ASH response to Transforming the public health system

Introduction

1. Action on Smoking and Health (ASH) is a public health charity set up by the Royal College of Physicians in 1971 to advocate for evidence-based policy measures to reduce the harm caused by tobacco. ASH welcomes the Government's commitment at the heart of the reforms to transform the public health to build back stronger, fairer, healthier and more resilient from the tragedy and disruption of COVID-19.

2. In addition to our online response to the request to help *"design a system fit for the future"* we have some more detailed proposals set out below to help deliver the vision that, *"Our system reforms will aim to transform our national health protection and capabilities, place prevention at the heart of government, and more deeply embed prevention and health improvement expertise, capacity and accountability across local and national government and the NHS."*

3. To address the risks and deliver the ambitions set out in the policy note we believe that the system needs to be designed so it includes:
    - A strong data, analysis and economic modelling function under the oversight of the CMO.
    - The "incubator" function for behaviour change interventions within OHP.
    - A clear framework for accountability across the system, both horizontally and vertically
    - The strengthened role for the Regional Director of Public Health as "a cross-cutting system leader" to include oversight of prevention plans within the NHS and UKHSA.
    - Health and Wellbeing Board oversight of the development of, and democratic accountability for, shared prevention objectives between local government and the ICS.
    - Appropriate engagement with civil society and with industry to support shared objectives.
    - Sufficient resource for prevention appropriately distributed throughout the system (figure 3)

4. Figure 1 illustrates what we understand to be the new public health system as set out in the policy paper, and figure 2 our suggestions for the modifications needed to deliver the government's vision under the headings set out above. The key is to help to navigate the diagrams.

