Royal College of Physicians

Submission

Health Select Committee inquiry: Public Health post 2013

Royal College of Physicians' submission

Introduction

1. The Royal College of Physicians (RCP) welcomes this opportunity to respond to the Health Select Committee's inquiry on public health post 2013. This response is based on the experiences of our members and fellows (primarily hospital-based doctors). The RCP has a long history of promoting public health through evidence based policy. The RCP believes that physicians and medical professionals have a key role to play not only in managing ill health, but also in supporting people to live healthier lives. Harnessing the skills and expertise of hospital doctors across the system can help to build a healthier future for individuals and communities across the UK.

Summary

- Following the Health and Social Care Act, fragmented commissioning arrangements have had an impact on the delivery of public health interventions and on patient care.
- In many areas of England, patients are experiencing the adverse consequences of fragmented care, particularly with regard to sexual health services.
- There is currently no effective mechanism for coordinating joined up action on obesity at the local level between Clinical Commissioning Groups (CCGs) and local authorities and at the national level between Public Health England (PHE), the Department of Health and other government departments.
- Cuts to spending on public health will incur serious and lasting implications for both the health of communities across England and the sustainability of the NHS.

Evidence

- **The delivery of public health functions**

2. One of the key challenges facing the new system is how to respond to public health challenges in a coordinated and systematic way, at local and national levels. Commissioning, contracting and funding arrangements must empower different parts of the health and social care system to work together, flexibly and sustainably to deliver improvements to public health. Yet the doctors, managers and commissioners who deliver vital public health functions face unnecessary barriers to making this vision a reality. Physicians on the front line of patient care have highlighted some of the key challenges they have faced following the introduction of the health reforms.

Fragmented commissioning arrangements for people with HIV and weight management services

3. Following the Health and Social Care Act, the different services that make up sexual healthcare are now commissioned respectively by Clinical Commissioning Groups (CCGs), NHS England and local authorities. Some local areas such as North West London and Leicester are leading the way, with integrated sexual healthcare that brings together the whole patient pathway[1]. These exemplars enable patients to access seamless care at every stage of their journey. Unfortunately, this patient-centred approach is not available everywhere, despite national guidance. In many areas of England patients are facing the serious consequences of fragmented care[2].

4. The following case study highlighted by the All-Party Parliamentary Group on Sexual and Reproductive Health found that: 'in some cases STI [sexually transmitted infection] services have been relocated away from the acute trust where HIV treatment is delivered without the involvement of NHS England HIV commissioners. These integrated services were a key point of contact in the lives of people living with HIV and relocating STI testing potentially reduc[es] the quality of care they receive[3].'

5. This fragmented arrangement poses a serious risk to safe, effective patient care. For example, in one service in south-east England, more than half (55%) of patients with HIV said that they'd be less likely to be screened for STIs since the two services were separated, leaving them vulnerable to undiagnosed, untreated conditions that could cause serious harm[4].

6. Furthermore, the localism inherent in the new system means national quality metrics and guidance such as the Public Health Outcomes Framework in Sexual Health, Commissioning for Quality and Innovation payments (CQUINs), and NICE standards do not have to be built into contracting for sexual health in local authorities. Accountability for clinical governance, patient safety and quality issues remain unclear at national level.

7. Fragmented commissioning arrangements can produce disjointed clinical pathways that threaten the quality of patient care. In contrast, joined-up care improves clinical outcomes and has been shown to promote efficiency[5]. The RCP believes that 'place-based' commissioning, where organisations work together to commission health and care for an entire local population, must become the norm[6]. Furthermore, clear lines of accountability must define which commissioner is responsible for each area of patient care. No services

[1] Making it work A guide to whole system commissioning for sexual health, reproductive health and HIV
[2] Putting the pieces together: Removing the barriers to excellent patient care. London: RCP, 2015
[3] All-Party Parliamentary Group on Sexual and Reproductive Health in the UK. Breaking down the barriers: The need for accountability and integration in sexual health, reproductive health and HIV services in England. London: FPA, 2015.
[4] Confidential audit results of a sexual health service in south-east England, 2014. Unpublished data.
[5] Humphries R, Wenzel L. *Options for integrated commissioning: Beyond Barker*. London: The King's Fund, 2015.
[6] Putting the pieces together: Removing the barriers to excellent patient care. London: RCP, 2015

should fall through gaps between commissioning organisations. Patients must be able to access the same high-quality standard of care wherever they live.

Lack of coordination in tackling obesity

8. Tackling obesity is another key public health challenge. In England, around one in ten children in Reception class is obese (boys 9.9%, girls 9.0%)[7] and around one in five children in Year 6 is obese (boys 20.8%, girls 17.3%). Excess body weight costs the NHS £4.7 billion a year respectively, while poor dental health costs the NHS £3.4bn per year respectively.

