The Association of Directors of Public Health

Embedding Public Health across Integrated Care Systems

ADPH Recommendations

Equal partners: Local authorities (LAs) and the NHS must be considered equal partners within Integrated Care Systems (ICSs) and be resourced as such.

Whole system understanding is crucial in order for ICSs to function effectively and truly collaborate across the system.

Governance: The governance structures and accountability for ICS partners should be clearly outlined to ensure clarity for all relevant partners.

ICS purpose: There must be clarity across all partners as to what the purpose of the ICSs is beyond the NHS's constitutional pledges.

Long-term focus: ICSs require a long-term focus, prioritising prevention and tackling the causes of health inequalities.

Co-terminosity: There should be co-terminosity between ICSs and LAs.

Prevention targets: ICSs should have a clear target to increase their spend on prevention.

Introduction

Public health is an integral component of ICSs and place-based partnerships.

Local leadership for public health in England sits in LAs with DsPH and their teams. They are ideally placed to work with and across the system to translate evidence into action to address the wider determinants of health and health inequalities. It is crucial that ICSs work with DsPH and their teams and do not develop in parallel.

The purpose of this document is to discuss the enablers and opportunities to effectively engage and embed public health across the ICSs.

ADPH Position

Enablers

Capacity and capability

While the acknowledgement of the DPH role in the Integrated Care Board (ICB) and Integrated Care Partnership (ICP) is welcome, capacity within public health remains a key issue, especially where there are multiple levels of geography to serve. The capacity and capability for public health to act at an ICS regional level must be urgently addressed, with a focus on workforce, as DsPH are keen to be involved with the work of ICBs and ICPs.

To strengthen the public health specialist pipeline and meet the increasing demand for public health specialists – for example, within ICSs – ADPH has previously advocated for an increase in the annual intake to the Public Health Specialty Training Programme. Improved workforce intelligence is also needed to support workforce planning and mobility.

Disparity in resource

The imbalance in resource between NHS and local government and between NHS and public health must be acknowledged. This has previously created tension and will make it difficult for LAs and NHS to be truly equal partners within ICSs. The roles and responsibilities of DsPH and the NHS Directors of Population Health must be clearly delineated, particularly within ICSs.

Whole system understanding

Breadth of experience and expertise is crucial for success within ICSs. Only through a whole system understanding can members of the workforce truly understand how each part of the system can play its part to make an impact. Further consideration is therefore needed around how the public health workforce will be able to move between the different levels of geography and different institutions. Removing bureaucratic barriers, such as loss of continuity of service, needs to be addressed urgently. This will enable ICSs to do what they were established to do and ensure they are truly a vehicle for collaborative working.

Accountability and governance arrangements

The system architecture is complex, with accountability and governance arrangements for the main system partners – LAs and NHS bodies – running through different lines. Further consideration is therefore needed around how the ICB and ICP will work together. This includes how they can be held to account through the different accountability mechanisms for local government and the NHS and how national accountability to NHS England can be balanced with local democratic accountability. The role of elected members on these boards also needs to be considered.

Furthermore, a clear definition is also needed of who is responsible and accountable for the gap in healthy life expectancy (HLE). It is essential that central Government provides the overall strategy, resources and framework, alongside leadership at a local level. Collaborative working between LAs and ICSs and indeed the business and third sectors is also needed in order to progress this.

Reactive vs proactive

Public health is largely proactive in its approach to keeping the population healthy, while ICSs are often reactive. There must be consideration for how these different approaches can be aligned. In addition, ICS colleagues should consider primary, secondary and tertiary prevention as part of their agenda.

Opportunities

Clarity and agreement amongst all partners of the purpose of the ICS

There must be clarity across all partners as to what the purpose of the ICSs are beyond the NHS's constitutional pledges. ICSs must be outward facing and centre around improving health and wellbeing outcomes for the population. There has previously been a concern that partner organisations have focused on their own priorities. Given the impact of Covid-19, there is a risk, for example, that the national

priorities of NHSE (ie getting back on track with elective care, bringing health institutions to financial balance etc) will dominate the resources and focus of ICSs. Although it is strongly recognised that the financial and service pressures are real, it is imperative that ICSs have a shared objective, built on mutual understanding of the population and a shared vision for that place.

Long term focus, prioritising prevention and tackling the causes of health inequalities

The sustainability of the health and care sector will be dependent upon the impact of the wider determinants of health on the population and requires a longer-term focus. ICSs must prioritise prevention, early intervention, and tackling the causes of health inequalities. Prevention and health inequalities must be embedded in all workstreams, with DsPH playing a key role in driving this agenda. The focus must be on outcomes, not processes.

Within ICSs, DsPH must be able to influence across the whole of the place and across all policy areas, this includes budgetary and allocative decisions at the ICB. There are concerns that previously, in many ICSs, the main role for public health has been within a prevention 'workstream' with an artificial separation of prevention from other issues.

