The Association of Directors of Public Health (ADPH)

A New Public Health System

This paper is written to propose a new model for a place-based locally led Public Health (PH) system. It is informed by a recent short survey to ADPH members, discussions with a range of stakeholders and strategic discussions at the ADPH Board.

The reorganisation of Public Health England (PHE) was received by our members with dismay. To destabilise the system mid-pandemic and demoralise already stressed staff was a high-risk strategy and not one that we endorse. However it does give us the opportunity to create a stronger 'local first' system across public health, and ADPH and its members are very willing to provide public health leadership to that system, given appropriate resource and support.

Executive summary

The current public health system has many strengths but the pandemic has highlighted four key fault lines which need to be corrected in any new system: data and intelligence flows; local public health input to national conversations; lack of local health protection capacity; and NHS and local authority (LA) accountability for health outcomes. To enable a better system there also needs to be enhanced interconnectedness between agencies (e.g. NHS and LA) and between footprints and levels: national; regional; supra-local; and local to give a whole system approach. It will also need sufficient funding at local and regional level as well as national.

ADPH is advocating subsidiarity: a locally led system where place is central to decision making as well as delivery; where Directors of Public Health (DsPH) can use their system leadership role to bring partnerships together to improve and protect health using research, evidence, intelligence and a close knowledge of their populations.

To ensure strong assurance to the government we propose a significantly stepped up sector led improvement programme providing both challenge and support. This is the subject of separate joint work with the Local Government Association (LGA) and Society of Local Authority Chief Executives (SOLACE).

We suggest that the structures underpinning this proposal are the following:

- National Institute for Health Protection (NIHP). This must have hard-wired links to public health functions sitting locally and elsewhere nationally. We would advocate that all national data sets sit within the NIHP to avoid fragmentation of health intelligence.
- A significantly expanded Chief Medical Officer's (CMO's) office to enable clear, evidence-based, independent advice across government and to stakeholders in business and industry. The CMO and his team would provide trusted health leadership at a national and international level and delivery of national campaigns.
- Regional public health teams. There are strong regional public health teams within PHE and also well-established ADPH regional networks. Our proposal suggests merging these with further expertise from PHE national to provide a locally led footprint for assurance and 'do once and share' issues. These teams could take on most of the healthcare public health and health improvement functions currently done nationally by PHE. ADPH would lead these collaborative arrangements across the country to ensure expertise and knowledge exchange and reduce duplication.
- NHS. True partnership working between LAs and NHS has been problematic. This must be improved through an understanding of mutual goals and sector strengths. Joint accountability for

health outcomes would be a driver as would further partnerships at Integrated Care System (ICS) level. This is not an either/or situation. The public's health needs a strong NHS working on prevention and inequality and collaborating with an equally strong local government public health sector. Similarly, the DHSC and MHCLG should work jointly to monitor and assure funding for local public health.

- Economic modelling for health. We propose a new organisation similar to the Office of Budget Responsibility (OBR) to undertake independent health economic modelling, monitoring, analysis and advice.

We suggest that these structures will provide the form to amend the flaws within the current system and ensure the functions within the new public health system achieve the best outcomes for the protection and improvement of the public's health.

Background

Much has been written and said about the "wider PH workforce" and "prevention" as well as the mantra that "public health is everyone's business". Directors of Public Health (DsPH) would agree with much of what is said and done to improve these roles but it should be clear that the public's health would not be systematically protected or improved without the system leadership provided at local level by DsPH. This has been startlingly highlighted by the work of DsPH and their teams during this pandemic. Public health is everyone's business but it needs highly trained, skilled and knowledgeable public health professionals to provide system leadership to that wider work. This in turn allows other professionals to use their expertise in their chosen fields to improve and protect health.

There are four major fault lines in the current system which have been magnified in the current emergency. These are largely a result of the lack of interconnectedness between different organisations exemplified in the difficulty achieving mobility around the system for public health staff. We have the opportunity to address these in the new system architecture.

