



Future Forum, phase two: Public health

Royal College of Physicians' response

28 October 2011



1. About the Royal College of Physicians (RCP)

The Royal College of Physicians (RCP) has been at the forefront of improving healthcare and public health since its formation in 1518. The RCP plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. As an independent body representing over 25,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

The RCP continues to play a leadership and advocacy role in relation to public health. As well as delivering seminal reports on public health-related issues, such as tobacco, the RCP coordinates the Alcohol Health Alliance UK. The RCP is currently undertaking a range of public health-related activity, including on the social determinants of health, sexual health and alcohol. An RCP working party, *Obesity care for all*, is due to publish its report in early 2012.

The RCP's vision for how doctors can contribute to public health and reducing health inequalities is set out in *How doctors can close the gap: Tackling the social determinants*, a copy of which is included with this submission.

The RCP also hosts the UK Faculty of Public Health (FPH). The FPH has submitted its own detailed response to the Future Forum.

2. Introduction

The RCP welcomes the Future Forum's focus on public health. The future viability of the National Health Service (NHS) depends on an effective, coordinated approach to public health, nationally and locally. Only through long-term strategies, investment and integrated action across all three domains of public health (health improvement, health protection and healthcare) can we reduce the burden of disease, disability and dependence caused by health inequalities, non-communicable diseases caused by smoking, obesity and alcohol misuse, and morbidity levels in an ageing population.

Tackling health inequalities, improving health and wellbeing, and protecting communities and individuals from harm rely on a coherent long-term vision and coordinated action across organisations, from central government and councils to hospitals and charities. This means adopting a joined-up approach to health improvement, protection and healthcare, and to the planning and provision of primary, secondary and tertiary care and local authority functions such as social care, housing and planning.

Secondary care specialists and public health doctors are crucial, providing specialist knowledge and expertise on clinical issues and population health.

Individuals have a responsibility for their own health, supported by health and other professionals who can empower them to change unhealthy behaviours through targeted interventions. Education and health promotion targeted at individuals must be complemented by a broader population view and national leadership and action, including the introduction of legislation where appropriate.



3. Summary of recommendations

The RCP's response to the Future Forum's public health workstream emphasises the following points:


- Government's proposed changes to the public health infrastructure should give greater recognition to the 'health service' aspect of public health, including the role of hospital doctors and secondary prevention services. Local government leadership and multiprofessional working in relation to public health is important, but public health must also retain its medical links.
- There should be explicit mechanisms to ensure secondary care doctors and public health specialists are involved in the planning and commissioning of public health and healthcare services, with input into clinical commissioning groups (CCGs), Health and Wellbeing Boards (HWBs), Public Health England (PHE) and the NHS Commissioning Board (NHS CB). We welcome the place for secondary care specialists on the boards of CCGs.
- There must be clear lines of accountability and responsibility across the health, public health and social care systems. This includes ensuring that directors of public health are expert, influential and independent.
- The movement into local authorities must not result in directors of public health losing access to valuable data and resources (eg NHS data systems).
- It is crucial that valuable public health expertise is not lost in the transition and that an authoritative, influential, resilient, multidisciplinary profession working across the three domains of health protection, health improvement and healthcare services is maintained. This includes making public health an attractive option for medical professionals. To ensure public and profession confidence, public health training should continue to be organised and provided alongside that for other medical specialities with similar arrangements for recruitment, standard setting and quality assurance.
- There should be more opportunities for doctors and doctors in training to gain a broad base of expertise relevant to public health. This could include, for example: encouraging rotations in other environments and settings, such as local health protection units, provider trusts, local authorities; more English medical schools offering a joint MD and Master's in Public Health (as offered at Harvard Medical School); embedding population health into medical education and training, and; including additional public health training in the GP specialist training programme.

4. Public health and health services

Ensuring the health and wellbeing of people, protecting their health, and reducing health inequalities is dependent on an effective and robust public health system that integrates each of the three domains of public health: health improvement, health protection and healthcare. The RCP is pleased that the Future Forum is focusing on how the full range of professions and organisations can work together to address health inequalities and improve population health outcomes.

Although there should be flexibility to tailor programmes to suit the needs of local populations, there will clearly still be a need for a national programmes, service frameworks and coordination, eg for alcohol consumption and smoking. Public Health England (PHE) will need to play a role, and will need to work closely with local public health teams, the NHS (including the NHS Commissioning Board), local authorities and clinical commissioning groups, and across the devolved administrations, to improve and plan for the public's health.

