# Public Health: a reinvigorated regional structure can mitigate the risks of reorganisation and help build back better

## ASH 2nd February 2021

## Introduction

1. The DHSC policy paper published in September 2020 committed to publishing options for *"strengthening national and local health improvement and prevention arrangements"*.[1] The options set out for the national functions were a move to a Government Department such as DHSC, a new stand-alone health improvement organisation or integration into an existing ALB such as NHSE/I.

2. There was, however, no mention of a regional function, other than an option of *"devolving functions to a more local level such as local authorities and/or integrated care systems."*

3. There is consensus among stakeholders on the need for a regional function within a new and improved public health system, and what it should include. However, there is less agreement about how it would best work in practice.

4. Following discussions with DHSC and PHE it was agreed that ASH would run a round table which would focus on the regional structure, and address a set of questions. While the round table did not settle these questions directly, it did facilitate useful discussions about the pros and cons of different options with key stakeholders in the public health system. This note builds on the discussions to try to answer the questions and synthesise a regional model which can secure support across the public health system. A schematic of the model we propose is set out on page 4.

5. In summary the questions and our recommendations are set out below:

## Questions and recommendations

### Regional options

**Question: What needs can a regional tier address, and why can't these be done locally or nationally?**

**Question: To what extent does the regional level need to be a support and enabling function, vs. actual delivery as both are valuable with different merits?**

***Recommendations (para 15)***

***A regional tier can avoid costly and inefficient duplication at local level, while being responsive to local needs and priorities. Much of this is support and enabling, but it also includes actual delivery often in collaboration with local authorities, to provide:***

- ***Leadership capability and the skills to build and maintain networks with other partners operating on a supra-local or regional footprint, such as ICS, as well as to provide enhanced links to national level.***
- ***Capacity to develop standard approaches on a 'do well once and share' basis, supporting local policy and outcomes as well as providing surge capacity in the event of emergencies.***

[1] The future of public health: the National Institute for Health Protection and other public health functions - GOV.UK (www.gov.uk)

- ***Public health workforce development both for public health specialists and to support the development of public health skills in the wider workforce.***
- ***Strong data and intelligence capacity – data analysts are an essential part of the public health workforce and regional capacity can provide the expertise at critical mass to support local authorities and provide the crucial link from national to local and back.***
- ***Topic specific expertise – to help with specific policy implementation challenges such as NICE guidance on smoking in NHS settings (PH48) or maximising the impact of national activity such as social marketing campaigns. (para 15)***

**Question: How defined do the structures at regional level need to be to ensure they are effective and accountable (given there is a lack of homogeneity across the country currently)?**

***Recommendations (paras 25-29)***

***Nationwide policy and guidance should continue to be developed at national level, supported by independent scientific advice to be provided by an enhanced CMO role, supported by the soon to be appointed Chief Scientific Adviser, and enhanced capacity. (para 25)***

***Local authorities should continue to be responsible for setting their public health priorities, but, as recommended by the Health Select Committee, they should be presented in a standard format underpinned by a benchmarking framework. This would allow for comparison and challenge which should be provided by the regional tier working collaboratively with local authorities. (para 26)***

***The RDsPH should be retained as joint appointments with the NHS reporting to the CMO to provide the link from local to national, as well as national to local and between the NHS and local government and between health improvement and health protection. Their role should be to ensure that national policy is informed by place-based evidence and experience and policy implementation is founded in place-based evidence and experience. Accountability needs to flow down to local authorities and up to DHSC, for the achievement of national objectives. (para 27)***

***Collaboration between the NHS and local government should be incentivised through additional funding at regional level, to support local areas working together on a wider footprint through joint commissioning on agreed regional priorities. (para 28)***

***RDsPH should remain part of PHE "Business as Usual" until the new national structure is fully in place. (para 29)***

## How can improved coordination between the NHS and local government be secured?

**Question: ICS are likely to be the key player at regional level in the longer-term, but there are risks as well as opportunities which need addressing:**

- **The ICS do not necessarily sit at an appropriate geography for regional public health delivery and to ensure effective cross sector working between local government and the NHS? There does not appear to be a one size fits all solution so how can this risk be managed?**
- **ICS are still maturing and need a statutory basis which won't be in place for at least a year, if not more. What transitional arrangements need to be put in place to prevent there being a hiatus?**
- **How can ICS be structured to ensure local government has appropriate level of influence and that health improvement is not restricted to a medical model neglecting**

**the most effective levers to address the leading causes of preventable ill health (ie smoking, obesity and alcohol-related harm).**

- **Are there other healthcare structures we need to consider alongside ICS as potential regional vehicles?**

**Question: How should the funding and commissioning process work to ensure effective working across local government and the NHS – is co-commissioning the answer?**

***Recommendations (paras 44-46)***

***Health and Wellbeing Boards (HWBs) should be given statutory responsibility as the accountable organisation for the delivery of place-based population health in an area, with ICSs being held accountable to HWBs. (para 44)***