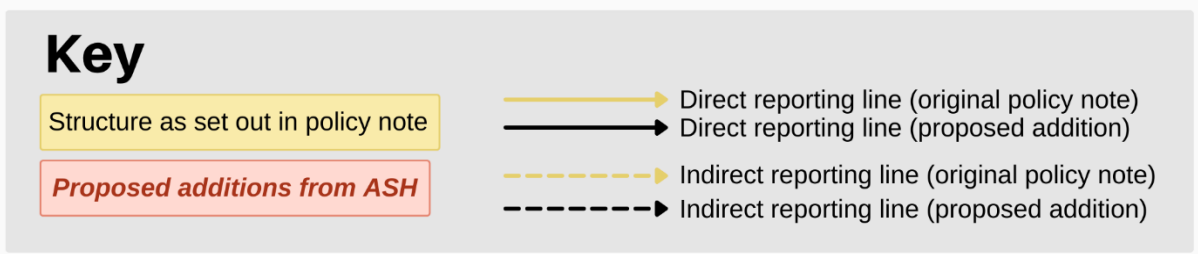


Figure 1: System described in the policy note

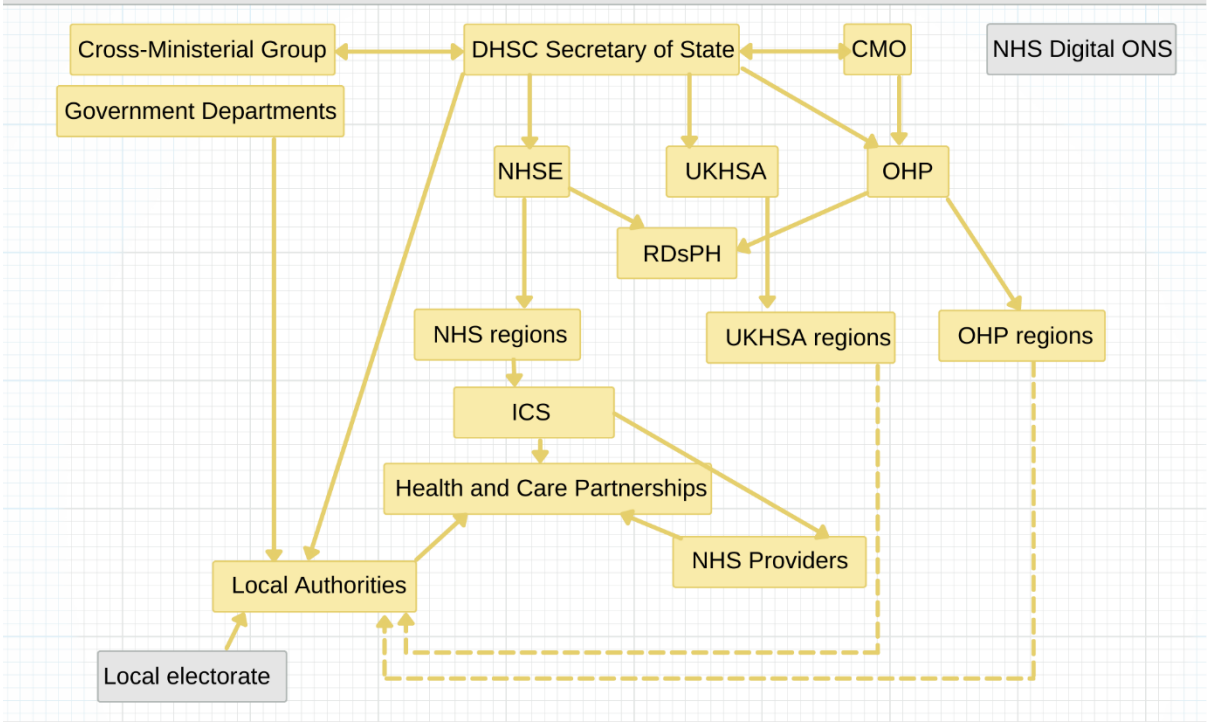
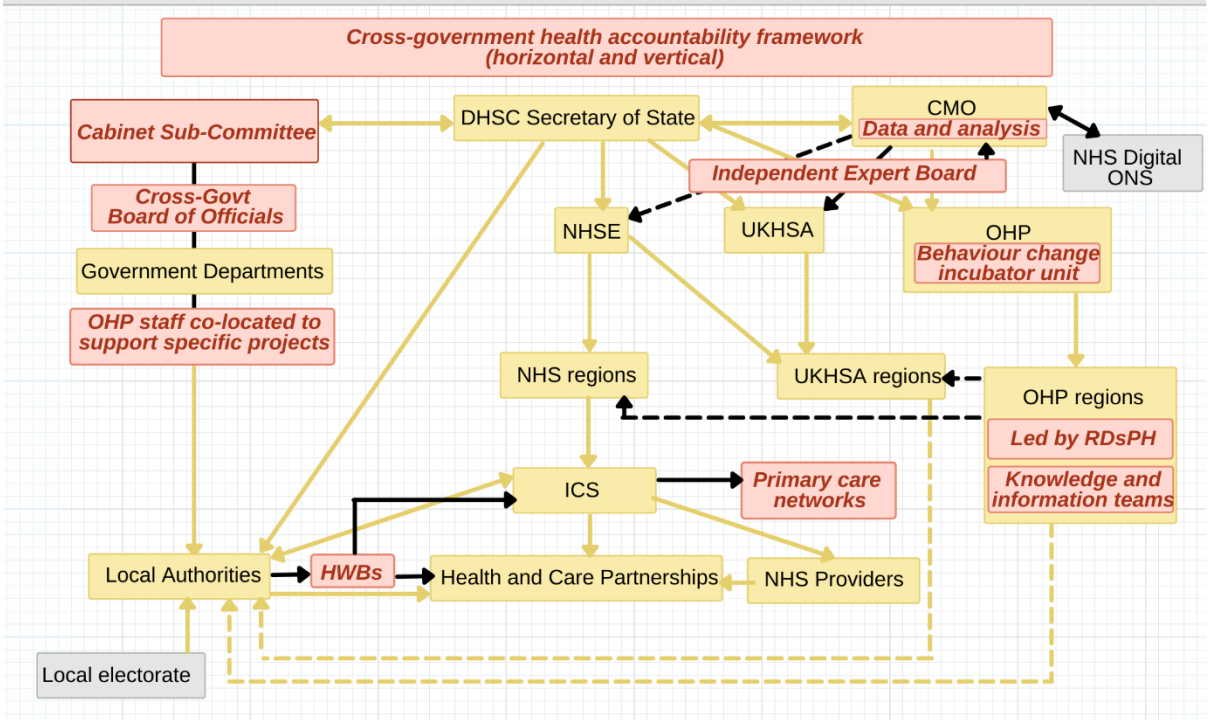


