FPH response to the Government policy paper: Transforming the public health system: reforming the public health system for the challenges of our times (April 2021)

1. ***Are you responding as an individual or an organisation?***

The UK Faculty of Public Health (FPH) is a joint faculty of the three Royal Colleges of Physicians of the United Kingdom (London, Edinburgh and Glasgow). FPH is a membership organisation for approximately 4,000 public health professionals across the UK and around the world and our role is to improve the health and wellbeing of local communities and national populations. We do this by supporting the training and development of the public health workforce and improving public health policy and practice in partnership with local and national governments in the UK and globally.

Securing our Health: The UK Health Security Agency

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

The Government's announcement on the future structure of the public health system comes after a long period of uncertainty. FPH has long advocated the importance of maintaining an integrated public health system across the three key domains of health protection, health improvement and healthcare public health. Therefore, the separation of health protection from other functions raises significant challenges which will need to be addressed.

The most pressing challenge regarding the new UKHSA is the relationship with the devolved nations within the UK and to local and regional health partners. The public health landscapes in Scotland, Northern Ireland and Wales are distinct from the one in place in England and a clear and transparent flow and accountability to and from the new agency and the devolved nations, Regional PH, the ICSs in England and local authority partners needs to be established. How this might be established would be open to debate – a 'memorandum of understanding' may be a suitable vehicle – but clarity would be required before the UKHSA is fully operational.

There also needs to be effective and appropriate access to data and analytics capability; the fragmentation of the public health system risks exacerbating the already significant challenges of accessing data in a way that is free, accessible and timely. The COVID-19 pandemic has highlighted some of the difficulties Directors of Public Health in particular have had in securing appropriate and timely access to data and there needs to be a transparent compact between the various parts of the system on availability of data and information, which might be facilitated by a 'data passport' allowing access to information within the public health eco-system.

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

The separation of the public health functions remains a concern and will present challenges in confronting the many health inequalities that we face today. Public health works best when delivered in a coherent national, regional and local framework and it is essential that the regional and local partners are adequately supported with resources. Following a decade of austerity policies, a 24% real term per capita reduction in the public health grant since 2015/16 and the deep, structural damage inflicted on our communities by the COVID-19 pandemic, a rebalancing of investment from test and trace to other core public health functions is critical. While recognising the resilience of communities and the extraordinary role that local partners and the voluntary sector have played in combatting the worst effects of the pandemic, no-one should underestimate the fragility of the nation's social fabric and the urgent need to invest in this.

As noted above, UKHSA must take a collaborative approach to working with the different tiers within the public health structures. Strong, clear engagement and communication with all parts of the system including the ICSs is critical, to ensure the links between health protection, health improvement and healthcare public health are maintained and strengthened. Any 'silo-ing' of the system and three pillars of public health would be a retrograde step and would lead to a lack of cohesion at local, regional and national levels. An illustration of this is the lack clarity on responsibilities for functions including screening and immunisation, health and justice, and dental public health; our members are reporting significant concerns over the paucity of detail for these functions and we believe the document should set out more clearly where these crucial functions will sit and the reporting arrangements, and similarly for healthcare public health.

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

PHE improved integration around the three pillars of health protection, health improvement and healthcare public health. The splitting of functions under the new system into different organisations has the risk of undermining this integration, so it must be coded into the new arrangements nationally, regionally and locally. While the CMO has clearly had a pivotal role in managing the current pandemic, the future role of the CMO in relation to UKHSA is not spelt out and this needs further clarification.

The new system needs to learn the lessons of the pandemic, rather than simply be reconfigured to address the requirements of the current emergency. The pandemic has illustrated the insufficient capacity currently in the system and this should be addressed now while further work on capabilities is developed. Pandemics are an inevitability and the next one is a question of 'when' rather than 'if', so future arrangements must be geared towards this preparedness. UKHSA will have a key role in training health protection skills across the whole public health workforce; it must have a strategy for this as, although it will be at the heart of the health protection function, it cannot deliver this alone and needs skilled personnel across the whole system.

The pandemic has demonstrated the need for strong international connections. Brexit has weakened the link to the ECDC and whilst exceptions were made in support of the COVID-19 response across Europe, UKHSA will need to have agreed data and information exchange and sharing agreements. We have seen greater collaboration in support of strengthening global COVID-19 sequencing announced as part of the pandemic response and UKHSA will need to build on this support if genomic sequencing is to become part of a more comprehensive global pandemic early warning system.