***The Regional Directors of Public Health, as joint appointments between the CMO's office and NHSE, should be employed by DHSC, have a place on the commissioning boards of the ICSs and work with local DsPH to support the development of the ICS population health strategy. (para 45)***

***Until the ICS legislation is implemented and the new system is up and running with strategic plans for population health in place, it should be "Business as Usual" for PHE and NHSE regional functions on prevention and public health. (para 46)***

## How can clear accountability for reducing health inequalities be embedded at every level of the system?

**Question: How can joint objectives be best embedded across the system?**

**Question: Should data and intelligence sit together and if so where – given that these are crucial crosscutting functions for Health Protection, Health Improvement and Healthcare Public Health?**

***Recommendations (paras 54-55)***

***The PHOF as a shared outcome framework is the right mechanism for embedding joint objectives across the system both horizontally and vertically. (para 54)***

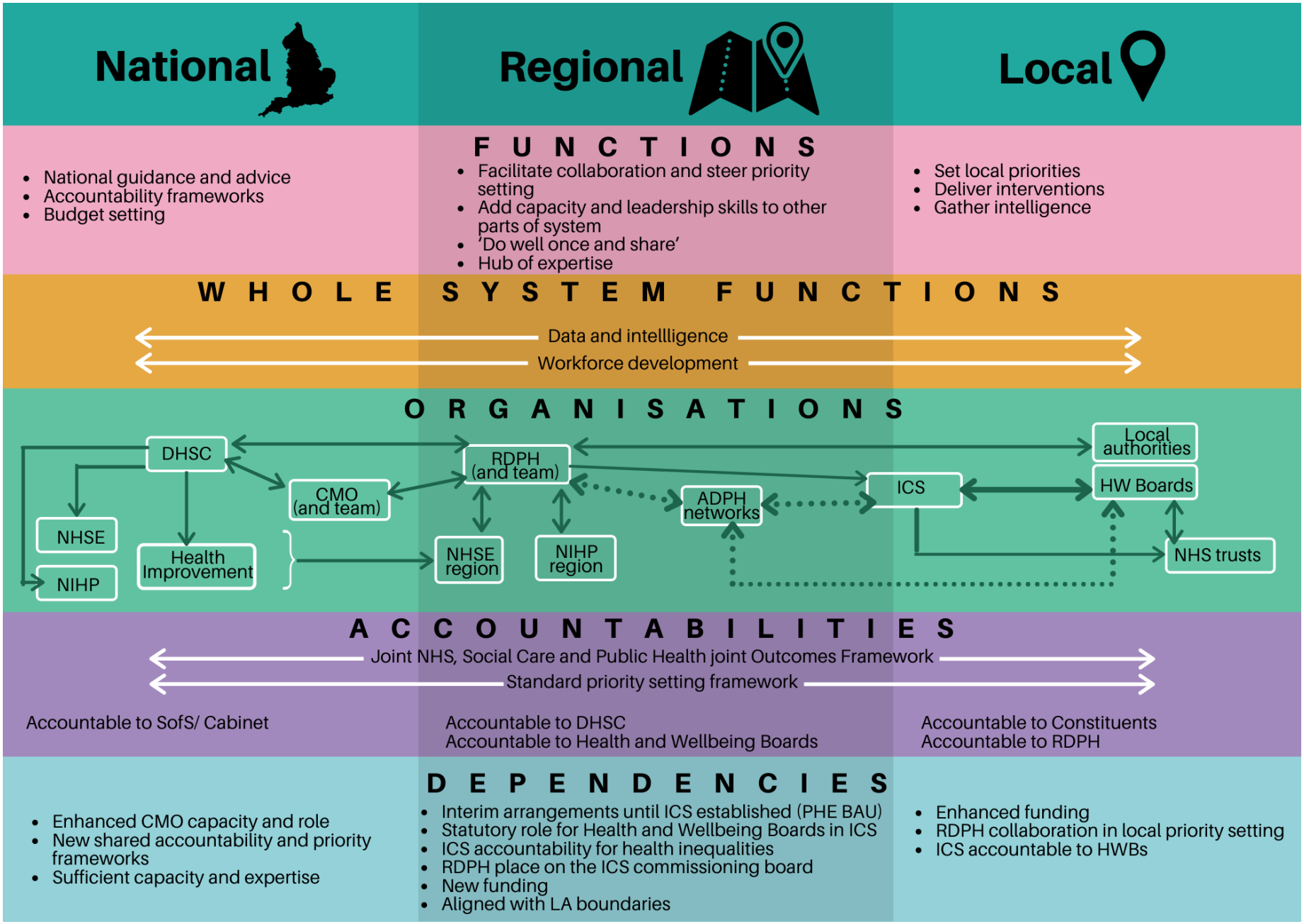
***Data and intelligence should sit together and not be housed within organisations only responsible for part of the public health system such as NIHP. The strong data and intelligence capacity at regional level in the current system should be retained to support flows of data and analysis up from local, down from national and horizontally across the system. (para 55)***