There is a risk, particularly with greater public health responsibility being given to local government, that there will be a dislocation of 'medical' and 'public' health. To avoid this, it is vital that the knowledge



and ability of hospital clinicians and others to influence good public health and to improve public health planning is not lost in this reorganisation. Hospital doctors have the expertise in their own specialties to work with GPs and other colleagues to promote:

- quality, integrated care for patients, including those with rarer/ complex conditions and co-morbidities.
- effective use of service, clinical and research data to identify need, clinical effectiveness, capacity and potential efficiencies.

Public health expertise is needed to assess risks to health and trends in ill health, for example: assessing the risks of alcohol to young people; trends in common cancers and addiction, and; recognising the benefits of new drugs. Public health expertise has devised new risk stratification for the treatment of heart disease and identification of people at highest risk from diabetes, alcohol problems or frequent admission to hospital.

4.1 Integration

To ensure an integrated approach to the public's health, secondary care specialists and public health doctors must be integral to commissioning and service planning arrangements at a national and local level.

Locally, specialist doctors will bring their experience and knowledge of secondary care and the hospital environment to the table, working with GPs to challenge existing practice where it does not deliver good outcomes for patients, and to promote innovation and high quality joined-up services across primary and secondary care. At a national-level, the NHS Commissioning Board should be required to work with the RCP on how to raise quality throughout the NHS in England. Likewise, clinicians of all types should be advisors to Public Health England in the same capacity.

The RCP has identified the following routes for secondary care and public health involvement in the proposed new health service structures:

i. **Clinical commissioning groups**


Secondary care doctors and public health specialists should have a place at the highest governance level of clinical commissioning groups (CCGs), with access to wider networks of clinical expertise. The RCP is pleased government recognised the importance of this in their response to the Future Forum's last report¹. Public health specialists should also be involved at the highest level.

ii. **Health and Wellbeing Boards (HWBs)**

Hospital clinicians should have a mandatory role on HWBs, alongside the director of public health. Other specialists should be called upon to advise as appropriate, with HWBs linking up with clinical senates and networks. Specialists should be involved in:

- analysing and interpreting data
- preparing Joint Strategic Needs Assessments
- setting local priorities via the Health and Wellbeing Strategy
- assessing if commissioning groups reflect local priorities in commissioning plans

¹ Department of Health. *Government response to the NHS Future Forum report*. London: Department of Health, 2011. [Government response to Future Forum](#)



The RCP also welcomes the government's announcement that it will promote the coterminosity of CCGs and local authorities.

iii. **Public Health England (PHE)**

Clinicians of all types should be advisors to PHE.

iv. **NHS Commissioning Board (NHS CB)**

Primary care and services for rare conditions will be commissioned by the Board. Specialist doctors and public health specialists must be integral to national commissioning decisions. Specialist services must be part of a total integrated pathway of care and not allowed to operate in isolation.

v. **Foundation and NHS Trusts**

The RCP also recommends that there are cross-representation appointments within providers, with GPs on trust boards and public health specialists across the system.

The RCP has suggested a number of specific amendments to the Health and Social Care Bill 2011² that would help to enshrine a number of these recommendations in legislation.

4.2 Commissioning of medical services by local government

The RCP's Joint Specialty Committee (JSC) for genitourinary medicine (GU medicine) has highlighted that sexual health services (GU medicine and reproductive health/community family planning) will be commissioned by local government.

It is vital that the money currently used to fund GU medicine services (and other service transferring from NHS to local government commissioning) is correctly identified and transferred across to the local authorities. Similarly, it is crucial that, given the financial pressures faced by local government, these services receive the necessary protection (ie that the ring-fencing of monies for sexual health is robust).