The first and most obvious has been the lack of data and intelligence flows between national and local. ADPH with others have been highlighting this issue since before the reforms of 2012. DsPH need the widest possible data and intelligence to ensure appropriate action. There are huge amounts of data available but access to quality intelligence is often problematic. A lot has been achieved in the last few months with the added urgency of the pandemic. We must ensure that these flows – between organisations, national to local and local to national – are strengthened and hard-wired into the new system.

The second is the lack of a local public health voice at national conversations about health. This has been corrected in the current interim pandemic arrangements bringing huge benefits. We must ensure that the National Institute for Health Protection (NIHP) in particular has strong local connections built into its governance, as well as public health professionals with local authority DPH experience at the highest levels within its staffing.

Third, when the Health Protection Agency (HPA) was formed (2003) the impact was that local health protection expertise was drawn to the centre. When the HPA was subsumed within PHE there was a closer connection with local teams but it remained the case that expertise in DPH teams, and the levers to protect the health of their populations were downgraded if not lost completely. This too needs to be corrected in the new system. Health protection is a local necessity as well as a national priority.

Lastly, we would argue that both local authorities and the NHS should be more accountable for health outcomes and in particular health inequalities. The way to tackle this is as a system, having closer relationships at national and local levels which recognise the strengths of both sectors. Of-course, the NHS

and Social Care should do more on prevention but inevitably that is targeted on secondary prevention and rarely looks at social, environmental and commercial factors. In England, DsPH sit within upper tier and unitary local authorities which has given them influence over those wider determinants of health. This is the correct positioning and puts them closer to their populations. The risk of this arrangement has always been that the links with the NHS (straightforward when public health was part of the NHS) would be loosened if not broken and this has proved true in many places. In correcting the fault of not being close enough to local government some DsPH now find they have little connection to the NHS. The new system must alter that by a stronger systemic - not structural - relationship and without losing the advantages of local authority based public health teams.

Place-based locally led public health

The importance of place and particularly the need to listen to and work with local communities to build places where everyone has the same opportunities to lead a healthy and prosperous life has never been stronger. Based on the community needs and priorities, place-based public health provides a focus on the upstream drivers of health outcomes such as: poverty; discrimination; green spaces; housing; safe streets etc.

The transfer of DsPH and their teams back to local authorities following the 2012 Act was an essential step in delivering place-based public health and the reorganisation of PHE provides an opportunity to further this by transferring more public health functions to local authorities.

Local public health teams are closer and more responsive to the needs of the communities they serve. By working in partnership with these communities as well as a wide range of system partners, including the NHS, social care, police, fire service, housing services, planning teams and schools, they can deliver real and sustainable change.

ADPH recognises that some functions may be more effectively delivered on a larger (supra-local or regional) footprint. However, this supra-local function should be developed bottom up with local authorities coming together in an appropriate footprint. The success of this approach has been proven many times, for example, Thrive (a pan-London initiative to improve mental health and wellbeing) and Fresh (a dedicated regional programme set up in the North East to tackle the worst rates of smoking related illness and death in England).

Greater local public health responsibility must be complemented by national action, with stronger and more influential public health expertise. In addition to developing national policy and strategy this must provide independence of voice and leadership.

The DPH role

ADPH has described the role of the DPH which has remined broadly stable for well over 150 years. It isn't a job description but details the purpose, qualities, functions and deliverables. This role has not altered markedly even though accountabilities and specific responsibilities have changed over time. We do not propose a deviation from this role but a strengthening of it to capture the higher profile and performance demonstrated during this pandemic.

The new system will require high quality DsPH capable of exceptional system leadership; innovative thinkers as well as experts in technical analysis; pragmatists and collaborators. To enable the proposed system architecture, the DPH will need to collaborate with their peers and explicitly take responsibility for improving their practice through sector-led improvement (SLI). They will need to accept challenge around outcomes and whole-heartedly join with partners to build a local, supra-local and regional public health

system capable of tackling local health deficits as well as protecting their populations from health threats. National health organisations will need knowledge of local conditions and DsPH will be required to contribute nationally to enable a truly whole system approach. Consideration should be given to reintroducing short-term part-time secondments to national bodies (DHSC; NIHP; CMO's office etc) as was business as usual before 2012. In return DsPH will need support and assurance as detailed below.