**Question: How could the model for tobacco control be applied for other modifiable risk factors for poor physical and mental health and wellbeing?**

***Recommendations (paras 69-70)***

***Further work is needed to determine the appropriate models for other modifiable risk factors such as sexual and mental health, obesity and alcohol. (para 69)***

***To support delivery of the time-limited Smokefree 2030 ambition as well as reducing inequalities and levelling up, a national commitment of £50 million a year should be made to support tobacco control interventions at regional level. These interventions should include enhancing national activity in social marketing; enforcement and wider tobacco control and smoking cessation outreach into disadvantaged communities by local authorities. (para 70)***


National
Regional
Local
FUNCTIONS
National guidance and advice
Accountability frameworks
Budget setting
Facilitate collaboration and steer priority setting
Add capacity and leadership skills to other parts of system
'Do well once and share'
Hub of expertise
Set local priorities
Deliver interventions
Gather intelligence
WHOLE SYSTEM FUNCTIONS
Data and intellligence
Workforce development
ORGANISATIONS
DHSC
CMO (and team)
RDPH (and team)
ADPH networks
ICS
Local authorities
HW Boards
NHS trusts
NHSE
NIHP
Health Improvement
NHSE region
NIHP region
ACCOUNTABILITIES
Joint NHS, Social Care and Public Health joint Outcomes Framework
Standard priority setting framework
Accountable to SofS/ Cabinet
Accountable to DHSC
Accountable to Health and Wellbeing Boards
Accountable to Constituents
Accountable to RDPH
DEPENDENCIES
Enhanced CMO capacity and role
New shared accountability and priority frameworks
Sufficient capacity and expertise
Interim arrangements until ICS established (PHE BAU)
Statutory role for Health and Wellbeing Boards in ICS
ICS accountability for health inequalities
RDPH place on the ICS commissioning board
New funding
Aligned with LA boundaries
Enhanced funding
RDPH collaboration in local priority setting
ICS accountable to HWBs

## What is the consensus?

6. Following the announcement of the abolition of PHE, ASH coordinated joint statements endorsed by 127 organisations setting out the principles all agreed should underpin the new public health system.[2]
    - Sufficient and secure funding to scale up health improvement interventions
    - Sufficient high-quality public health experts in health protection, health improvement and healthcare public health functions
    - The commitment and infrastructure to deliver health improvement at national, regional and local level
    - A stronger health intelligence function which supports both health improvement and health protection and underpins accountability
    - Improved co-ordination between the NHS and local government
    - Strong relationships across health protection and health improvement across all four nations of the UK
    - Clear accountability for reducing health inequalities at every level of the system

7. There is widespread agreement that current funding is inadequate to deliver an effective public health system[3], given reductions of almost a quarter in spending per person between 2014/5 and 2019/20.[4] The DHSC September policy note stated that the budget for prevention and health improvement, including existing PHE functions, would be agreed in the Spending Review in the Autumn. This did not happen and the one year spending settlement for public health, while inflation proofed, does not take account of the increases in population.

8. The Health Foundation has estimated that, at a minimum, £1.2 bn is needed to restore public health funding to its 2015 levels and a further £2.6 bn to level up public health across the country. Furthermore that public health funding needs to keep pace with NHS funding increases in future.[5]

9. There is also consensus that the transfer of DsPH and their teams back to local authorities following the 2012 Act was the right decision. Local public health teams are closer and more responsive to the needs of the communities they serve, as has been demonstrated most recently by their response to the pandemic.

10. The needs of local communities are fully taken into account, not just at local level, but also in both national and regional approaches to public health. 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, and safe streets.

11. 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, local authorities can deliver real and sustainable change. Significant benefits have been realised by the transfer. An analysis by the University of York suggests that the expenditure through the public health ring-fenced grant is three to four times as cost-effective in improving health outcomes than if the same money had been spent in the NHS baseline.[6]

## Regional options

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[2] Smokefree Action Coalition. Joint statements to the Government on public health reorganisation.

[3] Sloggett R. Saving a lost Decade. How a new deal for public health can help build a healthier nation. Policy Exchance November 2020.

[4] Buck D. The Spending Review and public health: the need for certainty in the shorter term and social value in the longer. Kings Fund. October 2020.

[5] Elwell-Sutton T. Briefing: Improving the nation's health The future of the public health system in England. The Health Foundation. November 2020.

[6] Martin S, Lomas J R S, Claxton K (2019). Is an ounce of prevention worth a pound of cure? Estimates of the impact of English public health grant on mortality and morbidity. York: Centre for Health Economics.

***Question: What needs can a regional tier address, and why can't these be done locally or nationally?***

***Question: To what extent does the regional level need to be a support and enabling function, vs. actual delivery as both are valuable with different merits?***

12. There is widespread support for retaining the national functions of Public Health England in one place. One proposal which we would support would be to return these functions to DHSC, from whence they were transferred to PHE as a result of the public health reforms. However, ministerial oversight of policy decisions would need to be balanced by the provision of independent advice, which is the function of the CMO and Chief Scientific Officer. This would be in line with the CMO's role which is to provide independent advice on public health issues; to recommend policy changes to improve public health outcomes; and to act as an interface between the government and medical researchers and clinical professionals.[7]

13. There is also broad consensus on the needs that a regional tier can address and why. Not everything works when delivered to the population as a whole, some efforts are most effective when community or place-based while others require a larger geography, but are diluted when delivered at a national level.