The RCP understands that local authorities will not need to commission health services according to national tariffs. It is unclear whether this is intentional or an oversight, and needs further clarification and exploration; it must not undermine current initiatives to integrate sexual health services (ie GU medicine services and reproductive health/ community family planning).³

4.3 Commissioning of uncommon conditions

There will also need to be proper consideration is given to the commissioning arrangements for 'uncommon conditions'. Access, and equity of access, to such services are also a core component of an effective public health service. Facilities such as a trauma centres, or severe burns units, and conditions such as immunodeficiency, haematology, and haemophilia require a critical mass to be cost effective

² Royal College of Physicians. Briefing for House of Lords committee stage: Health and Social Care Bill 2011. London: RCP, October 2011. [RCP proposed amendments to Health and Social Care Bill 2011](#)

³ Part of the national agenda for sexual health services for some time has been the need for integration between GU medicine services and reproductive health/ community family planning. At present, GU medicine is paid on the payment-by-results system, whilst reproductive health/ community family planning services remain on block contracts. To address the negative impact this has on integration, London sexual health commissioners have been developing an integrated sexual health tariff structure (due to be introduced in April 2012) with the assumption that it would then be subject to further roll out. The impact of the transfer to local government of GU medicine commissioning on this work must be assessed.



and are therefore currently commissioned on a regional basis. Clinical commissioning groups and the NHS Commissioning Board will need to work together to commission these services.

At present, the route for tertiary clinicians, such as the leading heart or tropical medicine hospital specialists, to influence public health has not been made clear. To be effective, the RCP believes that this must be (predominantly) at a national, rather than local, level. Although a tertiary specialist unit might be based in a local area, the knowledge of its specialist staff will be of national significance as its patients will come from across the region or, in some cases, the country.

4.4 Multiprofessional teams

The RCP, along with other medical royal colleges, supports ‘teams without walls’, an integrated model of care, where professionals from primary and secondary care work together across traditional health boundaries to manage patients using care pathways designed by local clinicians⁴. This encourages a more comprehensive approach to prevention (eg by considering both primary and secondary prevention as part of the service commissioning process) and encourages all partners to contribute to a holistic prevention agenda.

The importance of including secondary prevention (eg the provision of multidisciplinary alcohol care teams to work across primary and secondary care) in the delivery of public health services must be recognised. Multiprofessional working is particularly important for primary and secondary prevention and treatment services in relation to, for example, alcohol and obesity.

An RCP working party, *Obesity care for all*, is currently exploring how we could design and deliver more holistic services for people who are obese, and will report in early 2012. An outline of the need for multidisciplinary working in alcohol-related care and treatment is included as an appendix to this submission.

6. Access to health service data and expertise

6.1 Data and information

Councils will often be best placed to design services and deliver programmes that best meet the needs of communities. However, the movement of many public health functions from Primary Care Trusts to local authorities must not result in the directors of public health (DPH) losing access to valuable data and resources (eg NHS data systems). Likewise, links with local health service structures and the workforce must be retained or, indeed, strengthened. The DPH will need to ensure robust arrangements for seeking input and advice from colleagues working in primary, secondary and tertiary care.

The new system must ensure that there is access to timely, reliable, appropriate and relevant public health information and intelligence to inform decision-making and service planning. Understanding the health and wellbeing needs of local communities requires in-depth analysis and assessment.

Public Health Observatories (PHOs) are vital in providing this important function. A reduction to the capacity of PHOs will have serious implications for the collation, assessment, analysis and provision of essential public health intelligence. Public health observatories should be retained and, working closely with PHE, could play a crucial role in:

⁴ Royal College of Physicians, Royal College of General Practitioners and Royal College of Paediatrics and Child Health. *Teams without Walls: the value of medical innovation and leadership*. London: 2008

- gathering reliable information essential to the understanding of health needs
- undertaking modelling of future scenarios and assessment of impact and efficacy
- evaluating the effectiveness of local initiatives with different delivery methods
- gathering and disseminating examples of good practice
- providing a comprehensive and detailed understanding of their local population, across all three domains of public health
- coordinating longitudinal studies

Public health interventions delivered as part of local initiatives may not have the longitudinal, size of population, control or randomization processes, or rigour of design or evaluation, to allow us to determine their effectiveness. Steps will need to be taken to ensure that localism does not lead to public money being spent without meaningful evaluation metrics. Strong (but streamlined and non-bureaucratic) mechanisms for gathering information on outcomes and the effectiveness of interventions and initiatives must be introduced. This will enable local bodies around the country – including local government, health organisations and the voluntary sector - to take advantage of each other's experiences and expertise. Public Health England will need to play a role.

6.2 Expertise


The RCP believes we must ensure that all doctors identify opportunities to empower all patients to manage and take responsibility for their health, taking into account their social and physical environment. This includes encouraging patients from marginalised groups to access health information, screening and health promotion services. As the government's public health white paper notes: "[the creation] of PHE must not lead to the NHS stepping back from its crucial role in public health"⁵.