The role of Regional Directors of Public Health (RDsPH) is by no means a new one. Indeed, ADPH was formed from the merger of County and District Medical Officers associations. With the 2012 reorganisation the RDPH role lost any performance management of local DsPH and became much more a support function which is highly valued. Very recently the role has also included a place on the regional NHS Board. This is regarded as a positive step towards stronger links between public health and the NHS. From the local viewpoint the downside has been that the agenda for regional teams has been driven by national rather than local, supra-local or regional priorities.

The new system will need these regional roles (and their teams) and we propose that RDsPH would have a triangular responsibility: LA/NHS/NIHP. Their main agenda would be set locally and regionally. They would continue to have a seat on the regional NHS Boards and would also have strong links into national organisations such as NIHP and the CMO's office. They could for instance host the regional health protection teams.

What DsPH need

From the system as a whole:

- continuity through transition – vital particularly during COVID - with no loss of expertise;
- clear accountability (who, where and what) for population health outcomes;
- assurance of close collaboration with devolved administrations and strong links to global health;
- governance of NIHP and other national health organisations including the local authority voice;
- interconnectedness across the whole of the public health system: local - regional – national; organisations – sectors – professions. This includes the ability for PH professionals to move around the system for employment;
- subsidiarity - appropriate footprint for action with authority to deliver for maximum effectiveness and efficiency;
- a place-based approach to population health policy and practice;
- system leadership at local as well as national level;
- sufficient funding at all levels of public health. In particular increased funding for local teams;
- access to robust and complete data and intelligence across organisational boundaries;
- access to quality research, evidence and knowledge and strengthened ties to academic public health;
- DsPH should sit within local government in order to more effectively tackle the wider determinants of health and improve and protect community health;
- A strong national sector-led improvement offer to provide support, challenge and assurance;
- Public Health having the authority to advocate on behalf of the health of the population.

Within their place:

- a well-resourced budget to ensure sufficient expertise to provide system leadership to protect as well as improve the health of their local populations;
- high-quality professional public health expertise including Consultants and practitioners with

knowledge and experience in health protection as well as health improvement and healthcare public health;

- trained and experienced public health analysts with knowledge of epidemiology and wider public health to ensure availability of wider local intelligence to inform decisions;
- access to robust quality national data and intelligence (comprehensive and complete) to ensure local work is closely linked to national work and without duplication;
- influence across the local authority (including direct access to Councillors and the Chief Executive) to act on urgent issues to protect and improve the health of their populations;
- access to surge capacity for outbreaks or emergencies including regional health protection teams, NHS staff and services and wider deployment of resource through Local Resilience Forums;
- leadership of scarce PH expertise (such as dental public health) shared across bigger footprints;
- strong local and regional sector-led improvement programmes providing support, challenge and assurance;
- close ties with PH expertise within the NHS and other national organisations;
- interconnectedness between organisations across the place. In particular strengthening the local links between local authority public health and the NHS;
- mechanisms for local public accountability for health including a strong Health and Wellbeing Board.

Accountability

ADPH recognises that greater local responsibility for public health must be accompanied by clear accountability for population health outcomes. This should be first to their local populations but also nationally to Ministers.

Sector Led Improvement (SLI) has been agreed between national and local government as the key way to undertake quality assurance for local public health. A strengthened and transparent SLI process would not only provide this assurance but also continue to drive innovation and improvement by both challenging and supporting local and regional teams.

SLI needs to be accompanied by robust outcomes data with responsibility for some outcomes shared with partners such as the NHS. This would help to focus partnership attention nationally and locally on public health and support accountability to the population through local elected leaders. Accountability should be through existing structures such as Health and Wellbeing Boards with the creation of an equivalent national Population Health Partnership Board.

While most SLI processes would be triggered through routine monitoring and aim to identify and act on issues well before they become apparent in outcomes, SLI processes could also be triggered based on the outcomes data and/or significant concerns from politicians or other parties. For example, the Suicide Prevention SLI Programme which combines a range of measures such as a self-assessment exercise, regional exercises based on priorities and national masterclasses, was developed by the sector in partnership with national politicians, suicide prevention groups and academic experts. This model could be used to provide assurance nationally.