14. The evidence from tobacco control (see paras 58-68) is that while national and local leadership and expertise are essential they are not sufficient on their own to secure rapid achievement on health improvement while tackling inequalities. Different aspects of public health are best delivered at different geographical levels and this includes regional delivery. The regional tier delivers activity that neither national nor local actors are best placed to do and acts as a bridge vertically (national to local) and horizontally (across local health and care system).

***ASH Recommendations (para 15)***

***15. A regional tier can avoid costly and inefficient duplication at local level, while being responsive to local needs and priorities. Much of this is support and enabling, but it also includes actual delivery often in collaboration with local authorities, to provide:***

- ***Leadership capability and the skills to build and maintain networks with other partners operating on a supra-local or regional footprint, such as ICS, as well as to provide enhanced links to national level.***
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- ***Topic specific expertise – to help with specific policy implementation challenges such as NICE guidance on smoking in NHS settings (PH48) or maximising the impact of national activity such as social marketing campaigns.***

16. However, while the principle is generally agreed that regional delivery of public health is essential, there is less clarity about how this should be achieved.

[7] Institute for Government. Who is the Chief Medical Officer? (accessed 29 January 2021)

**Question: How defined do the structures at regional level need to be to ensure they are effective and accountable (given there is a lack of homogeneity across the country currently)?**

17. ASH proposes that Regional Directors of Public Health should be given a leadership and accountability role for delivering public health outcomes across NHS and LA across the region, with the resource in staff and funding to back this up. RDsPH should have a direct role in the development of regional strategies across ICS footprints and powers to challenge delivery that does not meet the standards needed to reduce health inequalities and extend healthy life expectancy.

18. While we agree that there is a need for local accountability there also needs to be a mechanism for national strategy/ policy setting to be taken into account at regional and local level.

19. This is what the ASH model proposes but we recognise that it is perceived as being top down and therefore insufficiently responsive to local needs and lacking in local democratic accountability. We believe that this can be addressed by ensuring that regional priorities are set by RDsPH jointly with local authorities and that Health and Wellbeing Boards are given a stronger statutory remit (see paras 30-46)

20. The Association of Directors of Public Health (ADPH) provides an important regional network, but the ADPH network structure relies on local authority DsPH who are already overstretched, and is comprised of relatively informal, self-organised structures with different approaches in different regions. While the ADPH network is an important function, it doesn't provide a template for clear leadership or regional strategy setting, or the capacity to deliver.

21. Local authorities and their DsPH should continue to set local priorities, in line with national ambitions for health improvement and RDsPH and their teams would help translate that into regional priorities relevant to local authorities through the broader footprint. The necessary regional expertise is clearly provided by the RDsPH, and it would be logical for them to have a stronger role as system leaders. Additional resources are needed to make this viable and effective, particularly with a view to tackling health inequalities. Current PHE regional resources are not sufficient.

22. While local authorities already collaborate on important functions such as transport, children and young people, and including public health[8], there is an additional necessity in public health for effective collaboration with the NHS. There also needs to be a solution to the *'incentive trap'* whereby local government bears the cost of public health delivery and innovation, but NHS receives the payoff.[9] Collaboration between the NHS and local authorities should be incentivised through additional funding at regional level, to support local areas working together on a wider footprint through joint commissioning on agreed regional priorities. This would not prevent additional co-commissioning by local authorities on other footprints where this was seen to add value.

23. ADPH, the LGA and SOLACE all support a stepped-up Sector Led Improvement (SLI) programme to provide quality assurance.[10] However, the independent review of the public health reforms the LGA commissioned from the King's Fund raises justifiable concerns, which even if the process is 'stepped-up' will remain valid:

    *"…despite its clear benefits is SLI enough for public health? The tools are voluntary, there is self selection in its use, and some of the tools are highly resource intensive, which asks a lot of those involved. Arguably those that understand that they will benefit from it are the areas that need it least. What is happening in those areas that have not engaged with*

[8] https://www.local.gov.uk/our-support/efficiency-and-income-generation/shared-services/shared-services-map
[9] https://www.kingsfund.org.uk/publications/local-government-public-health-reforms
[10] https://www.adph.org.uk/wp-content/uploads/2020/12/A-New-Public-Health-System_-2020-1.pdf

*support for improvement in their public health services and outcomes is perhaps the bigger question."* [11]

SLI is a useful tool but cannot provide a mechanism for intervening when outcomes which are the responsibility of local authorities are poor. It does not provide clear accountability or a mechanism for tackling unjustified variation in practice (taking into account differences in resources).