The RCP believes an expert, influential and independent director of public health, supported by robust data analysis and outcome monitoring systems, is essential. The DPH must be able to act as the 'voice' of the local community, including disadvantaged groups and children, and have influence across all aspects of local authority work and throughout the local health economy. To achieve this, the DPH must have direct access to the council's cabinet, councillors, chief executive and directors, and manage the ring-fenced public health budget. The DPH must be seen as the strategic leader for public health in their area providing, through their annual report, independent analysis of local needs and performance. To ensure the DPH has the skills and experience needed for this expert and specialised job, we believe that they (and all public health professionals) should be subject to statutory regulation.

The new system must empower all doctors to take a lead in addressing health inequalities. In order to deliver and design the local public health system effectively, the DPH must have appropriate support from public health specialists and practitioners, as well as professionals across a range of other areas, including secondary and tertiary care. The Faculty of Public Health has identified that the areas in which the DPH will need to be able to access public health expertise include:

- medicine
- epidemiology
- service commissioning and decommissioning
- service provision and effectiveness
- dentistry
- health protection
- health promotion and behaviour change
- sexual health

⁵ Department of Health. Healthy lives, healthy people: Our strategy for public health in England. London: DH, 2010

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- child health
 - mental health and
 - workplace health

Robust mechanisms must be in place for ensuring that public health competence has been obtained and is maintained by staff in all these areas. The DPH will need to ensure they put in place robust arrangements for seeking input and advice from colleagues working in secondary and tertiary care.

PHE should make use of the existing public health specialist workforce currently working in Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) so that valuable expertise is not lost. Expert PHE staff could be seconded to local authorities and clinical commissioning groups.

7. Education, training and expertise

7.1 Regulation of public health professionals

It is essential that public health specialists, including each DPH, are trained and registered to specialist level in public health.

7.2 Medical education and training


To ensure public and profession confidence, public health training should continue to be organised and provided alongside that for other medical specialities with similar arrangements for recruitment, standard setting and quality assurance. It is important that public health continues as a speciality that is attractive to doctors.

- English medical schools should examine the option of offering a joint MD and Master's in Public Health (as offered at Harvard Medical School); all medical students should study a population health course.
- additional public health training should be included in the GP specialist training programme
- rotations in other medical environments should be incorporated into the training process for specialists and public health specialists, with sufficient flexibility in the medical training programme to enable this; the range of training placements should be increased to ensure trainees gain experience in all relevant settings
- greater consideration should be given to how the continuing professional development of healthcare professionals could take better account of non-communicable diseases such as obesity, the medical complications of which are seen across a number of medical specialities.

7.3 Public health research

High quality public health teaching and research, addressing all three public health domains, are crucial to the success of public health. Our reputation for epidemiological research should not be threatened by a fragmented system (councils, in particular, do not have a strong research tradition), and our 'practice' research capacity should be developed. Appropriate funding will be required to ensure that the evaluation of evidence and research in public health is not sidelined during the current financial climate.

8. Funding



There must be sufficient funding to provide effective and sustainable public health services. Government has allocated 4% of the total NHS budget to public health, which it estimates at approximately £4 billion. The RCP believes the £4 billion figure underestimates the resources needed to achieve the government's wide-ranging vision for public health, and represents a significant cut to funding. The figure does not take into account a range of costs (eg overheads, on costs, etc) and money will be deducted for various activities (eg Health Protection Agency, public health and GP screening) before the it reaches councils.

There must be clarification of exactly what services are intended to be funded from the ring-fenced budget, and how funding will be split between the various public health functions, including PHE, the NHS and councils. These functions must be clearly defined to enable a robust assessment of the ring-fenced budget, calculated from a realistic baseline that considers activities across all three domains of public health. There must be sufficient funds to support the transition of public health teams and DPHs to councils, and projects that have not yet been rolled out, such as health checks.

It is vital that the ring-fenced budget is not seen as the only budget for public health. It must be clear that the ring-fenced money is intended only as a *core* budget intended to protect a clearly defined set of core services.

Measures must be put in place to ensure that localised funding does not lead to *unjustified* variation in services at a local level. This necessitates clear lines of accountability, robust data collection and analysis mechanisms, and valid indicators and outcomes.