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

A strong public health system isn't a luxury – beyond the obvious benefit to the individual, good health brings with it huge economic and social benefits that are vital to the country's prosperity. Citizen engagement - listening to, understanding and influencing people - is core to health improvement, and it is crucial that the public have coherent, consistent and complementary communications. Public health has been centre stage for the past year and there exists now an excellent opportunity to communicate to and engage with the UK population. The focus of the UKHSA will inevitably shift over time away from test and trace to future pandemics and longer-term challenges, but at the present time there are multiple priorities to engage with. Given the complexities of the new public health system, and the potential understandable anxiety of vulnerable communities receiving health information from a 'security agency', communications and public engagement should be using all the skills of public health and there needs to be close working together between the Office for Health Promotion and UKHSA. The Office of Health Promotion's 'incubator function' for behaviour change interventions should also be delivered to support UKHSA to avoid risk of duplication from multiple behavioural science teams.

At a more local level, most engagement with citizens should be through local authorities and their public health teams, rooted as they are in their communities and local democratic accountability. UKHSA must therefore seek to build excellent relationships with councils and local DsPH, communicate through them and listen to their understanding of local needs.

Improving our Health

6. *Within the structure outlined, how can we best safeguard the independence of scientific advice to Government?*

The strengthened leadership role of the Chief Medical Officer (CMO) is both welcome and essential. The independence of scientific advice to government is fundamental and the CMO's independence will also help to ensure the effectiveness of the public health system across government and at national, regional and local level. The CMO will need to be ably supported, with a strong, independent team – a firewall effectively – around that individual. Tough decisions will need to be taken on all sorts of issues – for example, on minimum unit pricing on alcohol – and the Office of Health Promotion must have adequate data and analytical expertise, along with data sharing agreements with the NHS to deliver on its health improvement agenda.

A strength of PHE and its governance was the transparency and openness of its advisory board. We look forward to further details on the governance of the Office of Health Promotion (OHP) and would welcome the adoption of guidance on working with, for example, commercial interests where health policy needs a degree of protection. We believe that increasing transparency of decision making is of benefit to everyone in the end.

7. *Where and how do you think system-wide workforce development can be best delivered?*

FPH strongly support the role of the independent CMO as a professional public health leader, spearheading a national, whole system approach to workforce development. This is an opportunity to refresh the national public health workforce strategy ('Fit for the Future') and strengthen workforce intelligence and planning. DHSC should clarify the roles of the organisations involved in workforce development, such as HEE, and resolve long-standing issues such as the blocks to movement between employers. Public health professionals including regional and local DsPH have a

critical role in translating this national vision by training future system leaders and public health specialists, scientists and practitioners, as in the past, as well as providing professional leadership. FPH as a professional membership body is increasingly aware that a workforce crisis is looming in public health and further investment is urgently required, particularly in local public health, and in an increase to recruitment to public health specialty training to ensure there is workforce capacity to meet public health needs in the future.

There is also insufficient mention of academic public health in the policy proposals, and the vital role it plays supporting the evidence base for public health strategies. The system needs secure pipelines and mechanisms of sufficient scale to allow movement between academic and service settings. This will facilitate the evidence generation that is relevant to population health challenges into the future. There needs to be an emphasis on strategic, rather than responsive, investment as a means of ensuring the right skills are in the right place at the right time.

Clarity is also urgently needed on revalidation arrangements, most notably those based in local authorities and those with academic links and honorary contracts. These arrangements are a cornerstone of professional development and continuity must be provided between the previous structures and the new ones.

8. ***How can we best strengthen joined up working across government on the wider determinants of health?***

This pandemic will leave a huge public health challenge in its wake. Last year, England saw the biggest drop in life expectancy since the Second World War, and COVID-19 has exacerbated the deep divide between the health of the richest and poorest in the country. Confronting these challenges will require a coherent vision that aligns the work of all government departments.

The commitment in the paper to joined up working across all government departments is welcome, as is the acknowledgement that health is driven by wider determinants, which are within the remit of all departments, not just DHSC.

Processes will need to be in place to ensure that the new ministerial board on prevention is capable of driving cross-government action on prevention. A new prevention strategy with shared accountabilities across departments should be developed to make a reality of cross-government commitments and a shared set of metrics for the whole of Government are needed to facilitate a joined-up approach. These should also flow across the whole system from national through regional to local level including the NHS as well as local government.

On a practical level, it is important that Government recognises and addresses those interventions only it can take, be it minimum unit pricing or setting ambitions around reductions in inequalities.

9. ***How can we design or implement these reforms in a way that best ensures prevention continues to be prioritised over time?***

The government must address the enormous public health challenges ahead. A new prevention strategy, building on the proposals outlined in the 2019 Green Paper would help focus action on a shared national purpose, tackling health inequalities. The proposed incubator function within OHP, which will deliver behaviour change interventions, has a key role to play and establishing it must be a priority.