*24.* Public Health England's role has been limited to supporting local government's public health role, not to hold it to account or performance manage it on finance or on outcomes. ASH agrees with the Health Select Committee recommendation in 2016[12] that, *"While public health priorities may be different for different areas, which is entirely appropriate, they should be presented in a standardised format, and underpinned by a benchmarking framework that allows for informed comparison and challenge."*

***ASH Recommendations (paras 25-29)***

***25. Nationwide policy and guidance should continue to be developed at national level, supported by independent scientific advice to be provided by an enhanced CMO role, supported by the soon to be appointed Chief Scientific Adviser, and enhanced capacity.***

***26. Local authorities should continue to be responsible for setting their public health priorities, but, as recommended by the Health Select Committee, they should be presented in a standard format underpinned by a benchmarking framework. This would allow for comparison and challenge which should be provided by the regional tier working collaboratively with local authorities.***

***27. The RDsPH should be retained as joint appointments with the NHS reporting to the CMO to provide the link from local to national, as well as national to local and between the NHS and local government and between health improvement and health protection. Their role should be to ensure that national policy is informed by place-based evidence and experience and policy implementation is founded in place-based evidence and experience. Accountability needs to flow down to local authorities and up to DHSC for the achievement of national objectives.***

***28. Collaboration between the NHS and local government should be incentivised through additional funding at regional level, to support local areas working together on a wider footprint through joint commissioning on agreed regional priorities.***

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## How can improved coordination between the NHS and local government be secured?

**Question: ICS are likely to be the key player at regional level in the longer-term, but there are risks as well as opportunities which need addressing:**

- **The ICS do not necessarily sit at an appropriate geography for regional public health delivery and to ensure effective cross sector working between local government and the NHS? There does not appear to be a one size fits all solution so how can this risk be managed?**

[11] The English local government public health reforms: an independent assessment (kingsfund.org.uk) p.49

[12] House of Commons Health Committee (2016). Public health post-2013 inquiry Second report of session 2016-17. HC140

- **ICS are still maturing and need a statutory basis which won't be in place for at least a year, if not more. What transitional arrangements need to be put in place to prevent there being a hiatus?**
- **How can ICS be structured to ensure local government has appropriate level of influence and that health improvement is not restricted to a medical model neglecting the most effective levers to address the leading causes of preventable ill health (ie smoking, obesity and alcohol-related harm).**
- **Are there other healthcare structures we need to consider alongside ICS as potential regional vehicles?**

**Question: How should the funding and commissioning process work to ensure effective working across local government and the NHS – is co-commissioning the answer?**

30. NHSE/I in its consultation document, says its proposals for the ICSs are designed to deliver by collaborative working between the NHS and local councils, *"to join forces to plan and provide around residents' needs."* The four *"fundamental purposes"* of its proposals are:
    - improving population health and healthcare;
    - tackling unequal outcomes and access;
    - enhancing productivity and value for money; and
    - helping the NHS to support broader social and economic development.[13]

31. These purposes are about much more than health and social care, at their heart is improving population health outcomes which requires a broader strategic focus on the wider determinants of health. NHSE/I itself recognises only 20% of health outcomes are determined by the ability to access good quality healthcare and the wider determinants of health play a crucial role.[14]

32. ICSs clearly offer an opportunity for stronger integration, but it must not be at the risk of over-medicalising public health, or at the risk of confusion of roles and duplication. The lessons provided by Sustainability and Transformation Partnerships are not promising. Only rarely, where local authority chief executives have been in the lead has there been a clear focus on the wider determinants of health, by and large STPs have not done well at engaging with public health colleagues in local government or focused much on areas such as prevention.[15] [16] This is essential if the ICSs are to have the strategic leadership that is needed to provide the necessary focus on all four fundamental purposes and thereby deliver better population health outcomes.

*33.* NHSE/I says that they *"want local government to be an integral, key player in the ICS*". That both the legislative options they propose would provide:
    - a basis for planning and shaping services across healthcare, social care, prevention and the wider determinants of health;
    - allow for the delegation of functions and money to place-based statutory committees involving NHS bodies and local government; and enable NHS and local government to exploit existing flexibilities to pool functions and funds.[17]

*34.* The proposals by NHSE/I are very woolly about how this might happen, saying only that. *"The greater development of working at place will in many areas provide an opportunity to align decision-making with local government, including integrated commissioning arrangements for health and social care, and local responsiveness through health and wellbeing boards. There is no one way to do this, but all systems should consider how the devolution of functions and capabilities to systems and places can be supported by robust governance arrangements."* [18]

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[13] Report template - NHSI website (england.nhs.uk) 1.3
[14] NHS England » Population Health and the Population Health Management Programme
[15] The English local government public health reforms: an independent assessment (kingsfund.org.uk)
[16] Housing and health report (kingsfund.org.uk)
[17] Report template - NHSI website (england.nhs.uk) 3.25
[18] Report template - NHSI website (england.nhs.uk) 2.34

35. The ASH model foregrounds the need to improve coordination between the NHS and local government, recognising that the ICS will play a key role, particularly once they gain statutory status which is expected to be in place by April 2022.