Supplementary documents

[RCP response to the Health Select Committee inquiry on public health](#)

[RCP response to the public health white paper](#)

[Alcohol Health Alliance response to public health white paper](#)

RCP policy statement - How doctors can close the gap

RCP working party report - Future Physician



Appendix

Example: The need multidisciplinary care – alcohol

(Edited extract from Alcohol Health Alliance UK's response to the public health white paper)

Secondary prevention has an important role to play in improving the outlook for people with, for example, existing alcohol-related ill health and dependence. The need for integration and coordination is very apparent in the care of patients with alcohol-related ill health. Greater coordination between all organisational levels involved in public health delivery - existing and proposed - is required to deliver the outcomes desired.

Local authorities should commission alcohol services that include a full spectrum of partners. This would be the best way to ensure integration. It is essential that alcohol care teams have components from psychiatry, gastroenterology and specialist alcohol support/counselling services. If local authorities commission alcohol services, then they should require these components are part of the service plan.

Implementation of properly funded programmes of detection, intervention and treatment of harmful drinking and dependency are required as outlined in the joint BASL/BSG/Alcohol Health Alliance 2010 document *Alcohol related disease: Meeting the challenge of improved quality of care and better use of resources*⁶. The establishment of multidisciplinary alcohol care teams which operate across primary care, secondary care and community care is advocated in the proposals. The proposals recommend:

- establishing a multidisciplinary Alcohol Care Team, led by a consultant
- establishing a seven-day alcohol specialist nurse service to ensure care, including brief interventions and appropriate follow-up, for patients within 24 hours of admission, when patient engagement with services is highest⁷
- establishing coordinated policies of care in A and E and acute medicine units, which include alcohol specialist nurses, liaison with psychiatry and alcohol link workers' networks
- establishing an assertive outreach alcohol service to provide more appropriate medical, psychiatric and social follow-up care for the most frequent attenders and biggest consumers of hospital resources
- integrated alcohol treatment pathways (ATPs) between primary and secondary care to help drive the shift from secondary care to care within the community, thus reducing costs
- enhanced services in primary care to screen and detect alcohol misuse and alcohol-related harm, especially liver disease, at an early stage
- better national indicators, with more accurate hospital episode, workload and mortality statistics.


A lot more activity to reduce harm from alcohol should take place in the community, as well as treatment services. At present, however, there is little capacity in primary care and this necessitates leadership from secondary care and the development of pathways and teams to prevent hospital admissions.

Primary prevention of alcohol-related harm at primary care level is effective and cost effective⁸ and has four components. First, GPs must have knowledge of a patient's alcohol intake; this means using one of the many well validated brief questionnaires. Second, a brief health invention should be delivered to hazardous and harmful drinkers; this can be done by a practice nurse, or by a dedicated alcohol health

⁶ Moriarity K. J. *Alcohol Related Disease: Meeting the challenge of improved quality of care and better use of resources*. A joint position paper from BSG, BASL and the Alcohol Health Alliance. AHA, 2009

⁷ Ryder et al. *Clinical Medicine* 2010, Vol 10, No 5: 435–40

⁸ National Institute for Clinical Guidance. *PH 24 Alcohol-use disorders - preventing the development of hazardous and harmful drinking*. NICE: 2010



worker via a variety of routes. Third, it must be possible to refer to subjects with significant alcohol dependency to a specialist treatment service. Fourth, seven out of every eight subjects undergoing and intervention will not respond, and these subjects must be reassessed and if necessary screened for the most important health consequences (eg breast cancer, colon cancer and liver disease). Screening for cancers is already well established. Screening for liver disease requires further proof of effectiveness and cost effectiveness, but more than 70% of the direct mortality from alcohol is from liver disease, and the novel approaches under development look promising⁹. We support the development of a Quality Outcomes Framework (QOF), which encourages primary care monitoring of early liver disease harm from alcohol and other causes.

In addition, GPs must be able to refer people to adequately funded local alcohol services who can assist with motivating long term change leading to improved outcomes. This needs to be systematically tested and proven or otherwise. This is a potentially strong and targeted level of behaviour change. Coordinated interventions at several levels (including education in schools, etc), rather than isolated projects, will be important to improving outcomes and reducing overall costs to local health economies.

⁹ O'Brien. *Alcohol and Liver Disease Detection Study (abstract)*. Gut. In press 2010.