9. The RCP understands that the causes of obesity are varied. Tackling the nutritional content, marketing and pricing of food and drink are part of the solution to our national obesity crisis. Public services of all kinds have an important role to play in tackling obesity and encouraging physical activity. For example, schools have a role to play in educating children on healthy eating, town planners allocating space for public exercise or transport authorities promoting safe active travel. The RCP is concerned that there is currently no effective mechanism for ensuring that these different areas of public service delivery are joined up, either locally or nationally.

10. RCP's members and fellows have also pointed to confusion around the commissioning of the various tiers of weight management services[8] which are now split between CCGs and local authorities.

11. The RCP strongly recommends that a national obesity lead should be appointed to coordinate strategies and policies across government and to champion action at regional and local level across the country.

- **The effectiveness of local authorities in delivering the envisaged improvements to public health**

12. While there remains the potential for innovative and progressive work across local authority commissioned services, such as developing joint sexual health/drug services for 'chem-sex[9]' and club drugs[10], these are yet to emerge.

13. PHE has a duty to provide local authorities, the Department of Health and the NHS with public health advice and evidence on what works best in protecting and improving public

[7] Health and Social Care Information Centre. *National Child Measurement Programme* 2013-14.
[8] Action on obesity. RCP: London. 2013. Chapter 6, p.23
[9] "Chem-sex" is used in the United Kingdom to describe intentional sex under the influence of psychoactive drugs, mostly among men who have sex with men.
[10] Club drugs are a pharmacologically heterogeneous group of psychoactive drugs that tend to be abused by teens and young adults at bars, nightclubs, concerts, and parties.

health. However, PHE has minimal levers to require local authorities to follow this advice. PHE has developed useful tools for local authorities to use to understand their public health needs and spending but without strong levers.

14. This is part of wider confusion around who leads on improving public health. PHE's role is to be the expert public health agency. The Department of Health has retained final decision making responsibility for public health policy. The National Institute for Health and Care Excellence issues evidence and guidance on a range of public health issues. The Chief Medical Officer produces an annual report on the public's health and advice to government. This often results in confusion as to which organisation has ultimate responsibility for delivering improvements to public health. The RCP recommends greater clarity on which organisation has overall responsibility over public health policies.

- **Public health spending**

15. The RCP has severe concerns regarding the planned £200million reduction in the public health grant to local authorities. This reduction will incur serious and lasting implications for both the health of communities across England and the sustainability of the NHS. We believe that the planned funding reduction represents poor value-for-money as a short-term saving that will incur greater costs to the NHS and wider society in the longer term.

16. It is a false distinction to differentiate between 'NHS' services and local authority-funded public health services: a substantial proportion of local authority public health monies are spent on services delivered by healthcare providers. Vital local services which help to save lives lost to avoidable ill-health, such as smoking cessation services, weight management services and sexual health services, will be cut. Data from local authorities tells us that a substantial proportion of public health funding is spent on services delivered by NHS providers – in some councils, this is as much as 80% of the total public health budget[11]. This means the planned £200 million funding reduction will have an immediate impact on the health service.

17. Overall cuts to public health budgets at a national level have already had a negative impact on the provision of stop smoking services. Since transferring responsibility for stop smoking services to local authorities, the number of smokers accessing these services and setting a quit date has fallen by half – from 816,000 in 2011/12 to 451,000 in 2014/15[12]. Part of this decrease can be attributed to low spending on media campaigns. However, cuts in funding at a local level and competition for funding with other local services are a significant factor for the fall in accessing these services.

[11]Taken from a survey of directors of public health conducted by the Association of Directors of Public Health.
[12] Health and Social Care Information Centre. Statistics on NHS Stop Smoking Services in England - April 2014 to March 2015

18. The public health benefits of key interventions are under threat from funding cuts. These include partner notification in HIV and sexually transmitted infections, easy access to testing to avert late diagnosis of HIV, community support for people living with HIV/Aids to sustain contact with clinical services. The UK has some of the best retention in care and on treatment rates for HIV in the world, but we lag behind many countries in detection and testing rates. The severe financial pressures that public health budgets are facing threaten to make this performance even worse.

19. The NHS faces unprecedented financial pressures, continued growth in demand, and an increasingly complex range of patient need. It is therefore a false economy to impose funding reductions that will directly and adversely impact on the health service and the health of the people who rely on it. Funding reductions will impede local authorities' ability to fulfil its public health responsibilities, thereby increasing the burden of ill health on the NHS.

Conclusion

20. Commissioning arrangements for a range of public health services are fragmented and are not responsive to patient needs. There needs to better coordination between PHE, Local Authorities and CCGs in delivering public health interventions. Funding cuts to local authorities' public health budgets risks exacerbating these issues. Investing in prevention ultimately saves lives and improves long term patient outcomes. This is in addition to saving money for other parts of the NHS by reducing demand for hospital, health and social care services.

About the RCP

21. The RCP plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing almost 30,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare. Our primary interest is in building a health system that delivers high quality care for patients.

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