Structures

National Institute for Health Protection (NIHP)

We believe that the new NIHP will bring a welcome addition to the public health system bringing greater

capacity and programme management to health protection issues. The inclusion of the Joint Biosecurity Centre is also welcome bringing together a wide range of data and information to provide national intelligence on threats.

This does not detract though from our major concern, that public health should not be split into its constituent parts. What will be important is that NIHP has sufficient public health expertise to ensure a public health approach to their work and also that they work closely with the other PH functions (wherever they sit) at local, regional and national levels to inform their work.

This pandemic has shown that the impact of infection falls differentially on populations and that most of this variation is caused by wider risk factors (eg obesity) and determinants such as employment, housing etc. This highlights that health protection cannot be isolated; NIHP will need the knowledge and expertise of wider public health in order to maximise benefit.

This is particularly true for data and intelligence and we propose that, like Germany's Robert Koch Institute, NIHP undertakes all national surveillance and data collation across all health domains. This should include the cancer registries. Access to this intelligence will be necessary at local level and it is vital that the improvements made over the last few months are maintained and strengthened to allow robust and complete data flows to support local action.

CMO's office

It is often stated that the DPH role is in many respects the local equivalent to the CMO role at national level. They both provide system leadership and trusted independent advice to politicians and the wider executive. In the not too distant past the CMO's office was significantly larger and provided a wider range of public health advice and challenge as well as the CMO being the head of the public health profession.

In our view it should now take back those national advice and leadership functions that currently rest with PHE. These should include: advice to government and parliament; public leadership for health; global and international links; research and evidence reviews; national campaigns and industry liaison (eg for reformulation). This would of-course necessitate close ties with NICE, NIHR, and relevant government departments. The CMO and an expanded team would be well-placed to undertake this liaison.

Regional teams

PHE regional teams are led by the RDPH and cover the breadth of public health functions as well as workforce development and local support to DsPH and their teams.

ADPH also has fully functioning regional DPH Networks that cover the 9 LGA regions (old PHE regions). Some of these also work at sub-regional level – particularly where there are combined authorities or equivalent. They currently have SLI programmes coordinated by ADPH nationally and reporting to the ADPH SLI Programme Board (which includes LGA and PHE representation). They provide peer support and challenge to improve public health practice. The networks also have leadership over communities of practice (eg for health improvement topics) and often host other regional collaborations. Several regions use the network to commission across bigger footprints. ADPH networks are however hampered in their work by a lack of funding and rely on end of year small grants and small pooled contributions from their PH budgets. Some have relied on coordination from PHE.

We propose that the PHE teams are merged with the ADPH networks. With sufficient resource, they could form the footprint for assurance of local and regional functions, using a stepped up more challenging SLI mechanism (jointly with LGA). Staff transferred with or appointed to the functions would be local

government hosted by one authority on behalf of the region. ADPH should be funded to co-ordinate work across the country to ensure 'do once and share' processes and lead the Public Health SLI Programme Board to provide structure and challenge and report impact. Where appropriate the networks could decide to drop certain functions to sub-regional / supra-local levels to suit local place-based arrangements. This is similar to the regional collaborative model used by ADASS and ADCS. These regional teams/networks could support local policy and outcomes and also supply public health surge capacity in the event of emergencies; something that is needed locally as well as nationally. They would also manage the regional Knowledge and Information Teams (currently in PHE).

We further suggest that these regional networks led by the RDPH with local DsPH could undertake many of the health improvement and healthcare public health functions currently under the PHE national remit. As well as work addressing risk factors such as tobacco or obesity, this could include national workforce development, do once and share issues such as guidance etc. Most of these functions could be undertaken on a regional lead basis. That is, one region would take on the lead for the whole country and share its work. ADPH would coordinate this knowledge and expertise exchange model and disseminate outputs. This model was used successfully by the Association of Public Health Observatories from 2000 to 2012.