36. Our model envisages a legal framework which would make ICS accountable to their local authorities for delivery of population health outcomes, to mitigate the risk that the NHS model of medicalised public health would be dominant in ICSs as it has been in their predecessors the Sustainable Transformation Partnerships (STPs).[19]

37. Health and wellbeing boards (HWBs) have a key role to play in ensuring that this can be delivered. This is the vision of the Secretary of State for Health and Social Care, Matt Hancock, who called for HWBs to be *"empowered"* as *"the vital component in bringing together local authorities, NHS commissioners and elected representatives to create a strategic vision for a local area so we're accurately identifying needs, and co-ordinating care".*[20] He challenged local government leaders by asking: *"How strong is yours? What can you do to strengthen it?".* But if HWBs are to be strengthened they need to be given responsibility as the accountable organisation for the delivery of place-based population health in an area, with the ICS being held accountable to boards.[21]

38. A model for what could work in practice is provided by Tameside where a strategic commissioning board (SCB) focuses on population health, with an overarching goal of increasing healthy life expectancy. The SCB is a fully integrated organisational and governance structure across the CCG and Tameside Council, with democratic accountability ensured by the involvement of elected members The SCB has a single senior leadership team, shared teams and co-location and has saved 20% on running costs (meeting the NHSE target). [22]

39. On a wider geographical footprint the Greater Manchester Combined Authority through the GM Health and Social Care Partnership, (GMHSCP) is following the same model. The GM equivalent of the HWB and Health Scrutiny function in local authorities are the GM Health and Care Board and the Health Scrutiny Board, rather than being accountable to local HWBs the GM Board is accountable to local authorities.

40. However, these are isolated examples of a model which will only be widely implemented if it is given a statutory underpinning in the ICS legislative framework.

41. Lastly although the ICS are expected to be up and running by April 2021, and *"Developing strategic commissioning through systems with a focus on population health outcomes*"[23] they are still a work in progress and it is not clear how many there will be in their final form. NHSE/I that ICSs need to have the ability *"to more formally combine as they take on new roles where this is supported locally",* as *"ICSs need to be of sufficient size to carry out their 'at scale' activities effectively, while having sufficiently strong links into local communities at a much more local level in places and neighbourhoods."* [24]

42. However, not all ICS footprints are currently aligned with local authority boundaries. Co-terminosity with local authorities or groups of local authorities would significantly ease collaboration and issues around democratic engagement and accountability and we would argue this needs to be encouraged rather than just supported.

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[19] https://www.kingsfund.org.uk/publications/local-government-public-health-reforms

[20] How local and national government can work together to improve health and care - GOV.UK (www.gov.uk)

[21] Evaluating HWBs FINAL REPORT - April 2018 Final.pdf (ncl.ac.uk)

[22] Thinking_differently_commissioning (web).pdf (kingsfund.org.uk)

[23] Report template - NHSI website (england.nhs.uk) p.2

[24] Report template - NHSI website (england.nhs.uk) 4.14-4.15

43. It is not entirely clear yet what the appropriate geography is for the ICSs, and it is likely to vary depending not just on the NHS but also on the political and geographical structure of their local area, which could well be affected by the Government's plans for devolution.[25] To summarise, the ICSs need time to mature, and in the interim existing systems must be maintained.

***Recommendations (paras 44-47)***

***44. HWBs should be given statutory responsibility as the accountable organisation for the delivery of place-based population health in an area, with ICSs being held accountable to HWBs.***

***45. The Regional Directors of Public Health, as joint appointments between the CMO's office and NHSE, should be employed by DHSC, have a place on the commissioning boards of the ICSs and work with local DsPH to support the development of the ICS population health strategy.***

***46. Until the ICS legislation is implemented and the new system is up and running with strategic plans for population health in place, it should be "Business as Usual" for PHE and NHSE regional functions on prevention and public health.***

## How can clear accountability for reducing health inequalities be embedded at every level of the system?

**Question: How can joint objectives be best embedded across the system?**

**Question: Should data and intelligence sit together and if so where – given that these are crucial crosscutting functions for Health Protection, Health Improvement and Healthcare Public Health?**

47. The Government's manifesto commitments to increase healthy life expectancy by five years by 2035 while reducing inequalities and levelling up society[26] provide the overarching objectives that must inform and underpin the new public health system currently under construction.