Figure 2: Proposed additions to the new system



A strong data, analysis and economic modelling function under the oversight of the CMO

5. The proposal: *"to transfer PHE's cross-cutting national knowledge and intelligence capabilities into DHSC, with PHE's health protection analytic functions moving into the UKHSA"* creates significant risks that sharing of data and expertise will be compromised. The OHP must have adequate data and analytical expertise and data sharing agreements to facilitate improved data co-ordination with the NHS to deliver on the health improvement agenda.

6. With the initial transfer of staff to UKHSA happening ahead of the transfer of staff to OHP and the fact that many data analysis roles are shared across health protection and health improvement activity, with the current focus being heavily on health protection, there is a risk that insufficient expert analysts will be transferred into the new function. Further separating the function between UKHSA and OHP is far from ideal given the overlapping data interests and the benefits of concentrating expertise.

7. We believe further consideration should be given to maintaining this function intact within the CMO's office. This would maximise the opportunity for synergy with the responsibility for research policy, research management and delivery of the £1.3 billion research budget which sits with the Chief Scientific Officer who reports to the CMO.

8. The same challenge of retaining high quality integrated data and analysis nationally is replicated at regional level. Key to the successful functioning of regional activity is adequate Knowledge and Information Teams (KITs) currently sitting within PHE regions. These should be retained and put under the direction of RDsPH within the OHP regional structure.

The "Incubator" function for behaviour change interventions should be part of the OHP

9. We strongly support the proposal to set up an "*incubator" function"* to *"draw together behavioural science, digital and design expertise, and work to support policy teams in designing and delivering behaviour change interventions".*

10. Behaviour change interventions are at the heart of the work of the Office of Health Promotion, so we believe that is where this function should sit. The "incubator" must be led and shaped by behaviour change experts with a close understanding of the evidence. However, it also requires the creativity of those with marketing expertise, the insights of data analysts and input from communications professionals who can secure additional reach through engaging the media.

11. Situated in the OHP under oversight of the CMO, the incubator could support behaviour change to improve health across public health system and as a hub of expertise for other government departments, the NHS, regions and local government.

Accountability across the system

12. The government's vision is clear, *"The Office for Health Promotion will help the whole health family focus on delivering greater action on prevention; and – working with a new cross-government ministerial board on prevention – it will drive and support the whole of government to go further in improving health."*

13. To quote the King's Fund, "These reforms are an opportunity to develop stronger and clearer accountability relationships across the system, both horizontally (at cross-Whitehall level, regionally, and at local level) and vertically (between national, regional and local level).

14. However, while the opportunities are there, there are risks which need to be mitigated. To be effective accountability needs to be focused on improvement not blame, and requires clarity about who is responsible and for what; consequences for poor performance; transparency and access to information, all backed up by the independent oversight provided by parliamentary scrutiny. Weak accountability has been shown to lead to repeated patterns of failure in government policy.

15. For the Office for Health Promotion (OHP), under the leadership of the CMO to deliver the government's ambitions requires a shared accountability framework across government with clear terms of reference, objectives and metrics based on outcomes not outputs. Accountability and oversight of UKHSA is unclear. The CMO has a key role to play as "the lead independent public health advisor" …"ensuring the independence of public health advice to government." The oversight role of the CMO in relation to UKHSA needs to be spelt out.

16. There need to be shared objectives across the system underpinned by metrics. The objectives could be based on the Public Health Outcomes Framework or potentially the ONS Health Index currently in development. Reporting on progress not just for the OHP but also for UKHSA and for each Government department could be undertaken by the CMO as part of an annual review of progress on improving the public health.

17. Furthermore it is not clear political accountability for public health across government would be ensured by a "*cross-government ministerial board on prevention".* A cabinet sub-committee might be more effective, backed up by a cross-government board of officials as suggested by the King's Fund.