This model would be a locally led solution using a subsidiarity approach which with the three-way joint RDPH could provide enhanced links across to NHS and up to national. They could also provide stronger ties with academic public health which has been diminished in some places since 2012.

NHS and other clinical services

Local Authority (LA) commissioned services

ADPH has welcomed and participated in previous conversations about improving outcomes for services commissioned by LAs, in particular, the commissioning review of sexual health, health visiting and school nursing triggered by the NHS Long Term Plan. The result of this review was a clear endorsement of LA commissioning along with the recommendation for closer alignment with the NHS.

Local authorities remain well placed to commission these services in the context of integrated early years and public health services and strategies and in ways which ensure links to other council responsibilities. DsPH are ambitious about improving public health services and (with the right resources) about taking on more public health functions as detailed in this paper. Further talk of returning services to the NHS is an unhelpful distraction. We need to focus on working together to join up services.

Links with NHS

Public health has always been important within the NHS. That is why it was moved from local authority control in 1974. However the recognition that only around 20% of health outcomes are affected by the NHS led to the successful transfer back to LAs after the 2012 Act. It remains the case that there should be public health action within the NHS and we regard it as a positive trend for the NHS to employ more public health professionals.

Recent changes in the NHS have seen the emergent Integrated Care Systems (ICSs) taking on a wider approach to health with a prevention remit and in many cases true local authority engagement. However in NHS led partnerships there is clearly an emphasis on secondary prevention and treatment rather than the primary prevention and protection championed by LA led public health. These are not opposing sides and must work together as a local and regional system to get the highest health gain across the population. It is important that this co-dependence for health and well-being between NHS and LAs is recognised and strengthened with DsPH taking a full role in ICSs and NHS working closely in health and well-being partnerships led by LAs.

In some areas DsPH have Consultants who work in their local NHS Trusts. This is a strong model and we would like to see more joint appointments at Consultant level. In all cases public health professionals working within the NHS must have close working relationships with their local DsPH.

Section 7a

Section 7a functions are commissioned and delivered by NHS but with assurance and staffing from PHE. Some of these functions (Child Health information Service, sexual assault services; health in secure and detained settings) would be more suitable to be commissioned through the above locally led arrangements).

Screening and Immunisations & Vaccinations (I&V) are exceptional in being highly technical universal public health protection programmes which would need to continue to be delivered by the NHS. We would strongly argue that commissioning and delivery should be separated to provide accountability particularly around maintaining the high levels of take-up necessary. Whichever way they are structured, there needs to be closer links with local DsPH who should provide oversight, support and challenge for their local population, particularly around take-up.

There is an argument that I&V should be commissioned locally since the delivery is largely within primary care. ADPH members would consider this but would be content if it is felt that it should sit within the NIHP. In either case there would need to be particular expert public health advice and quality assurance independent from delivery.

The expertise provided by the independent National Screening Committee is essential in providing credibility to the screening programmes and advice across the four UK countries. ADPH strongly believes that this should be seen to give independent advice to commissioners and delivery. We suggest that it could sit within a strengthened CMO's office.

The commissioning and quality assurance programmes for screening should again be separated from the delivery and so ADPH would suggest these should sit in NIHP.

Other national functions

Whilst we propose that most healthcare public health and health improvement functions are locally led (using the regional knowledge and expertise exchange model) and some national functions should be led by the CMO's office, there are others that in our view should sit elsewhere:

- national surveillance, data collation and monitoring - NIHP as above;
- grant monitoring & accountability and financial assurance - jointly with DHSC and MHCLG;
- Health economic evidence and modelling – an independent organisation such as the Office of Budget Responsibility (OBR). This could then provide trusted expert advice on the economics of health.

Conclusion

We welcome comments and questions on this proposed model which would obviously need much more detailed design. ADPH would be happy to work with others to ensure there were no gaps or inconsistencies. The important thing for everyone in public health is to get a new system that works for the public's health.

We see this model's strength as supplying a locally led nationally assured system rooted in place and making best use of scarce expertise, able to tackle wider determinants but also deal with emergency situations such as the current pandemic.