes. It introduces another tier to for public health action and the need for appropriate public health specialist input and support. The three tiers are outlined in Appendix 2 and make a distinction between the provision and commissioning functions in PCTs.

Consideration of the development of a tiered approach should not be done in isolation of reviewing the relationship and working arrangements with other public health organisation. Key to this will be integrating the roles of the Health Protection Agency and Public Health Observatories to the reconfigured PCTs. In addition there are likely to be significant opportunities for greater engagement with academic public health, civil service practitioners, local authority staff and training schemes.

Delivery

In response to the multi-faceted approaches needed to improve the public health many public health specialists are likely to be working in all three tiers of PCT public health functions. Some will be needed to work as part of clinical and other networks on behalf of other PCTs. This will continue through the transition to the reconfigured PCT. In addition there is a growing consensus that more public health specialists and practitioners will be spending dedicated time in the local authority setting and at reconfigured Strategic Health Authorities /Regional

Government Offices. To secure a sustained public health function as well as reconfiguring, and enhancing it, plans need to ensure that during the transition:

- The good work undertaken by PCT public health teams and networks is built on
- The existing positive relationships with local authorities, the NHS, and the voluntary sector are secured and developed further
- Business continuity is maintained through the change
- Public health risks consequent on the transition are identified and appropriate controls and assurance mechanisms are in place
- Staff in each public health team are supported through the transition
- Best use is made of existing resources but recognise additional investment from the NHS and local authorities may prove to be necessary
- Public health high impact work areas continue to be delivered

Conclusion

The ADsPH recognises that this major reorganisation of PCT structures and the introduction of PBC provide significant opportunities to improve the public health. Prospects of this will be greatly enhanced through much closer working between PCTs and local authorities, in particular further integrating public health specialist work into the two organisations. This paper supports the concept of separating the commissioning and providing functions and indicates that public health specialists should be networked and play key roles in both. The paper stresses the ongoing important role for the DPH to provide public health leadership and strategic direction for local health improvement initiatives as well as performance monitoring progress. The ADsPH is ready to provide more advice and detail if required.

Dr Andrew Clark	DPH and Medical Director - Craven and Harrogate and North Yorkshire
Dr Catherine Woodward	Director of Health Improvement – Telford and Wrekin PCT

On behalf of the ADsPH Executive.



Appendix I

The roles of the Director of Public Health

- Public health advocacy and leadership
- Director of an organisation with statutory public health responsibilities for a defined population
- Chief public health adviser to the Board, accountable to the Chief Executive
- Producing an independent annual report on the health of the population
- Accredited public health specialist leading the public health team in partnership with others and working across the ten competencies
- Integrating the three domains of public health protection, health improvement, and health and social care quality, both vertically and horizontally
- Ensuring vertical integration with appropriate communication systems to regional and national levels (especially for health protection)
- Leading horizontal integration by including non-specialist public health practitioners in primary care and partner organisations and engaging the public
- Forging strategic partnerships particularly to reduce health inequalities
- Working with primary care and local communities to develop public health capacity and capability
- Working with public health networks to provide support and share expertise.

Source: Association of Directors of Public Health (2004)

Examples of the roles and functions of public health tiers in PCT areas

Tier 1 Providers of public health initiatives - Local communities such as Primary Care Teams, schools, and other population clusters (provision of public health interventions)

- **Health intelligence:**
 - Local needs assessment to inform strategic direction and planning
 - Reporting notifiable disease, recording lifestyle information, immunisations, chronic illness monitoring,
- **Prevention of poor health:**
 - Provision of health promotion/education campaigns and initiatives
 - Supporting community development initiatives
 - Active promotion of healthy lifestyles including smoking cessation
 - Targeting disadvantaged communities
 - Providing population screening programmes
- **Protection of health:**
 - provision of immunisation and infection control
 - active participation in detecting and contributing to the management of vulnerable children through child protection arrangements
 - providing appropriate active support during major incidents
- **Provision of health promoting services:**
 - Supporting people through self care/expert patient initiatives
 - Health improvement provision through systematic management of long term conditions
 - Active participation in agreed care pathways

Tier 2 Practice based commissioning (PBC) teams (commissioning public health interventions)

- **Health intelligence:**
 - Supporting, assessing, and using local needs assessment to inform strategic direction and planning
 - Monitoring local progress
- **Prevention of poor health:**
 - Commissioning locally sensitive health promotion/education campaigns and initiatives in line with public health priorities
 - Commissioning community development initiatives
 - Commissioning initiatives to promote healthy lifestyles such as smoking cessation, tackling obesity, healthy diets etc
 - Working in local authorities as the public health champion/advocate and advisers supporting LSP work programmes and developing the Community Plan
 - Ensuring commissioning plans address health inequalities
 - Commissioning and quality assuring local population screening programmes
- **Protection of health:**
 - Commissioning local immunisation programmes
 - Commissioning appropriate infection control arrangements
- **Provision of health promoting services:**
 - Promoting evidenced based interventions