The strengthened role for the Regional Director of Public Health as "a cross-cutting system leader"

18. The commitment to *"strengthen the role of the Regional Director of Public Health as a cross-cutting system leader, able to convene partners across a region, influence and challenge, in order to drive more joined-up action."* is strongly supported by ASH:

19. However, in the structure as set out it is not clear how this will be delivered. RDsPH need to be accountable to the CMO and have the authority of the CMO to play a fully effective role in co-ordinating coherent regional approaches to public health, and must be able to escalate through the CMO to address challenges in the system.

20. Regional teams need to be adequately staffed to be able to effectively support RDsPH in their convenor role. They need to be able to work across UKHSA, OHP, NHS and local government across the region to provide the chain that links the system together. This requires adequate staffing with diverse teams. These include Knowledge and Information Teams, policy experts and network builders – all of which are crucial for regional tier to be able to develop a coherent public health infrastructure across all the organisations in which it needs to be embedded.

21. To ensure that accountability to the overarching Governmental objective is a golden thread through the system ICS should be accountable to RDsPH for the Prevention Plans, who are in turn accountable to the DHSC and the CMO.

22. RDsPH should ensure that ICS prevention plans meet whole of Government priorities while also reflecting the local realities and priorities generated through the Joint Strategic Needs Assessments (JSNAs) developed by local authority Health and Wellbeing Boards as part of their statutory responsibilities. Regions need to have the scope and independence to develop regional 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 are able to deliver a locally responsive but nationally accountable strategy for the region.

Health and Wellbeing Board oversight of the development of, and democratic accountability for, shared prevention objectives between local government and the ICS.

23. Local Authorities are an important point of continuity between the old arrangements and the new. They are also a key point in the system where the pillars of public health need to be integrated to meet the needs of local populations. Directors of Public Health are need sufficient capacity and mandate to make this happen. This means ensuring that DsPH have a meaningful role in both Integrated Care Systems (ICS) and Health and Care Partnerships (HCP) to ensure that they can play their essential prevention role across the system.

24. The obvious route is through Health and Wellbeing Boards (HWBs) which are already in place as a statutory function and should be the driver of partnership working between local government and the NHS. However, the implementation of HWBs has been diverse across the country and they play different roles in different local health systems. A review of the formal powers of HWBs and how they relate to ICS and HCPs should be undertaken alongside the other White Paper reforms under consideration, to ensure they are fit for purpose in the new public health system.

25. The one part of the health and care system that does not yet appear to have a clear line of accountability for delivering prevention is primary care. Action is needed through PCNs and GP contracts to address this and enable ICS to hold primary care to account for delivery of prevention activity.

26. The statement in the policy note that UKHSA will provide operational leadership not just at national but also at *"local level"* is concerning as the lesson of the pandemic is that operational leadership, as opposed to strategic leadership, is most effective delivered at local level. DsPH as the local public health leaders should be at the heart of developing the new regional structures and drawing in the input of wider professional groups from within local government. It is therefore welcome that the policy paper commits to: "*build on current partnership working arrangements with local leaders by designing a strong sub-national operational structure for the UKHSA that will work closely with Directors of Public Health to deliver health protection that is responsive to the needs of local communities."* A clear consultation plan and timetable must be set out to ensure this is achieved while recognising that DsPH remain busy managing the current crisis.

27. The policy note asks if local authorities need further powers in order to play a full role in addressing the public's health across wider determinants. Securing greater powers to address public health issues in other areas of local policy would make a reality of the ambition for policy levers outside of health to be better used to secure improved health outcomes.

28. Government should consult on what additional powers and responsibilities could accelerate local public health action on the wider determinants of health. Planning, transport, licensing and other areas offer potential for more action in support of public health. The consultation should include consideration of the inclusion of public health as a licensing objective for local authorities. Such a consultation would be a useful input to, or output from, a new Prevention Strategy, depending on its timing.

29. Any consultation should also look at the capacity of existing local government functions which currently contribute to health outcomes, such as environmental health and trading standards. The consultation should seek to provide an assessment of whether they are able to fully play their current role and if they are able to take on expanded functions under their current funding and structures. Funding is discussed in more detail below.

Appropriate engagement with civil society and with industry to support shared objectives.