48. There is no need to reinvent the wheel as these objectives are already embedded in the Public Health Outcomes Framework (PHOF), which places reducing health inequalities at the heart of its vision.[27] A vision which is *"To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest".* The PHOF also sets out the four pillars needed to deliver the vision which are:
    - Improving the wider determinants of health
    - Health Improvement
    - Health Protection
    - Healthcare public health and preventing premature mortality

49. The PHOF needs to be sustained. It includes the key indicators for all the pillars of public health, right across the system and the data are available at national, regional and local level. It also provides a foundation and key inputs for the Health Index to track the health of the nation alongside other top-level indicators like GDP, which is currently under development.[28]

[25] Clarke: Devo white paper will bring 'more mayors and more unitaries' | Local Government Chronicle (LGC) (lgcplus.com)
[26] https://assets-global.website-files.com/5da42e2cae7ebd3f8bde353c/5dda924905da587992a064ba_Conservative%202019%20Manifesto.pdf
[27] https://www.gov.uk/government/consultations/public-health-outcomes-framework-proposed-changes-2019-to-2020
[28] https://www.ons.gov.uk/releases/healthindexdevelopmentengland

50. However, data and intelligence are not just about measuring objectives, they are crucial tools to inform decision making, as has been shown by the pandemic. To quote ADPH, *"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."* [29]

51. This was also recognised by the House of Lords Public Services Committee and we support its recommendation that, *"Local areas should have the means and autonomy to maintain the data-sharing innovations developed during the COVID-19 pandemic. The Government should set out in the white paper on English devolution how it will support local areas and city regions to adopt new data standards, and how it will invest in common approaches and tools for information governance."* [30]

52. There is widespread support for retaining national surveillance and data collation across all health domains in one place. However, if the health intelligence function is located within NIHP which does not have any health improvement responsibilities, it risks public health issues outside health protection being de--prioritised. Having it located centrally, as part of the DHSC Chief Scientific Adviser's remit rather than NIHP would avoid fragmentation of health intelligence and provide good links with the National Institute of Health Research (NIHR) which is the CSA's responsibility.

53. The question then is about how to link national infrastructure to regional and local needs and what capacity is needed at regional level to make the system work. ASH believes that the strong data and intelligence capacity at regional level in the current system should be retained as this can provide important additional analytical capacity for local authorities and the NHS.

***Recommendations (paras 54-55)***

***54. The PHOF as a shared outcome framework is the right mechanism for embedding joint objectives across the system both horizontally and vertically.***

***55. Data and intelligence should sit together and not be housed within organisations only responsible for part of the public health system such as NIHP. The strong data and intelligence capacity at regional level in the current system should be retained to support flows of data and analysis up from local, down from national and horizontally across the system.***

## Tobacco control as a model

**Question: How could the model for tobacco control be applied for other modifiable risk factors for poor physical and mental health and wellbeing?**

56. The round table demonstrated that there was support for the idea that regional activity can add value for other modifiable risk factors such as sexual and mental health, obesity and alcohol.

57. However, while the regional model for tobacco control has been effective and should be sustained, it was clear that more work is needed to determine the right model for other modifiable risk factors for physical and mental health.

[29] https://www.adph.org.uk/wp-content/uploads/2020/12/A-New-Public-Health-System_-2020-1.pdf
[30] A critical juncture for public services: lessons from COVID-19 (parliament.uk)

58. However, there is an immediate priority to sustain and extend the regional model for tobacco control as the Government has put in place a time limited ambition for England to be Smokefree by 2030. Tobacco control is a long-established and effective model which has been most effective where it has combined:
    - National population level action: regulation, tax rises, population surveillance, national social marketing campaigns
    - Local place-based action: enforcing regulation, providing access to treatment, engaging partners in VBA (very brief advice), social media communication to communities
    - Regional supra-local/sub-national action: targeted social marketing campaigns, enforcement of age of sale and countering illicit tobacco, co-ordinated approaches between NHS and LA to supporting smokers to quit

59. Social marketing campaign delivery is a good example of the added value of a regional tier. Nationally, the Government have run a number of highly successful evidence-based national campaigns to promote quitting. Regionally, some areas have invested in additional campaigns which have been able to cost-effectively complement and enhance the national messages.

60. Regional campaigns can utilise local insights, using imagery and accents which the audience can strongly identify with, earning unpaid media at regional and local level much more effectively than national campaigns can, and supporting local communications activity around co-ordinated messages.

61. At a local level individual local authorities and NHS organisations can amplify paid for national and regional messages and target key communities cost-effectively, engaging partners and seeking their own unpaid media. Working together this communications activity is more than the sum of its parts, each building on the other.

62. The best established and longest-running regional programme is Fresh, the tobacco control office in the North East. Fresh was a regional initiative, established in 2005 with funding from all the Primary Care Trusts in the region, with funding taken over by local authorities on the transfer of public health functions to local government. Fresh was only established as a result of a top-down process, as were the other regional offices of tobacco control.

63. Long term investment in regional tobacco control has had a significant impact. In 2005 smoking prevalence in the North East was much higher than the average for England, at 29% compared to 24% for England, and the disparity was growing. Between then and now the North East has seen the greatest decline in smoking prevalence of any region and smoking prevalence is now only a little higher than the England average, 15.3% compared to 13.9%.