- Supporting sound governance, PBC business planning, and LDP development
- Commissioning services to provide systematic management of long term conditions

Tier 3 PCT headquarter function (commissioning and performance monitoring public health interventions)

- ***Health intelligence:***
 - Assessing the needs of the PCT population using a range of information including local needs assessment
 - Performance monitoring health improvement and demonstrate progress through the DPH annual public health report
 - Developing proxy indicators to performance manage local progress in the national health improvement and inequalities targets
- ***Prevention of poor health:***
 - Produce comprehensive prevention strategies to underpin commissioning of services, the development of Local Area Agreements etc
 - Working in local authorities as the public health champion/advocate and advisers supporting LSP work programmes and developing the Community Plan
 - Overall screening programme quality assurance and performance monitoring
- ***Protection of health:***
 - Developing health protection strategies and policies for the PCT population
 - Agreed SLA and business plan for specialist health protection services from the Health Protection Agency
 - In partnership with the Police, local authorities, and NHS partners ensure that major incident arrangements appropriate and robust
 - Quality assuring child protection arrangements
- ***Provision of health promoting services:***
 - Setting the public health strategic context for practice based commissioning, specialist NHS commissioning, the Local Delivery Plan, Local Strategic Partnerships, Local Area Agreements
 - Supporting the implementation of evidenced based interventions through links with clinical networks, local and national NICE, PH Observatories, and local authorities
 - Supporting the commissioning of evidenced based specialist services
 - Monitoring the implementation of NICE guidelines, National Service Frameworks etc
- ***Quality assuring the public health function and developing public health capacity***

Victoria House
Capital Park
Fulbourn
CB1 5XB

Sir Nigel Crisp
The Department of Health
Richmond House

79 Whitehall

London
SW1A 2NL

21st September 2005

Dear Sir Nigel

Commissioning a patient led NHS

The proposed restructuring of the NHS will have a profound impact on the public health function and the delivery of 'Choosing Health'. The Association of Directors of Public Health executive team have considered the issues, particularly from a PCT perspective and enclosed a short paper for consideration (attached)

Our Association believes it important for the NHS and Local Authorities to understand and develop the role of a Director of Public Health. DsPH should be appointed at Executive Director level to statutory organisations with public health responsibilities for a defined population. As we move toward greater co-terminosity of local authority and NHS boundaries we should provide joint appointments between the NHS and local government.

Commissioning a patient led NHS risks the public health function at commissioning level being split from providers and local neighbourhoods. The tiered approach proposed in the paper will secure integration into local neighbourhood organisations and practice based commissioning. In order to secure an integrated public health function we believe PCTs DsPH need to lead a network of public health practitioners across the different tiers and settings. The DsPH needs to be assured - through commissioned or directly provided services – that the three domains of public health (health improvement, protection and service quality) are secure for their population.

The ADsPH who represent all DsPH across the country would welcome an opportunity to discuss these issues with colleagues at DH in order to make the changes proposed “fit for purpose” and not waste an opportunity for progressive development.

Yours sincerely



DR TONY JEWELL
President

CC Lord Warner – Minister of State for NHS Delivery
Rosie Winterton – Minister of State for Health Services
Rt Hon Jane Kennedy – Minister of State for Quality and Patient Safety
Rt Hon Patricia Hewitt – Secretary of State for Health
Caroline Flint – Parliamentary Under Secretary of State for Public Health
John Bacon - Group Director of Health and Social care services and delivery
Sir Liam Donaldson – Chief Medical Officer
Dr Fiona Adshead – Deputy Medical Officer
Carolyn Regan – Chief Executive NE London Strategic Health Authority
Mike Farrar – Chief Executive West Yorkshire Strategic Health Authority

Tim Crayford - Director of Public Health Croydon PCT
Nick Hicks - Director of Public Health Milton Keynes PCT
Catherine Woodward – Director of Health improvement Telford & Wrekin PCT
Alison Frater – Director of Public Health Bristol North, South & West PCTs
Janet Atherton - Director of Public Health South Sefton PCT
Andrew Clark - Director of Public Health Craven, Harrogate & Rural District PCT
Mike Robinson - Mike Robinson East Leeds PCT
Nigel Monaghan - Local Public Health Director Bro Taf H
Dorothy Moir - Director of Public Health Lanarkshire NHS Board
John Watson - Director of Public Health NHSSB
Simon Tanner – Director of Public Health & Medical Director Hampshire & Isle of Wight, Dorset and Somerset SHAs
Dympna Edwards - Director of Public Health North Liverpool PCT