30. Stakeholders outside of Government are important drivers and inhibitors of the Governments ambition for improved population health. Among the major causes of poor health in this country is the consumption of products that are bad for health such as tobacco, alcohol and high fat and sugar foods. Many of these industries typify the *"power imbalance"* noted in the policy paper between consumers and industries that profit from addiction.

    The Responsibility Deal set up by the Coalition Government, provides recent experience of a public-private partnership, which was designed to improve public health in the areas of food, alcohol, health at work and physical activity. However, the outcomes were not encouraging.

31. Research into their effectiveness concluded that for voluntary agreements like the Responsibility Deal to produce gains to public health that would not otherwise have occurred, government needs to: increase participation and compliance through incentives and sanctions, including those affecting organisational reputation; create greater visibility of voluntary agreements; and increase scrutiny and monitoring of partners' pledge activities.

32. Engagement with tobacco companies is strictly limited through the UK's legal obligations as a party to the WHO Framework Convention on Tobacco Control, so they were not included in the Responsibility Deal. This is also the area of public health where the greatest progress has been made.

33. ASH recommends that as part of the new approach to public health Government should adopt clear cross-Government framework for protecting health policy from commercial interests. This should be developed based on the existing PHE guidance. This is something strongly supported by the public. A representative survey of 11,068 English adults recently conducted by YouGov for ASH found support for protecting health policy from the influence of different industries:

Protect health policy from the influence of…				
	tobacco industry	food and drink industry	alcohol industry	gambling industry
Support	73%	71%	71%	76%
Oppose	3%	6%	5%	4%

34. Many parts of civil society, however, are actively engaged in prevention activity – particularly across broader determinants of health such as mental wellbeing. Organisations working across public health issues have a valuable contribution to make to policy development and to supporting independent oversight of Government strategy and activity. Partnership with civil society and the voluntary sector needs to be embedded in the system as it has a key role to play in ensuring the independence of scientific advice and helping address health inequalities.

35. Additional oversight of the Government's public health ambitions by civil society would help safeguard independence of advice. One route to do this would be through an Independent Advisory Board with membership drawn from academia and civil society and chaired by the CMO. Such a Board could potentially have focused sub-committees on areas of priority with co-opted members. This approach would be in line with the recommendations of the Framework Convention on Tobacco Control, to which the UK is a party, which states: "*The participation of civil society is essential in achieving the objective of the Convention and its protocols"*

Sufficient resource for prevention appropriately distributed throughout the system

36. Funding is a major barrier to achieving the Government's vision of a new public health system with the focus and capacity to really drive up healthy life expectancy for all. The Singapore Health Promotion Board has been cited by Government as an example of success for the OHP to model itself on, but the per head investment is estimated to be more than double that currently in place in England.

37. The King's Fund has estimated that coming out of the coronavirus pandemic, local government's core public health grant is still almost a quarter per capita lower in real terms than it was at its highpoint, in mid 2015-16. At this level it cannot be expected to achieve more than when public health was still the responsibility of the NHS and funding significantly higher.

38. The reduction in public health and other local government funding undermines their ability to improve the health of their local population and diminishes the likelihood of an equitable partnership with the NHS, where budgets have been largely protected. In addition, local government also faces uncertainty around public health funding with additional allocations sometimes not committed past a single year and decisions on the allocation of the public health grant often coming very late in the year. Local authorities need stable and predictable funding arrangements that allow them to undertake the long-term planning and make the investments needed to secure improvements in public health.

39. ASH and stakeholders in other sectors such as gambling have long argued that the industries that profit as a result of market failure caused by addiction should be levied to resource the prevention activity to reduce the impact of their business on society. ASH would be happy to provide further information on how such a levy could be established and the ways in which it could support a world class public health system.

40. In the absence of additional funding for public health either through a levy or as a result the forthcoming Comprehensive Spending Review, the Secretary of State for Health and Social Care must deliver on his commitment to the LGA/ADPH 2021 Annual Conference to, *"put the power of the NHS budget behind the prevention agenda",* by empowering the ICS locally to support the integration of NHS and local authority responsibilities to promote good health, and give them the powers to work together to deliver on that promise. Furthermore, the UKHSA budget should be applied to support local authority

partners' delivery on health security, and health promotion work crucial to delivery of health security.

Figure 3: Funding imbalance