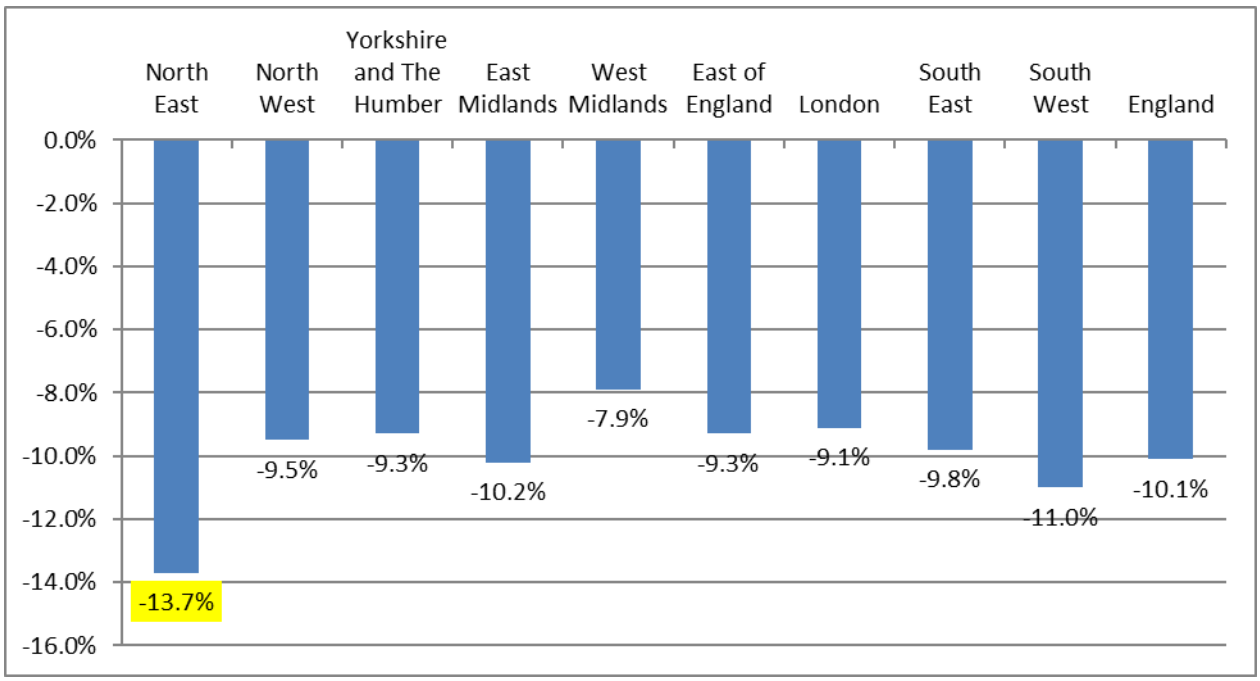
64. Smoking rates have also fallen faster among routine and manual workers in the North East, by 8.6 percentage points since 2012, compared to only 7.9 percentage points for England as a whole. Fresh provides regional social marketing campaigns to motivate quitting, and regional activity to reduce both supply and demand for illicit tobacco, as well as strategic leadership around important issues including implementation of treating tobacco dependency within NHS settings.

65. Where regional activity has been implemented elsewhere, such as the North West, Yorks and Humber and the South West it has similarly enhanced the decline in smoking rates. However, the regional offices in the North West (set up in 2008) and in the South West (set up in 2009) were abolished after the local authorities ceased funding them following the cuts in the public health grant in 2014/15.

66. In the North West GMHSCP has taken on tobacco control as a key population health function and in Yorks and Humber Breathe 2025 still exists though with limited funding. As a result of having tobacco control experts the West Yorkshire and Harrogate ICS and the Humber Coast and Vale have funded media campaigns to encourage quitting in Yorks and Humber (Don’t be

the 1), and the Northern Cancer Alliance funded a North of England anti-smoking campaign (16 cancers), while the North East and North Cumbria Integrated Care System has funded campaigns in the North East (Don't Wait).

**Graph 1: Percentage point decline in prevalence 2005-2019**




67. However, only in the North East has there been a consistent year in year out programme of work since 2005 and nowhere else has equalled the impact of Fresh. Even in the North East securing funding for a regional programme has become increasingly difficult in recent years, with 5 out of 12 local authorities removing their funding leaving only 7 still funding the programme. Programmes like this are not put in place, or sustained, through a bottom up approach, they need support from the top down if they are to be delivered on a consistent, adequately funded basis going forward.

68. The question is complex and the round table discussion showed that the answers are likely to be different for each risk factor. What is clear is that there is a successful model for tobacco control already in place, which should be extended to support delivery of the Government's time limited ambition for England to be Smokefree by 2030.

***Recommendations (paras 69-70)***

***69. Further work is needed to determine the appropriate models for other modifiable risk factors such as sexual and mental health, obesity and alcohol.***

***70. To support delivery of the time-limited Smokefree 2030 ambition as well as reducing inequalities and levelling up, a national commitment of £50 million a year should be made to support tobacco control interventions at regional level. These interventions should include enhancing national activity in social marketing; enforcement and wider tobacco control and smoking cessation outreach into disadvantaged communities by local authorities.***