Funding remains key. Local authority public health budgets have suffered chronic underfunding for several years, and there has been a £1bn real term reduction in the public health grant. Until there is

a restoration of cuts to public health budgets, and recognition of the return on investment in prevention measures, realising these laudable aims will be an uphill struggle. The Singapore Health Promotion Board has been cited by Government as an example of success for the OHP to model itself on, but its per head investment is more than double that currently in place in England.

A proportion – and it would only need to be a very small proportion – of the UKHSA budget and the NHS budget, channelled through the ICS, should be dedicated to support local authority partners' delivery on health security and health improvement. The power of the NHS budget must be applied to ensure that prevention measures are embedded, and we erode inequalities that risk being further widened.

If the UK wishes to increase its global influence in support of health and health security, the OHP and UKHSA will need stronger global capacity. The pandemic has highlighted the impact of disease on the disadvantaged, and the global threat of a rising burden of NCDs requires collective international action. This is an area which has been inadequately supported in the past and which the creation of dedicated capacity within DHSC has the potential to address.

Strengthening our local response

10. ***How can we strengthen the local authority and Director of Public Health role in addressing the full range of issues that affect the health of local populations?***

The leadership role of DsPH is now recognised in the White Paper, with their presence on both boards within each ICS, but local leaders do not and cannot act in isolation. The DsPH need to be supported in both their health protection and health improvement roles by strong regional and national leadership. The pandemic has demonstrated the interrelationships at local level between health improvement challenges such as obesity, health inequalities challenges such as poor housing, and the patterns of COVID-19 cases, hospitalisations and deaths. The policy paper states the intention to maintain and strengthen the roles of the RDsPH as a system leader to drive joined-up action and maintain systems important at local level such as knowledge and intelligence, which relies on access and availability of data, and strategic workforce support. The interaction between the national, regional and local organisations is critical to a coherent, successful public health.

The DPH annual report and their Joint Strategic Needs Assessment are key responsibilities and provide an audit and overview of the health and wellbeing of local communities and both local government and the NHS should be expected to respond formally to recommendations that DsPH make. DsPH have gained well-deserved recognition for their role in the pandemic. It is important to continuing to strengthen the role of the DPH. They also need to have similar levels of independence to the CMO and be able to advocate in response to the needs of their population.

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

Regional public health teams play a vital role in supporting local systems and leaders, facilitating collaboration, directly delivering health interventions, and helping to inform and translate national policy and priorities. There must be a clear relationship between the national, regional and local public health system. Local and Regional PH teams are well placed to integrate the three domains of public health and provide a joined up public health service. This is more important than ever given the potential fragmentation of public health functions at the national level. Clarity around regional responsibilities is essential to deliver the complexities of public health and each local DPH needs the

support of the system coordinated at a regional level. This will be heavily reliant on the implementation of both the recent White Paper, specifically the successful embedding of the statutory ICSs, and also the prevention Green Paper. Prevention plans at ICS level should provide a framework for a strong set of national objectives with local circumstances, developed in partnership with councils. Finally, at a local level, there needs to be a clear requirement on primary care to address health inequalities and participate in prevention needs if a truly comprehensive local approach to public health is to be delivered.

Public health professionals must be able to get experience in all parts of the system. There is a risk in the current reforms that staff may become functionally and professionally isolated; public health staff need to maintain links with other public health professionals - alongside other parts of the system - and ideally be line managed or at least be professionally managed by another public health professional. These reforms are an opportunity to dismantle bureaucratic barriers to movement between employers, such as loss of continuity of service, to enable a fluid and responsive public health system.

12. ***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 public health system rests on effective working between the different tiers. While national priorities set direction and tone, and the integrity and sovereignty of local DPHs is paramount, the regional public health teams are the 'glue' holding together all the different elements. The regional and local level is where in the new structure the is an ability to integrate the skills and practices of the three domains of public health, together with data intelligence and workforce development. The RDsPH will need to be able to exert leverage; 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, and they will need to be adequately staffed to deliver this role.

The region will also have a key role in hosting knowledge and information teams. The operation of these needs to be clearly set out showing how they will support the functions of the RDsPH and provide the insights and data needed locally, regionally and nationally.

Regions should continue to play a key role in training and appointing future system leaders as well as providing professional leadership – there may be a need for a structured mentoring programme for new consultants as the future leaders of public health.

A strong regional role will help support the statutory ICSs. Each ICS will have an NHS body and a health and care partnership body and with the new challenges of reorganisation there will need to be a systems approach to population and public health within both if resources are to be effectively directed to prevention.