Further concerns have been raised that ICSs are setting up their own population health infrastructure, separate from local government public health. If the strategic intention is to have a single integrated approach to a population, then coordination between population health and public health is imperative.

Clarity of responsibilities within the ICS

It is vital that the roles and responsibilities of all partners are understood, respected and resourced. Without clarity of roles and responsibilities within an ICS, it is a challenge to achieve real progress. This also means valuing the role of LAs as an equal partner within the ICS and recognising the different perspectives LA colleagues – including DsPH, Directors of Adult Social Services, Directors of Children's Services and Chief Executives – bring to the table. LA representation is wider than public health representation.

There must be a focus on building a 'team of teams' approach. Understanding each other's team structures and ways of working and establishing shared values, behaviours, understanding, vision and agreements all contribute to this. There must also be clear and equal accountability in order to achieve an effective way of working.

Co-terminosity between ICSs and LAs

Co-terminosity with LAs would significantly ease collaboration and issues around democratic accountability. ICSs are by no means all 'local' with some spanning more than one region and there is potential for disconnect, particularly with the work on wider determinants. The ICS should be orientated to place; a locally led system where the place is central to decision making as well as delivery (principle of subsidiarity and appropriate footprint for action). A shared language of what 'place' and 'neighbourhood' mean is essential to building relationships and shared ways of working.

It is clear that where there is co-terminosity ICSs are taking a more cohesive path and performing more successfully.

A range of models and systems have been developed across the country and, alongside these, different governance arrangements designed to fit the needs of local places. It is important to learn from these

models to identify the most effective arrangements.

Financial transparency on prevention spend in ICSs

There needs to be better monitoring of spending on prevention and a clear commitment from ICSs to increase spending on prevention (eg by 1% a year up to an aspirational target of 10-20%) is vital.

There is also scope for much greater devolution of funding, through place-based partnerships and Health and Wellbeing Boards (HWBs), to support health improvement.

Valuing and recognising existing structures and local assets

It is crucial that ICSs value and use the assets already in place in local communities. Rather than reinventing the wheel and seeking to find new solutions to long standing challenges, ICSs must recognise and build on the work of the voluntary sector and other local partners, including those beyond health and care.

There should also be greater emphasis on HWBs as the basic building blocks within ICSs. Greater clarity is needed on the role of HWBs and their links to ICPs and Place Boards to avoid duplication. Opportunities should be developed for using the Joint Strategic Needs Assessments (JSNAs) to link to resource allocation and inform strategy and policy.

Effective local data and intelligence sharing

Information sharing across the system is widely recognised as a major enabler for the delivery of integrated care. ICSs need to allow for robust and complete data flow across organisational boundaries with geographical granularity and timeliness to support local action and meet the needs of local users including local DsPH. Sharing local data effectively will help ensure the organisations involved can take a targeted, evidence-based approach to designing and delivering services, identifying and reducing inequalities and improving population health. DsPH and their teams have the epidemiological skills to enable the right story to be told.

Hardwired links between NHS public health workforce and DsPH

DsPH as local system leaders for public health must have strong links with public health people employed locally and regionally by the NHS including the Regional Directors of Public Health. This will help to strengthen the response to health inequalities and health improvement, enhance relationships for emergencies and avoid duplication.

Conclusion

Public health is an integral component of ICSs and place-based partnerships. Many of the opportunities for an improved working relationship between public health teams and ICSs relate to workforce capacity and mobility. Workforce resourcing must be addressed in order to continue to involve DsPH and their teams with ICSs and local partnerships. Many of the opportunities of ICSs rely on clarity and understanding of priorities amongst partners. It is therefore imperative that public health teams and ICSs are fully collaborative, not operating in parallel or in silos.

The DPH role

The core purpose of the DPH is as an independent advocate for the health of the population and system leadership for its improvement and protection. As such it is a high-level statutory role bridging LAs, the NHS and other appropriate sectors and agencies with responsibilities for health and wellbeing for a defined population. They have a critical role in leading work on prevention, shifting the focus of systems to prevention where real health and wellbeing gains can be made, and in turn, reducing demand on the NHS.

DsPH and their teams have a deep knowledge of their local population and its health and wellbeing needs. They can provide a whole life and whole population perspective to ensure both population and individual needs are met'. DsPH also provide vital technical skills such as health intelligence, developing an evidence base, epidemiology, and health economics.

This document has been developed with input from the ADPH Board and Council, ADPH NHS, ICS and Social Care PAG and further reflects the results of our most recent ADPH Member Survey. The purpose of this document is to discuss the issues currently experienced by Directors of Public Health (DsPH) and their teams and their key recommendations for Integrated Care Systems. This document has been developed primarily for use by ADPH and our members. Sharing with key external stakeholders is permitted.

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